York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public Meeting)

27 January 2021

York Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

The programme for the next meeting of the Board of Directors will take place:

On: 27 January 2021

In: via Webex

TIME	MEETING	LOCATION	ATTENDEES
8.30 – 9.15	Corporate Trustee Year-end Meeting	Via Webex	Trustees External Audit
09.30 – 10.30	**Board of Directors meeting held in public**	**Via Webex**	**Board of Directors Members of the public**
10.45 – 11.45	Board of Directors meeting held in private	Via Webex	Board of Directors
13.00 – 17.00	IT Session with NHS Providers	Via Webex	Board of Directors

York Teaching Hospital
NHS Foundation Trust

Board of Directors (Public) Agenda

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Apologies for absence and quorum** To receive any apologies for absence.	Chair	Verbal	-	9.30 – 9.40
2.	**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest or to consider any conflicts of interest arising from this agenda.	Chair	A	7	
3.	**Minutes of the meeting held on 25 November 2020** To receive and approve the minutes of the public meeting held on the 25 November 2020.	Chair	B	11	
4.	**Outstanding actions** To discuss any actions arising from the action log.	Chair	Verbal	-	
5.	**Chief Executives Update** To receive an update from the Chief Executive	Chief Executive	C	To follow	9.40 – 9.50

Strategic Goal: To deliver safe and high quality patient care

	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**Quality and Resources Committees** Items for escalation to the Board. • 08.12.20 to receive and note the minutes • 19.01.21 to receive and discuss the Committee Logs • Quality Committee - Oakenden Review Report for discussion	Committee Chairs	 D D1 QC log to follow D2	 21 43 45	9.50 – 10.15
Strategic Goal: To deliver safe and high quality patient care					
Strategic Goal: To ensure financial sustainability					
Strategic Goal: To support an engaged, healthy and resilient workforce					
7.	**Integrated Business Report** To receive and discuss the IBR, highlighting any areas of concern not already discussed or escalated by the Quality & Resources Committees.	All	*Separate Report*	-	10.15 – 10.25
Governance					
8.	**Reflections on the meeting** • BAF	Chair	Verbal E	- 77	10.25 - 10.30
9.	**Any other business**	Chair	Verbal	-	10.30

	SUBJECT	LEAD	PAPER	PAGE	TIME
10.	**Items for information:**	Chair			
	• Continuity of Carer Report		F	97	
	• Medical Directors Report		F1	101	
	• To receive the January 2021 Star Awards booklet		F2	107	
11.	**Time and Date of next meeting** The next meeting will be held on 31 March 2021 via webex.				

Items for decision in the private meeting: - None

The meeting may need to move into private session to discuss issues which are considered to be 'commercial in confidence' or business relating to issues concerning individual people (staff or patients).

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

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Additions:

A

Changes:

Lynne Mellor—Position with BT (telecom suppliers) removed

Deletions:

Director	Relevant and material interests					
	Directorships including non -executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Ms Susan Symington (Chair)	**Non-executive Director—**Beverley Building Society **Director** - Lodge Cottages Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member—**the Court of University of York	Nil
Jenny McAleese (Non-Executive Director)	**Non-Executive Director**—York Science Park Limited **Director**—Jenny & Kevin McAleese Limited	**50% shareholder and Director**—Jenny & Kevin McAleese Limited	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member**—Audit Committee, Joseph Rowntree Foundation	**Member of Court**—University of York	Nil
Dr Lorraine Boyd (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Lynne Mellor (Non-executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Steve Holmberg (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Dillon (Non-Executive Director)	Nil	LLP—Members Representative	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	**Relevant and material interests**					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Prof Matt Morgan (Stakeholder Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Deputy Dean**—Hull York Medical School	Nil
Mr David Watson (Non-executive Director)	Battersea Dogs & Cats Home York University			**Act as Trustee** –on behalf of the York Teaching Hospital Charity		Hull York Medical School via York University
Mr Simon Morritt (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Act as Trustee** Medicinema		Nil
	Other: Member of the Independent Reconfiguration Panel (Independent Committee advising the Secretary of State on contested health service reconfiguration.					
Mr Andrew Bertram (Executive Director Director of Finance/ Deputy Chief Executive)	Nil		Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representative	Nil
Mrs Heather McNair (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr James Taylor (Medical Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mrs Wendy Scott (Chief Operating Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Ms Polly McMeekin (Director of Workforce & OD)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	HR Director—Nightingale Hospital (Yorkshire & Humber)	Nil
Mrs Lucy Brown (Director of Communications)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Dylan Roberts (Chief Digital Information Officer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

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Board of Directors – 27 January 2021
Public Board Minutes – 25 November 2020

Present: **Non-executive Directors**

Ms S Symington	Chair – via video conferencing
Mrs J McAleese	Non-executive Director – via video conferencing
Dr L Boyd	Non-executive Director – via video conferencing
Mr S Holmberg	Non-executive Director – via video conferencing
Ms L Mellor	Non-executive Director – via video conferencing
Mr J Dillon	Non-executive Director – via video conferencing
Prof. M Morgan	Non-executive Director – via video conferencing
Mrs J McAleese	Non-executive Director – via video conferencing
Mr D Watson	Non-executive Director – via video conferencing

Executive Directors

Mr S Morritt	Chief Executive – via video conferencing
Mr A Bertram	Deputy Chief Executive/Finance Director – via video conferencing
Mrs W Scott	Chief Operating Officer – via video conferencing
Ms P McMeekin	Director of Workforce & OD – via video conferencing
Mrs H McNair	Chief Nurse – via video conferencing
Mr D Roberts	Chief Digital Information Officer – via video conferencing

Corporate Directors

Mrs L Brown	Director of Communication - – via video conferencing

In Attendance:

Trust Staff

Dr D Richardson	Consultant (deputising for the Medical Director)
Mr E Smith	Consultant/Care Group 2 Director
Mr A Bennett	Head of Capital Projects
Ms J Southwell	Strategic Capital Projects Manager
Ms S Barrow	Head of Business Development
Ms L Hill	Care Group Manager
Mrs T Astley	Assistant to FT Secretary (note taker)

Observers:

6 Trust Governors
6 Members of the Public

Ms Symington welcomed everyone to the abbreviated public Board meeting at York Hospital. The meeting was held in public via webex.

20/50 Apologies for absence

Apologies were received from Mr J Taylor, Medical Director.

20/51 Declarations of interest

The following new members of the Board were added to the declarations of interest:

- Dylan Roberts, Chief Digital Information officer
- David Watson, Non-executive Director

20/52 Minutes of the meeting held on the 30 September 2020

It was noted that the minutes of the meeting held on the 30 September 2020 were approved as a correct record.

The Board:

- **Received and approved the minutes of the meeting held on the 30 September 2020.**

20/53 Outstanding Actions

There were no matters arising.

The Board:

- **Noted the action log**

20/54 Chief Executive Overview

The Chief Executive provided an update on the following key areas:

Covid-19 update – Mr Morritt stated that the second wave of Covid was expected this week and next. Although the numbers seemed to have plateaued with the exception of Critical Care, the Trust was very busy. Mrs Scott, Chief Operating Officer, will be giving a presentation on this later in the meeting.

Devolution for North Yorkshire and York – The Board has been given to understand that the devolution proposal for North Yorkshire County Council and City of York Council has been submitted. The devolution deal is dependent on simplifying local government arrangements across the county. All stakeholders have been involved in discussions and the government will conduct a formal consultation in the new year.

A new name for the Trust – Mr Morritt stated that the proposed name change for the Trust was 'York and Scarborough Teaching Hospitals NHS Foundation Trust' and was currently engaging with partners, staff and members of the public. The proposal will go the Council of Governors in December and, subject to approval, and the course of the pandemic, the new name will be introduced early in the new year.

Partnerships - Mr Morritt referred to the changes that were happening more widely in the NHS with the development of the Integrated Care System and advised that a document "Accelerating ICS in England" will be published this week which he will share with the Board. It is expected legislative changes will be made in the new year.

Grant to reduce carbon footprint – Mr Morritt stated that the government had made available a £1 billion grant to help reduce carbon footprint and the Trust has submitted a bid for £18 million in total. A more detailed paper will be presented at the December meeting. Mr Bertram added that he should hear something within the next 10 days. It was a great opportunity to help the Trust reduce its carbon footprint and also help deal with some backlog maintenance issues as well.

Covid 19 Presentation – Mrs Scott provided a presentation on the current pandemic situation in the Trust and highlighted the following key issues: -

- Workforce – as of Monday 23.11.20 there was 257 staff absences of which 60 of those was as a result of 'track and trace'. There were challenges around staffing Covid areas, maintaining the elective programme and the out of patient programme, as well as managing the significant challenges around 'track and trace' and staff needing to isolate.
- Long waits and backlog – priority was to see those patients with the greatest clinical needs.
- Productivity – ongoing social distancing restrictions and complying with Infection Prevention Controls (IPC) has had an impact on productivity. The Trust has been trying innovative ways of seeing patients, i.e. Virtually which limit social contact.
- Fatigue, staff burnout and impact on morale – while staff were geared up for wave 1, wave 2 has brought additional anxiety and stressful challenges. Front-line staff are tired, and in many cases are also dealing with associated issues relating to Covid which impact on their lives away from work.
- Space – the Trust is limited with space because of social distancing measures and compliance with IPC rules and have therefore transferred some of its services to Nuffield and Ramsey Hospitals in order to continue to treat patients.
- 3rd Wave – there was a concern that if lock down was lifted, and dependent on which tier each region was put in, there would be a resurgence of Covid in the new year. This needed to be considered.
- Winter – under normal circumstances the winter season was hugely challenging for the Trust. There will be additional challenges dealing with Covid. There are plans in place to seek to manage the challenges ahead.
- Staff testing – the majority of staff will now be routinely Covid tested twice a week.
- Backlog/Associated Clinical Risk and Capacity to Delivery Activity – this will be managed based on the clinical needs of the patient.

- Long Covid – there are ongoing associated health issues with the virus and all ICSs around the country are establishing Long Covid Clinics to support the ongoing health issues associated with the coronavirus.

Ms. McMeekin stated the following: -

- Staff absence had increased during this month from 4.5% to 6.7% and was currently standing at 5.9% (which was "good" in comparison to its partners across the ICS who were reporting absenteeism in excess of 10-11%) 48% of absence was Covid related and 'track and trace' isolation requests is a significant factor. The Trust is trying to mitigate staff absence by having a 7-day PCR swabbing service for the staff. 20-25 staff were being seen per day with a positive response rate of around 20%.

- The Flu Vaccination Campaign currently stands at 62% of front-line staff being vaccinated. Staff absenteeism was having a detrimental impact.

- Referrals to Occupational Health had increased by about 33% compared to the same time last year. Additional counselling sessions, resilience sessions, drop-in sessions have been set up and the Wellbeing Team has been running virtual sessions on how to stay well during the winter period.

- From next week the Lateral Flow Testing kits will be rolled out to enable front line staff to test themselves twice a week. If they receive a positive result then they will be triaged to come to the hospital and have a PCR swab in Pathology to confirm the result.

- Regarding the Covid Vaccination Campaign, more details will be available next month. The Trust has currently been told to use the Pfizer vaccination for front line staff beginning the first week in December.

Mrs McNair commented that it had been hugely challenging on the nursing front but compared to their neighbours in Hull and NLAG who have been really challenged, she gave assurance to the Board the Trust was able to staff wards safely. It continued to be a challenge and will be for some time during the winter months.

Ms Mellor was assured that a lot of effort was being put into the mental wellbeing of staff as discussed in the Resources Committee meeting. She alluded to PPE and spoke about a recent visit to the hospital to see how that was being managed and was assured that this was being well managed. In addition, she asked what plans the Trust had to use the Oxford vaccine as it was much cheaper and did not require the significant refrigeration.

Miss McMeekin stated that the Oxford vaccine had a shelf life of 6 months. It was still a two-dose model. The Trust has been told to plan for the Oxford vaccine to be available from the beginning of January. The government directive was to roll out mass vaccination to NHS staff as soon as possible so Pfizer will initially be used and the Oxford will be available later in the year for the public. Mr Morritt added that it was important to note the pandemic had been reinstated as a level 4 incident and the issues around Covid vaccination was being managed nationally and regionally and the Trust was in receipt of instructions and will respond accordingly.

Dr Boyd asked if there was any change in the number of patients coming to hospital with Covid illness and have higher acuity, compared with the number of patients who were being found to be Covid+ as part of the screening process when they came for other reasons.

Dr Richardson stated that during wave 2 the number of patients being identified with Covid as inpatients was roughly the same as in wave 1 but there was a lower proportion of deaths. In addition, it was noted that there was a higher number of slightly younger patients coming in but this should be taken with caution as wave 2 was still ongoing. Additional spaces have been prepared in the ICU this week. There was a lower number of deaths amongst admissions now which may be in part to the slightly younger age, it might be that people were coming with non-Covid illnesses who were being picked up as part of the testing process and only patients who were very unwell with Covid would remain in hospital and others sent home to isolate so mortality may climb as everybody's illness was played out.

Mr Holmberg stated that in both waves the number of people dying versus the number of people getting into high levels of critical care was quite high which may reflect the cohort of patients not deemed likely to survive critical care admission. He asked if there was any information about benchmarking whether the Trust's profile of deaths to escalated patient care was similar to other hospitals.

Dr Richardson replied that he was in touch with a network of people across the region and the Trust's proportion of deaths during the first wave was very similar to many Trust's across the country. Again, the proportion of patients surviving intensive care was very similar. There was a higher mortality of those patients in ICU as they were very unwell.

A discussion took place around the decision-making process regarding patients entering ICU/HDU. Dr Richardson stated that it was based on a patient's comorbidity and whether a patient could benefit from intensive care. He explained that the majority of patients who needed ventilatory support were receiving it on the Covid wards, so effectively the Trust had expanded its HDU capacity to be the Covid wards and many patients have chosen this as their ceiling of care.

The Board:

- **Received and noted the Chief Executive's Report including the Covid update**

20/55 Scarborough Capital Outline Business Case

Mr Bertram stated that this was the second approval document from a suite of three documents that related to the major capital infrastructure investment on the Scarborough site. Included in the pack was the Outline Business Case (OBC). As a reminder, the first document, Strategic Outline Case, was approved by the Department of Health & Social Care at the start of this year. The Full Business Case (FBC) was due for completion around Spring time next year.

Mr Bennett referred to the upcoming presentation 'Scarborough Hospital Transformation of Urgent & Emergency Care Outline Business Case' which gave an overview of the very detailed OBC and the scope of the project together with the options within and the financial elements together with recommendations that required Board approval today.

Mr Bennett spoke about the two main strategic objectives and the management arrangements. He spoke about the competitive procurement process that took place for an Integrated Design Team and gave an overview of the companies who were successful. He also spoke about the tender for a Principal Supply Chain Partner (PSCP) which was concluded last Friday and the successful bid was from Integrated Health Projects (a joint venture between Sir Robert McAlpine and Vinci Construction UK) for which he was seeking Board approval today. He referred to the programme timeline and stated that he was confident this could be improved and gave the Board assurance that this was what he was aiming to do.

Ms Southwell presented the Board with the 4 options available and was informed that both option 2 and 3 were within the affordability of the original Strategic Outline Case. Option 4 had an augmented funding request of £10m due to the fitting out of Critical Care on the first floor and this was the preferred option which required Board approval today.

The Board was assured that discussions had taken place with all stakeholders regarding priorities for the site. The infrastructure priorities were discussed and the first 4 out of the 8 priority packages were deemed essential. The other 4 priority packages will be carried out if and when more funds became available. The presentation then moved on to the Site Development Plan, the key features of the Acute Medical Model and patient flow within the area.

Ms Barrow spoke about the financial/economic cases of the business case. Option 4 resulted in the most value for money resulting in a Benefit Cost Ration (BCR) of 4.04 in line with the value for money threshold and it was also ranked first above all the other options. If the Trust's capital funding was restrained and it needed to work within the £40m envelope then the preferred option would be Option 2 which had a BCR of 2.64.

Ms Barrow then moved on to the summary of economic analysis and how this supported the chosen options. She then gave an overview of the financial case for Option 4 and a summary of the revenue implications. She advised that the scenarios and the revenue implications of all the options had been shared with the CCGs to enable the letter of support that was required as part of the business case submission.

Ms Symington thanked the team for such an informative presentation and asked for any questions.

Mr Watson asked if the team had spoken to any other trusts who had done similar builds and what lessons we could take from them. Ms Southwell explained that the team had visited 5 different hospital sites across the country who have had new builds either of a critical care nature or an emergency department. In addition, the PSCP that was chosen were currently undertaking 19 emergency departments across the country. She assured the Board that the team was very passionate about the project and was very conscious about stretching the budget as far as possible. Mr Dillon added that he was involved in the Project Board and was involved in the PSCP interviews on Friday. He assured the Board that the process was very robust and was entirely confident with the chosen contractor. He believed the new build would become a Centre of Excellence and it would solve the recruitment/retention issues in Scarborough. It would also give a strong message to the local community of the direction of travel for Scarborough Hospital.

Mrs McAleese wanted assurance that the Scarborough Mortuary will be addressed. Ms Southwell confirmed every penny that is saved will be for that ambition. She gave assurance that if they can deliver it then they would.

Mrs McAleese referred to the number of teams involved in the project and although she was assured that it had been through a thorough process, she wanted assurance that it was future proof. Dr Smith gave assurance that this had been the direction of travel for the site for a significant time and reflected the majority of clinical views moving forward. The logic to the second floor was to move services out of the part of the hospital that was not fit for purpose.

Mr Holmberg asked if the clinical case could be made much stronger for the preferred option 4. He also asked if Mr Bertram was the responsible Director at Board for this project? Mr Bertram confirmed that he was the responsible Director at Board. He explained that the Trust had a £40m fund which needed protecting and would deliver option 2 whilst having extensive discussions with NHSE/I on where the extra £10m would come from to deliver option 4. It was unlikely that the Trust would receive national support but this has had its first airing with the Department of Health & Social Care Capital Cash Team who will be discussing this with the Treasury and they were really keen to help the Trust find a way through this. At the moment the Trust was engaged in a piece of work with NHSE/I, supported by ICS colleagues, to ascertain whether the £50m budget could be reduced. On the assumption that the budget could be reduced to £46/7m they were looking at whether the funds could be obtained locally. Both Mr Bertram and Mr Morritt were currently in discussions with the ICS to help the Trust to meet the difference. He agreed that the wording in the business case could be modified to make a stronger case for option 4.

The Board:

- **Approved the Option 4 business case.**
- **Approved the mandate to proceed with the Full Business Case.**
- **Ratified the appointment of the PSCP, IHP.**

20/56 Quality & Resources Committees – Items for escalation

Resources Committee – Mr Watson highlighted the following:

- Concerns about underlying risks on the corporate risk register not being properly reflected on the BAF. There seems to him to be a disconnect. The Committee have asked management to have a look at this. In a follow up, Mr Watson had a conversation with Ivan Le Roux and this was something he had also identified.
- Concerns around IT/digital capacity and single points of failure within key systems on the personnel side. Additional funds/resources were most likely required and Mr Bertram, Finance Director, has benchmarked the Trust's IT spend against the model hospital data with the expectation that it might highlight the financial support that was required.

Quality Committee – Mr Holmberg highlighted the following:

- the CQC had stopped asking for regular reviews of nurse staffing which the Trust has interpreted as an increased confidence in the Trust's Nursing Workforce Programme.
- Concerns were raised regarding medical staff compliance with statutory and mandatory training and adequate job planning for 7-day services, particularly in Scarborough.
- Further assurance was required around decision making and priorities for treating patients. The executives have been asked to provide the Committee with ongoing assurance that the right patients were being prioritised.
- The Board was asked to consider BAF risk 10 regarding partnership working in light of work with the ICS and other partners.

The Board:

- **Noted the items escalated from the Committees**

20/57 Reflections on the Meeting

The Board agreed there was some high-quality conversations today.

Ms Symington informed the Board that there will be an abbreviated Board meeting in December.

20/58 Any other Business

Questions to the Board – Ms Symington stated that because of time restraints she did not propose to read the question and answer at the meeting but wanted to ensure that the Board had read it and was satisfied that this was the correct answer in their opinion.

The Board:

- **Noted the question and agreed that the answer was correct.**

No further business was discussed.

20/59 Items for Information

Ms Symington referred to the Integrated Board Report (IBR) and advised it was currently in that section whilst a discussion took place on how it will be treated within the Committees.

20/60 Date and Time of next meeting

The next public meeting of the Board will be held on 27 January 2021 via Webex. Details TBC.

Outstanding actions from previous minutes

Minute No. & month	Action	Responsible Officer	Due date
19/68	Consider in discussion with new CE, PCN presentation to board. Consider in 2021 after April.	Ms Symington	~~Oct 19~~ ~~Jan 20~~ ~~Jul 20 review~~
19/93	Mortuary to be kept under review on the action list.	Board	Until completed
20/11	Report front sheets to include items of real concern for Board discussion together with actions to address the concerns.	All	Feb 20 - ongoing
20/25	Invite Dr Jayagopal to provide an HYMS update to the Board in December 2020	Mrs Provins	Dec 2020
20/26	Clever Together feedback to the Board	Mr Morritt	~~Sept 2020~~ Oct 20 time out
20/40	IPC Presentation (every 6 months)	Mrs McNair	Mar 21

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Quality Committee Minutes – 08 December 2020

Members in attendance: Stephen Holmberg (SH) (Chair), Lorraine Boyd (LB), Heather McNair (HM), Jenny McAleese (JM), Wendy Scott (WS), James Taylor (JT), Lynette Smith (LS), Caroline Johnson (CJ), Rhiannon Heraty (RH) (minutes)

Attendees: Ivan Le Roux (ILR), Donald Richardson (DR)

Apologies for Absence: Lynda Provins (LP)

1. Welcome

SH welcomed everyone and declared the meeting as quorate.

2. Declaration of Interests

There were no declarations of interests declared.

3. Minutes of the meeting held on 17 November 2020

The minutes of the last meeting held on 17 November 2020 were agreed as a true and accurate record.

4. Matters arising from the minutes and any outstanding actions

Action 66 - JT gave a progress update and confirmed that any decisions regarding changes in treatment are being recorded, noting that this is a variation from normal cancer pathway decision-making practice. The Committee discussed the impact this may have on patients and noted no negative feedback to date although there are a large number of complaints regarding appointment delays and lack of communication. The Committee noted the likelihood of a delayed excess mortality spike over five years for cancer. There was discussion around whether we have a statement to support our decision-making and WS agreed to circulate the Trust's SOP that was written for the first wave for clarity.

Action 73 – JT confirmed this is regularly discussed in various meetings and that GP colleagues receive weekly data updates. The Committee agreed to close the action and that the Chief Operating Officer Report would include updates as we move through the phases of our restoration plan.

5. Escalated Items

There were no items escalated from the Board or other Committees.

Focus on Risk

6. Executive Reports

To receive the following updates on risks and related issues including any Covid-19 updates:

Chief Operating Officer

Performance Update:

LS gave an overview of the report, noting that item 2.2 should read November Actual rather than October Actual, and identified key figures as follows:

The Trust Emergency Care Standard is 83.5% and includes seven 12-hour breaches (the first cases since the start of the pandemic, all on the SGH site).

60-minute ambulance handovers are at 26 compared to 476 in November 2019. The Ambulance handover plan on both sites is being reviewed.

Non-elective paediatric admissions are down by 54%, which is being monitored through the Children's Board.

67.5% of patients on our waiting lists have waited less than 18 weeks for treatment, which is an improvement but there is a back-ended waiting list on which 2250 patients have waited over a year as of November. Our surge plan forecast was 2676 patients so we have treated more patients than anticipated.

We are still being monitored and regulated against our phase 3 plan and we have over-performed for November in all areas except ordinary elective care.

The Committee discussed the significant challenges we may face in January as a result of the completion of the IS contract being brought forward to 24th December and the repatriation work that is being done to move all IS work onto the YH site by this date. The contract will change in January but we will not have access to the same range of specialties.

The Committee noted that across HCV, all Trusts have been asked to review their phase 3 plans and provide a narrative around risk to delivery going forward. We have been asked to plan for a third wave from 14th January to the end of February and to refresh our current surge plans in anticipation of a super surge.

Chief Nurse

- ### Infection Control Risks

HM gave an overview of the report with a focus on the Covid-19 outbreaks. There have been three outbreaks on the SGH site that confirm nosocomial infection and HM confirmed she would circulate a paper to the Committee members with a detailed breakdown of figures. HM identified PPE breach and frequency of staff movement between wards as an IPC issue and noted that there is higher footfall between wards than there was in the first wave.

The Committee discussed the risk of nosocomial infection and current transmission rates compared to the first wave (23% and 15% respectively) and noted the possibility that there were more cases of undetected nosocomial transmission in the first wave and the SGH outbreaks largely contribute to the current rate.

DR confirmed he had gone through the SGH outbreak cases in great detail and reviewed clinical records, Medical Examiner notes and death certificates to ascertain whether Covid-19 was incidental or the cause of death. DR confirmed that out of all the deaths as a result of the SGH outbreak, 3-4 were directly due to Covid-19 and approximately 13 were incidental where the patient may have had metastatic cancer and been discharged to either hospice or palliative care but their death was hastened by Covid-19.

SH agreed to escalate this to the Board of Directors and HM agreed to update the paper with more detail for escalation.

DR gave the Committee assurance that the IPT team are re-affirming the PPE policy, software has been updated to alert downstream ward staff if a paired patient tests positive so that they can isolate immediately, and that routine swabbing at day 5-7 has now changed to a repeat swab at day 3 if the patient tested negative on admission.

The Committee noted that the SGH outbreak is being treated as an SI and that NHSE/I have requested our 72-hour reports as a result of two further SI's being declared in ED w/c 7th December. There was a discussion around whether the Board of Directors needs a broader picture of events for context rather than escalating isolated issues as there are concerns around staffing and quality of care in general.

SH asked if there was information around the number of MSSA infections that were related to medical interventions or were due to lapses in care. HM noted that the Trust was unusual in not having an IV-line team.

Action: HM to update IPC report with further detail for escalation to the Board of Directors

Action: HM to include MSSA data in next IPC report

- ### CQC Report

CJ gave an overview of the report and the Committee noted the positive progress to date, specifically around mental health and paediatrics, including each site now having a clinical

risk assessment tool in place and the shortlisting of two PEM Consultants. The Committee approved Appendix 5 being shared with the CQC.

There was a discussion around whether the report is losing value as an assurance document whilst also recognising its utility as a management tool. CJ gave the Committee assurance that the Quality & Regulations Group is self-assessing against our transitional regulatory framework to identify probable CQC issues that the Committee needs to be aware of. HM noted that there are areas not listed on the report that the CQC may flag and the Committee agreed to discuss potential risks in greater detail at the next meeting.

- **Continuity of Carer in midwifery services**

The Committee noted the progress outlined in the report and no further action was required.

- **Patient Experience Report**

The Committee noted the paper and discussed the possibility of a more condensed format going forward, such as papers going through the Quality & Patient Safety Group (QPAS) first to identify assurance issues to be escalated to the Committee. SH suggested that a 5-10 page report might be an optimal length with any supporting material included as appendices.

The Committee commended the Covid-19 work but identified the consistency of complaints around nighttime noise and clinical staff attitudes. There was a discussion about whether there needs to be more focus on clinical staff attitude as a whole rather than just nursing and CJ confirmed she and Tara Filby are working closely on combining QI work and patient experience. The Committee also recognised the need for collaborative working between the Patient Experience Team and clinical staff and noted that improvement work has lost momentum due to Covid-19.

- **Pressure Ulcer Report**

HM gave an overview of the report and gave the Committee assurance that this area is now being given the attention it needs as it is a significant concern.

The Committee acknowledged the significant pressures that the Community Teams are under, including the pandemic as a whole, primary care support and soon the Covid-19 vaccinations, and that they often do not get the recognition they deserve. It was noted that the Perfect Ward app provides more insight into both pressure ulcers and falls but that there is not enough data yet.

- **Falls Report**

HM gave an overview of the report and noted that falls are inevitable so the focus is around getting the assessment right at the outset and minimising risk where possible. The

Committee agreed that, for assurance, harm and avoidable harm needs to be effectively highlighted and improvements must be identified and reported.

- **Maternity Safety Standards Report**

HM gave an overview of the report as a patient safety initiative and confirmed that it was discussed at the Executive Committee on 2nd December and costings were approved. The Committee noted that we are currently an outlier for regular scanning of high risk patients and acknowledged sonographer staffing as the biggest challenge. HM assured the Committee that there is a plan in place to train midwife sonographers and noted the qualifying timescale of 9 months.

- **Dementia Report – for information**

HM gave an overview of the report and assured the Committee that an overarching strategy is in development. JM raised her concerns that there are no current resources considering our patient profile and there was a discussion around whether this should be escalated as an area of vulnerability that the CQC could flag as a concern. The Committee discussed the importance of the Board knowing where gaps in our resources lie. CJ agreed to include this in the next CQC report as well as the current lack of a nutritional nurse and the Committee agreed to escalate this to the Board of Directors once the strategy is confirmed, which is expected to be January.

Action: HM to bring a dementia update to the April Committee meeting

Medical Director

- **Medical Director Report**

The Committee noted the improvement on the SGH site around SAFER and 7-day services and formally acknowledged the excellent achievement that our stroke service was A-rated for the last quarter despite only having two stroke physicians and the pandemic pressures. JT commended the full stroke team for undertaking additional training and extended roles and the Committee acknowledged this work.

JT assured the Committee that he is involved in conversations to ensure continued improvement around Duty of Candour and noted that overall, compliance is improving albeit slowly. The Committee received assurance that Ed Smith (Care Group Director, CG2) is looking at ways to improve IPC on the SGH site and discussing social distancing issues and the outbreaks at their Care Group Quality Meeting. The Committee received assurance of good compliance with the use of SDEC on the SGH site, with 19% of patients being treated in ED through SDEC (compared to 12% on the York site) and 74% of these patients being discharged. This shows growing evidence of appropriate risk assessments being used at the front door, managing patients appropriately on the same day and avoiding admission. In addition, the average length of stay for elderly medicine has improved from 11.3 days to 8.4 days (Oct 2019-Nov 2020) and other specialties are also showing improvements in flow at the front and back door.

The Committee discussed the two SI's detailed in Appendix 1. JT and DR confirmed plans to meet with ED for assurance that system improvements for overcrowding take place re SI 2020/12712. The Committee raised concerns around SI 2020/14756, specifically around the consultant's competency, and requested assurance that patient safety is not being compromised further. JT assured the Committee that an audit of the consultant's work is being done in line with clinician guidance.

- **Quality Improvement Report**

CJ gave an overview of the report and the Committee acknowledged this as a positive piece of work about empowering frontline clinicians to improve and promoting a positive culture change. The Committee agreed that it was important to promote a collaborative, inclusive approach. JT confirmed he was ready to advertise for a QI clinical lead consultant to work across both York and SGH and CJ confirmed a Quality Improvement Matron post will also be created from an upcoming vacancy.

- **Quality & Patient Safety Group Minutes**

The minutes from QPAS were received by the Committee. The Committee noted that this is a newly-formed group that will strengthen as it continues, and that the expectation is for it to escalate issues to the Committee for assurance or lack of assurance.

- **Clinical Risk & Oversight Committee Minutes**

The Committee received the minutes from the Clinical Risk & Oversight Committee. The Committee noted its concerns that the meeting seemed more focused on information sharing rather than outlining key actions around prioritisation issues and providing assurance on this.

There was a group discussion about whether this meeting is time-limited, and the Committee agreed that it likely was but there is still approximately six months of work on clinical validation of waiting lists and some challenging work around clinical prioritisation.

Action: JT to incorporate an action log into the Clinical Risk & Oversight Committee

Action: JT and ILR to discuss ways to improve the functionality of the Clinical Risk & Oversight Committee

- **Board Assurance Framework Review**

The Committee agreed to review the BAF in January and ILR confirmed that he would bring the revised Corporate Risk Register to the Committee in February.

Action: ILR to bring revised CRR to February Committee

- **Corporate Risk Register Review Report**

The report was received by the Committee for information and no further discussion was required.

Focus on Governance and Policies

8. Consideration of items to be escalated to the Board or other Committees

The Committee agreed the following items for escalation:

- SSNAP data getting 'top marks' for our stroke service
- Concern about Scarborough re CQC in terms of Covid-19 outbreak, 12 hour trolley waits and SI's
- Change in therapies for cancer patients due to long waits and limited theatre times
- The challenges of running Covid-19 and non-Covid-19 services simultaneously and the associated risks around 2nd Covid-19 wave in terms of nosocomial infection/staff exhaustion

9. Any other business

The Committee noted the PMRT report for information and assurance as a regulatory requirement, and HM and SH agreed that more in-depth discussion is required around maternity services.

10. Time and Date of next meeting

The next meeting will be held on 19 January 2020 at 1pm by teleconference. Dial-in details will follow.

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
27/11/19	4.	JT to consolidate information streams from multiple external sources into, & within the Trust.	JT	Jan 21 (Q4)
18.08.20	42	HM to bring the ward establishment review back in November 2020 – this needs to go through Executive Committee first	HM	Jan 21

18.08.20	43	JT/CJ to provide update/feedback from Risk & Oversight Committee	JT CJ	Ongoing
18.08.20	45	TF to discuss Estates & Facilities involvement around Inpatient Survey at next LLP Management Group meeting and provide update to Committee	TF	Jan 21
22.09.20	49	JT to bring sepsis report to Committee in c.4-6 months - date to be confirmed once data received	JT	TBC
22.09.20	52	HM to bring accreditation process report which relates to the Perfect Ward	HM	Feb 21
22.09.20	53	HM to bring nutrition report priorities to December meeting for discussion	HM	Jan 21
22.09.20	54	CJ to provide monthly update on patient reporting and reviews	CJ	Ongoing
20.10.20	57	HM to bring IPC audit results to next Committee meeting	HM	Completed
20.10.20	59	JT to bring update on antimicrobial stewardship re IPC control risks	JT	Jan 21
20.10.20	62	HM to bring quarterly complaints report to next Committee meeting and look at more granular presentation of complaints data on IBR	HM	Completed
20.10.20	64	HM to provide Continuity of Carer action plan at next Committee meeting	HM	Completed
20.10.20	65	HM to bring audit report and results on why we are an outlier for post-partum haemorrhage to Committee	HM	Jan 21
17.11.20	66	JT to discuss principles around the governance of decision-making and offering alternative treatment to surgery whilst surgical capacity is limited with colleagues	JT	Completed
17.11.20	67	LS to raise governance and decision-making principles at Cancer Delivery Group	LS	Jan 21
17.11.20	68	Steve Reed to be invited to a future Committee meeting to lead on a community services discussion	LP	Completed
17.11.20	69	HM to include a quarterly Legionella update in the IPC report	HM	Jan 21
17.11.20	70	HM to provide a quarterly update on C Diff progress against actions	HM	Jan 21

17.11.20	71	SH to email Dylan Roberts about prioritisation of new Cancer Information System	SH	Completed
17.11.20	72	WS to speak to Yvonne Elliott about capturing patient harm across the system	WS	Jan 21
17.11.20	73	JT to discuss Trust flagging of delayed patients with GP surgeries and update Committee once he has discussed in detail with GP colleagues	JT	Completed
17.11.20	74	JT to update Committee on where patient harm (cancer and psychological) is being discussed	JT	Feb 21
17.11.20	76	HM to provide whistleblowing outcome update in CQC report	HM	Jan 21
17.11.20	77	CJ to provide an update on SI trends and incident report improvement work	CJ	Jan 21
08.12.20	78	JT to incorporate an action log into the Clinical Risk & Oversight Committee	JT	Jan 21
08.12.20	79	JT and ILR to discuss ways to improve the functionality of the Clinical Risk & Oversight Committee	JT ILR	Jan 21
08.12.20	80	HM to bring a dementia update to April Committee *Update: Work on this has started with a plan to do some engagement in Q4 to refresh the strategy and then launch in Dementia Awareness week May 2021.*	HM	May 21
08.12.20	81	HM to include MSSA data in next IPC report	HM	Jan 21
08.12.20	82	HM to update IPC report with further detail for escalation to the Board of Directors	HM	Dec 20
08.12.20	83	ILR to bring revised CRR to February Committee	ILR	Feb 21

Resources Committee Minutes – 8 December 2020

Attendance: David Watson (DW) (Chair), Lynne Mellor (LM) Jim Dillon (JD), Andrew Bertram (AB), Polly McMeekin (PM), Delroy Beverley (DB), Dylan Roberts (DR), Penny Gilyard (PG), Malcolm Veigus (MV), Mark Steed (MS), Lynda Provins (LP), Joanne Best (minute taker)

Apologies:

The following staff were stood down from attending due to the Covid 19 situation: Graham Lamb, Steven Kitching

1. Welcome

DW welcomed everyone to the Resources meeting and declared it quorate.

2. Declaration of Interests

There were no changes to the declarations and no one declared any conflicts of interest arising from the agenda.

3. Minutes of the meeting held on 17th November 2020

The minutes of the meeting held on 17th November 2020 were approved as a correct record once the following amendments are made.

LM – Page 13 of the pack – Action PM to be noted under the following paragraph.

‘LM referred to Page 20 of the IBR stating it was reassuring a workshop ‘Understanding and Maintaining Resilience’ had been designed with 126 people already booking on to it, also asking if there is concern for the additional pressures on Occupational Health and individuals supporting staff dealing with mental wellbeing’?

LM – Page 17 of the pack – Action DR to be noted under the following paragraph.

‘Data protection officer and senior risk officer report should be split into a number of key risks on the RAG’.

4. Matters arising from the minutes and any outstanding actions

DW stated his preference to reduce the volume of minutes produced for this meeting and moving forward the focus will be to record challenges made and matters arising from discussions.

AB confirmed previous reviews have suggested minute should focus on the challenges made; the Committee agreed this is a positive move.

Action Log:

Item 4 - Minutes from committees reporting into Resources Committee to highlight items for escalation or be FIO – LP stated the new Terms of Reference and work programme will be presented at the January meeting.

DW stated Sue Symington's intention is to Chair a regular meeting involving the Chairs of the Resources Committee, Quality Committee and Audit Committee suggesting this would be a good forum to review the Terms of Reference to ensure Committee alignment.

Action: LP

Item 15 - To submit a report on the CDIO initial recommendations – DR confirmed a comprehensive report will be submitted on a bi-monthly basis.

Item 18 - BAF – LP to discuss with DW – on going.

DW told the Committee, Ivan Le Roux had been appointed on a six month temporary contract to support the management of risk processes. Following Ivan's presentation to the Audit Committee he confirmed one of his key tasks is to tie together the CRR and the BAF. Ivan's name to be noted against item 18 with an action time for February.

Action 18.1: JB

Item 19 - LP / PG to discuss committee dates / LLP report submission – LP confirmed Resources Committee and Board dates will not change.

DW asked DB how this issue will be addressed?

DB confirmed data required for this meeting is not able to be processed in time to meet the required report submission dates.

DW asked if it would be possible for the LLP to run reports at an earlier date?
PG confirmed the issue relates to the ability to process data through the Trust's system and analysing trends. She confirmed although challenging the submission dates are generally achieved as the data is available for 12/13th of each month, but as the December Committee was earlier than usual, the LLP have not been able to provide appropriate data to support the level of assurance required by the Resources Committee.

DW acknowledged the December meeting is a week earlier than usual and his intention to discuss the frequency of the Resources Committee later in today's meeting.

DW acknowledged the pressure to produce the required data but noting the Committee would rather receive incomplete current data rather than the previous month's data.

5. Executive Reports

YTHFMLLP

DB stated JD and LM had attended a LLP virtual meeting and received a presentation on the progress and transformational changes with regards to Compliance & KPI's, allowing them the opportunity to speak with managers and hear first-hand the work that is underway within the LLP and Facilities Management Team.

Compliance Report - PG gave a brief overview of the submitted Compliance Report highlighting the continued positive trend with an additional nine KPI's reported for November and an additional eight KPI's recorded at green.

PG stated both catering hygiene audits and ground condition audits on all three sites have delivered a green result for the first time but confirmed some areas require further focus. The rise in sickness absence was highlighted which correlates to seasonal changes and the rise in Covid cases and has impacted on the KPI reports. A breakdown of this non Covid / Covid related absences will be included in the January report.

Action 26: DB / PG

PG confirmed although food waste remains an issue there had been some positive improvement, also noting the reduction in compliance of Health and Safety Induction training will be explored further.

JD stated that the progress made in the previous 6 months is outstanding and a complete tribute to the LLP team who have grasped the importance of getting things right and acknowledged the hard work to ensure the message is not just shared by management level but noting strong evidence that front line staff had taken this on board ensuring they are getting it right, especially in catering and cleanliness.

LM confirmed along with the positive results which are being submitted to the Committee the energy and change of culture from the LLP team is fantastic, noting the positive attitude from staff is supporting these results.

LM acknowledged PG will be submitting a more detailed report next month including the split in Covid / non-Covid related sickness rates / food waste data and asked updates be included for general waste across the hospital and an update on the CAFAM system.

Action 27: PG/ DB (updates for general waste and CAFAM system)

PM noted Covid related sickness absence for the LLP is 17% which is much lower than the Trust's Covid related an absence which is 26%.

DB stated sickness management has been highlighted as an objective on all employee appraisals, the aim is to create a sickness performance clinic which will give management and staff the opportunity to explore issues/causes and how to address these in a proactive way.

PM suggested DB access the staff survey results to support development of the above clinic.

Sickness Management absence - MV stated best practice is being explored not just across LLP functions but across estate function inside NHS Trusts with the aim to develop benchmarking for a range of areas including sickness management. He discussed preventative processes which are being used by other Trust's to support staff continuing to work when there may be issues, e.g. accessing physiotherapy. Further investigation is required.

Domestics Transactional /Transformational Changes - MV stated tablets are being used on wards in York to provide real time data for front line staff allowing access to exact requirements, noting the tablets are linked to a symbiotic system for audit purposes and to supports accurate completion of tasks.

In Scarborough managers are working directly with their teams, tool box talks take place first thing each morning along with management checking in with staff throughout the day to review requirements supporting smarter working but confirmed this is not a long term option.

Additional tablets will be purchased and used on the York site in the first instance with the intention of rolling them out across the whole estate in the interim period before the CAFAM system is implemented.

LM asked MV for clarity on insight obtained from the tablets which will support the LLP, patients and staff.

MV explained the data used is similar to symbiotic with on screen instructions which highlight different cleaning options and checks, e.g. shower areas, checking mirror condition, cleanliness of taps, level of staining on floors and asking if they could be cleaned or if it is general wear and tear. Checks are undertaken by the audit team which has raised some issues which will be investigated further and shared with the Committee in the New Year.

LM, noting the two different processes for York and Scarborough sites, would like to see the actions taken from the data on both sites included within the report.

DW asked MV to clarify the issues with the audit team and who the audit team is?

MV confirmed feedback data received from staff on all site is being analyzed, acknowledging work is being managed more closely there had been reports from individuals who feel they are not able to perform any better. MV gave an example of an issue which is under investigation.

AB confirmed the Cleanliness Monitoring Team who undertakes these audits are Trust employees and a new addition to the finance team under the management of Sarah Barrow, their aim is to support by monitoring service delivery.

MV confirmed he will be meeting with Sarah Barrow to discuss a collegial way of working.

Action 28: MV

DW asked for an explanation as to what food waste is being referred to in the updates.

MV discussed the range of foods which are included in food waste noting the different production processes for both York and Scarborough sites. Update to be included in the next report.

Action 29: MV

JD noted a discussion had taken place at a previous meeting covering the introduction of tablets to support less waste and asked for an update.

MV confirmed he had contacted both the charity group and IT who have indicated there maybe some tablets which are currently being used on wards which could be made available in the future.

MV stated a successful bid had been made to the Charity to support the development of the wellness garden located next to Ellerby's and once this process is complete, he will request funding for tablets.

LM stated to maximize and enhance experience for patients and staff from both the Trust and the LLP there needs to be an integrated solution to access the use of tablets.

DR confirmed initially a large number of different tablets with a mix of software/security packages had been donated from several charities, there were primarily for patient use, but he agreed moving forward an integrated solution is required.

Culture Work - DB stated a comprehensive action plan which includes positive interventions to address the findings of the ACAS report had been developed noting generally the suggestions had been received positively. Future updates will be shared with the Resources Committee.

LM referred to page 27 of the LLP Report asking for clarity on the mandate of the workshop facilitator Dean Royles and asked if his report will be shared with the Resources Committee.

DB confirmed Dean Royles had completed his report along with an action plan which will be taken forward by the appropriate management team within the LLP. He confirmed the findings from Dean Royles will be combined with the ACAS report to produce a single action plan which will be shared with the Resources Committee.

Action 30: DB

DB confirmed Dean Royles' appointment had been made following concerns highlighted by the CQC / anonymous letters.

PM gave an overview of the origin of cultural concerns within the LLP which were highlighted by the CQC, confirming the Trust appointed ACAS to review the situation last year and their report was received by the Trust in April 2020. Subsequent to this Occupational Health and the CQC have raised concerns which has prompted Dean Royles to be commissioned with a diagnostic approach with his report to include how improvements could be implemented. His high-level report is currently being reviewed by the LLP who will produce a "smarter" action plan. PM confirmed she is the conduit

between the CQC and the LLP and will ensure implementation of the required actions to support cultural changes moving forward.

PG assured the Committee the action plan will evidence improvements as they are implemented, noting a number of historical issues will be addressed within the next 12-18 months with the expectation it will take a minimum of 3 years to achieve compliance.

MV discussed video blogs which the LLP teams have been producing; these will be shared within the organisation.

DW referred to page 26 of the LLP report which refers to ongoing employee relations cases being challenged by Trade Unions along with ODIL team engagement and asked if it would be possible to include these within one single action plan which covers all cultural issues.

DB confirmed a workshop had been arranged involving Trade Union representation which will explore building positive relationships when addressing difficult and challenging issues. Once this has been completed DB will review.

Action 30.1: DB (review data following workshop)

PM confirmed due to the Covid pandemic there had been a national agreement with the NHS and Health Service Unions to pause non-essential and non-urgent employee relations activity. The perception is this may not always have been adhered to. PM will discuss outside the meeting if necessary.

DW asked DB to highlight the main action points as the interlinking cultural changes are moved forward.

DB stated the LLP's focus is to transform culture whilst working proactively with the Trade Unions to gain support during the implementation of these improvement.

LM referred to the flu vaccination programme noting currently only 37.4% of LLP staff have been vaccinated and asked what the plan is to achieve the 90% target for all front line staff to be vaccinated? Also asking if the plan is for the Covid vaccine to be delivered LLP staff.

PM confirmed flu vaccination compliance within the LLP had improved on previous years and is at 40.9%, noting vaccination clinics supported by Occupational Health have received poor attendance. The Trust will continue with the flu vaccination programme although advice is to conclude it prior to commencement of the Covid vaccination programme.

PM confirmed NHS staff have not being prioritised to receive Covid Vaccinations, the planned recipients for the initial vaccine are the over 80's and discussed the Trust's plan to manage these vaccination through outpatient clinics as from next week. The challenge will be to ensure the second dose of the vaccine is given within the correct time period to ensure 95% effectiveness. It was noted that the vaccine's fragility makes it hard to be administered in the community and, as a high number of the over 80 year old require patient transport to get to outpatient clinics, this may prove problematic. It is expected NHS staff will be vaccinated early in 2021 through vaccination hubs on both Scarborough and York sites only due to the vaccine storage issues.

LLP's Health and Safety Policy- PG asked the Committee to note the LLP's Health and Safety Policy had been reviewed and approved by their management Board.

Items to be escalated to Board

- LLP progress in respect of KPI's
- Cultural issues PM lead liaising with CQC / positive changes
- Flu / Covid Vaccination Campaign

DB, PG, MV left the meeting.

Finance

AB told the Committee the Trust reported an I&E balance at the end of month 8 against a planned deficit of £1.5m delivering a positive variance against the plan submitted to NHSE/I of £1.5m. Although the trend shows the Trust is performing better than plan income was £0.3m behind plan for November.

Covid Spend - AB confirmed the Covid spend for November was £1.6m which continues to be marginally less than anticipated, noting this may fluctuate if Covid spikes occurs.

Cash - AB confirmed the Trust's cash position is similar to last month reporting a cash balance of approximately £60m with no material fluctuations within month.

AB discussed concern relating to the current advance payment scheme which will cease at the end of this financial year, noting no national directive had been issued by NHSE/I.
He stated the Trust's cash position is positive and, if the April advanced payment is withheld and measures taken to slightly slow payments, the Trust cash flow model indicates there should be no major liquidity issues.

Capital - AB confirmed the Trust's Capital programme is tracking to plan as at the end of month 8, but highlighted as only 1/3rd of the programme was spent in the first 2/3rds of this financial year there will be a significant spend during the final four months. AB confirmed the risk had been highlighted to the Board.

BAF / CRR

- Delivery of the Trust plan
- Delivery of the system plan

AB gave a brief overview of both noting spend is monitored daily, confirming everybody within the Trust's ICS is either on plan or performing slightly better than plan.

Items to be escalated to Board

- Month 8 position
- Lack of resolution to April cash flow position
- Capital – major spend in final 4 months of financial year

LM asked AB the following questions;

Capital Spend, referring to the significant capital spend required for the final 4 months of the financial year, is there a plan which will assure the Board the target will be achieved and is any further support required from the Board?

Covid vaccine, who will be responsible for costs incurred by the vaccination programme?

Brexit, are there any issues in relation to the supply chain?

AB told the Committee the Capital Spend Executive group has offered assurance the anticipated spend is on plan, although this will be reviewed early in the new calendar year.

AB confirmed the vaccination programme will be funded by NHSE/I.

AB confirmed the Trust is not able to stock pile goods, highlighting there is no National agreement at the present time with regard to Europeans who require access to NHS Accident and Emergency services as of 1st January 2021.

Workforce

Staff absence - PM confirmed absenteeism in the Trust had improved significantly reporting 4.8% absenteeism of which 26% was Covid related against 6.7% for last month of which 48% was Covid related.

PM discussed the ICS resilience hub which supports Health and Wellbeing. The Trust has already implemented some of the initiatives which others members are looking at moving forward, such as psychology support session and noted the Trust plans to access ICS funding to continue with these sessions along with the RAFT scheme which supports teams / individuals following difficult shifts.

PM confirmed the Trust received £30k from the charitable fund which is being used to support the Capital fund development of the Junior Doctor mess facility on the York site, noting a similar amount is being spent on the Junior Doctor breakout facility at Scarborough ensuring both areas are now at an acceptable standard. Marques have been erected to expand the canteen areas on both York and Scarborough sites supporting socially distance breakout areas.

Appraisal rates - PM confirmed the appraisal window closed at the end of November reporting 91.8% of all staff had received an appraisal.

JD asked PM if the Marque's are solely for the use of Covid staff? PM confirmed the Marques breakout area should be used by all staff.

LM, well done on achieving the high number of appraisal during such a difficult time, noting it is reassuring to hear about the ICS integrations to support staff wellbeing.

LM referred to the £30k charitable funds which the Trust had received asking if other donations may be available which could be used to support the mental wellbeing of staff in relation to the Covid pandemic.

PM confirmed the £30k had been received from the National NHS Charity and discussed the availability of funds and how they will be divided and issued throughout the NHS.

AB confirmed there is an expectation other tranches of money will come through from NHS Charities.

LM suggested it would be good to see a list which any additional funds could be used for. AB confirmed this is underway.

Action 34: AB

Equality and Diversity and Inclusion Workforce Report - PM gave an overview of the submitted report, highlighting it referred to Trust staff only. Noting an error on page 41 of the pack which states for governance purposes the report will be signed off by the Trust's Resources Committee, this is not correct it will be signed off by the Executive Committee.

JD asked how the outcomes from the report will be cascaded throughout the organisation to support cultural changes?

PM discussed the NHS skills passport which supports staff moving across Trusts, confirming the Trust had recently given approval to adopt it and gave examples of core skill within the framework. The Trust is exploring a virtual training programme for Senior Managers to complement current training programmes.

LM suggested it would be good to see a plan to introduce reverse mentoring across the organisation.

Action 35: PM

PM confirmed the ODIL team is leading on this and feedback from other Trusts who had participated in reverse mentoring schemes had been very positive, also noting some Junior Doctors had undertaken a similar shadowing programme within the Trust which also produced positive feedback.

DW noting an email exchange with PM relating to cultural changes within LLP and the Trust, confirming his enquiry had been addressed throughout today's meeting.

BAF/CRR

The Committee discussed comments from the CQC related to the need to improve leadership, confirming there had been several changes since these comments had been received. The Committee agreed the risk level associated with this comment is acceptable.

Items to be escalated to Board

- Staff absences down to 4.8%
- Non-medical appraisal 91.8%
- NHS Charities Together Fund - Spend from charity for wellbeing of staff

<u>Digital</u>

DR gave the following updates to the Committee.

Use of Tablets on Wards – The number of tele-consultations is continuing to increase and work is continuing to engage additional services in the use of both telephone and video communications.

Tables on wards – There are 82 tablets currently available for the sole use of patient communications, use of these tables is supported by the patient experience team. Noting usage differs on each ward therefore not measurable.

DR confirmed moving forward the need to standardize tables which will incur costs.

Digital & Information Services Plan – Appendix 1 - DR discussed the intention to produce updates on a bi-monthly basis noting the BAF/Risks are highlighted in red.

IBR Performance Indicators – Appendix 2 - DR referred to the previous request for digital performance indicators to be included on the IBR. He discussed a number of measures which relate to areas under improvement at the present time and how these measures could be used to track performance and inform governance for the next 12 months. Noting this is very much at draft stage and suggested updates on how the Trust is progressing on priority programmes could also be included, with the aim of offering assurance to the Committee that projects are progressing to plan.

DR asked for comments with regard to the suggested KPI's to be email after the meeting.

JD asked for assurance dialog is taking place between digital and finance with regards to funding.

AB confirmed a draft programme is underway which included essential programme requirements to support all services. The report will be discussed at the Executive Committee in January 2021 and reported to the Board prior to the start of the next financial year.

LM noted her assurance that additional resources had been made available to support the service desk and suggested the possibility exploring an integrated service desk within the ICS.

LM also asked as it is unlikely the windows 10 rollout will be completed by the end of December, what is it expected date for completion?

DR stated the Windows 10 rollout should be completed by the third week in January 2021 noting the delay was not just due to resource issues but also due to access to ward areas.

DR confirmed additional support services for the service desk will be explored further.

LM requested the process behind patient access to the use of the tablets in ward areas be made more accessible.

Action 31: DR

DW suggested once LM and DR have reviewed the suggested digital measures to be included within the IBR, a broader forum then discuss the second draft.

Items to be escalated to Board

- Draft KPI
- Dashboard
- Funding IT works going forward
- Essential services programme

6. Any other Business

DW discussed reducing the number of Resources Committee meetings from 12 to 10 a year proposing August and December be stood down with the current bi-monthly reporting system followed by bi-monthly brief updates continuing.

The Committee agreed to this proposal.

Action 32: DW

The committee discussed LLP's updates confirming the Resources Committee is for Assurance only.

Action 33: DW to discuss with DB

7. Time and Date of next meeting

The next meeting will be held on 19th January 2021 at 9am via webex. Dial in details are within your diary invite.

ACTION LOG

Item number	Meeting date	Action	Owner	Due Date	Complete	last update
33	08.12.20	DW to discuss RC attendance from the LLP	DW / DB	Jan-21		08.12.20
32	08.12.20	DW to discuss with Chair plan to reduce to 10 meetings	DW	Jan-21		08.12.20
31	08.12.20	Review patient access to tablet process	DR	Jan-21		08.12.20
30.1	08.12.20	Review cultural change plan following workshop	DB	Jan-21		08.12.20
30	08.12.20	Cultural Change, report / Action plan to RC	DB	Jan-21		08.12.20
29	08.12.20	LLP Foodwaste report to Committee	DB / MV	Feb-21		08.12.20
28	08.12.20	LLP to discuss Audit Team processes with Sarah Barrow - Domestic report to RC - Feb 21	DB / MV	Feb-21		08.12.20
27	08.12.20	Update for general food waste and Cafam system	DB/PG	Jan-21		08.12.20
26	08.12.20	Breakdown of Covid/non-covid related sickness absence for the LLP to be highlighted in next months report	DB/PG	Jan-21		08.12.20
25	17.11.20	IT spend to be benchmarked against model hospital data	DR	Jan-21		
23	17.11.20	Add patients who opt out of data sharing to risk register	DR / FJ	~~01/12/2020~~ January 21		08.12.20
22	17.11.20	Digital – section to be included on the IBR	DR	Mar-21		
21	17.11.20	Paper to RC – relationship between the Trust and the LLP	DB	Jan-21		
20	17.11.20	Funds to change wet-mops to microfiber mops	MV/AB	Jan-21		
19	17.11.20	LP / PG to discuss committee dates / LLP report submission	LP / PG	Nov-20	Complete - no changes to submission dates	08.12.20
18.1	08.12.20	Ivan Le Roux to be included on the actoin point 18 BAF discussion with LP/DW	LP/DW	Feb-20		

18	20.10.20	BAF – LP to discuss with DW	LP / DW	Dec-20	ongoing	
17	20.10.20	To provide update on food waste / Matron support	LJB / DB	Dec-20	ongoing	
16	20.10.20	To update on domestics transactional / transformational changes	MV	Dec-20		
14	22.09.20	Present an update on video consultation	DR	Dec-20		
13	22.09.20	To review if the use of tablets on the ward can be used to support communication with patients families linking in with the LLP and the perfect ward programme	AS	Dec-20		
11	22.09.20	Provide an update on the people plan – to include colour coding and a clearer timeline	PM	Jan-21		
10.1	18.08.20	Discuss possible use of bench mark project data		Jan-21		
10	22.09.20	~~Provide update COVID spend bench mark~~	AB	Nov-20	Completed	
9.1	18.08.20	Update on handsets to support CAFM system		Jan-21		
9	22.09.20	Update on manual workarounds to use before CAFM system is in place	AS/Abe/DB	Sep-20	completed	
8.1	18.08.20	Further update required.		Dec / Jan 21		
8	22.09.20	Sustainability Team Management to move from Trust to Estates Management.	DB	~~Sep-20~~		
4.1	08.12.20	LP to discuss with Chair, RC T of R to be reviewd by new 3 way Chair meeting ensuring committee alignment	LP	?		08.12.20
4	21.01.20	Minutes from committees reporting into resources committee to highlight items for escalation or be FIO	All	Monthly	LM/LP to discuss – include in RC's TofR	

D1

NHS
York Teaching Hospital
NHS Foundation Trust

CHAIR'S LOG: Chair's Key Issues and Assurance Model

Committee/Group: Resources Committee	Date: 19.01.2021	Chair: David Watson

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
LLP	LLP produced an excellent report on governance which highlighted the number of Trust committees to which the LLP reports (approx. 25). It was proposed that Delroy and Andy jointly make a proposal to EPAM in respect of the governance map for the LLP	EPAM	ACTION
Workforce	Polly highlighted the current levels of staff sickness (6% of which 38% COVID-related). Polly also expressed very serious concerns about the level of unfilled staff nurse vacancies at 35%	Board	FOR INFORMATION
Workforce	Polly reported on the outstanding progress that has been made in relation to the COVID vaccination programme (76% of staff vaccinated to-date). Also, to-date no vaccine has been wasted. Concerns remain about vaccine supply and about maintaining momentum as programme is rolled-out to broader priority groups	Board	FOR INFORMATION
Workforce	Polly reported the positive news that we have secured a grant of c. £250k to support the medical e-rostering rollout	Board	FOR INFORMATION
DIS	Dylan presented an outstanding report on the Essential Services Programme aimed at reducing risks of IT failure and cyber-attack. This programme to bring the Trust's IT estate back to base line will require a spend of £11m over 3 years	Board and Executive Management	ACTION
DIS	Dylan identified the need to bring-in external expertise to support the analysis for, and roll-out of, the Essential Services Programme	Executive Management	ACTION
DIS	Dylan reported that our Trust has been identified by the ICS as its Digital Aspirant priority	Board	FOR INFORMATION
Finance	Andy highlighted the huge demands on the Trust for capex in21/22 including LLP (£2-4M), DIS £5m and other schemes in excess of £75m in total against capex budget of c. £5m highlighting urgent need to identify other permitted sources of funding	Executive Management	ACTION

Finance	Andy reported that as at end of Month 9, Trust is ahead of plan by some £0.5m with a potential year-end upside of £2m	Board	FOR INFORMATION
Finance	Andy reported his concern in relation to 21/22 budget that whilst he had significant visibility of expenditure, there was no visibility on income save that the current funding model is expected to be extended into 21/22	Board	FOR INFORMATION

D2

York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 January 2021
Responding to the Ockenden Report (Dec 20)

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☒		

Purpose of the Report

This report contains a self-assessment against the Immediate and essential actions that all Trusts provide maternity services must comply with, as highlighted by the Ockenden report (Report into Maternity Safety in Shrewsbury & Telford Hospital Trust) December 2020. The purpose of this paper is to give the Trust Quality Committee and Board of Directors assurance regarding our compliance with those actions, highlight areas of risk and any areas of ongoing support required through recommendations.

Executive Summary – Key Points

In December 2020, NHSE/I published the Ockenden Report which detailed a review of maternity care and subsequent failings in Shrewsbury and Telford. The report contained a series Immediate and Essential Actions (IEA) of which all providers are expected to present and provide assurance to their Trust Boards by 15th February 2021.

The below outlines the key areas of risk / note to the Board of Directors and where further action will be required to become fully compliant, (Further information can also be found at section 2.1 of this report):

IEA 1 – All Maternity SI's to be shared / discussed at Trust Board
A revised process has been instigated for all maternity SI's to be formally shared at Trust Board and will be in place from January 2021.

IEA 2 – Provision of an Independent Advocate for Women and Families
It is planned for the trust patient experience team to provide some interim support to this function whilst further work is undertaken. It is likely that investment will be required to provide this role on a substantive basis.

IEA 3 – Consultant Led ward rounds twice daily (Day / Night)
Whilst immediate action has been taken to implement consultant led ward rounds every day and night (8.30am and 8pm) seven days per week, this does require the diversion of resource from other, planned activities in order to support. Sustainability of this action particularly at the SGH site is a key risk due to the small size of the team and frequency /

intensity of the need to provide more out of hours working. Further work is required to ensure sustainability in the medium term which will require an options appraisal and potential investment in the medical workforce, at the SGH site.

IEA 3 – Evidence of MDT training including the need to be 90% compliant for all staff
In place and monitored by governance team however risk remains in the delivery against the 90% standard due to the impact of the COVID19 pandemic, particularly in the training of Anaesthetic staff and teams.

IEA 3 – Ring fencing of any external monies relating to maternity training and evidence of CNST maternity incentive rebate being invested in Maternity Safety
Assurance can be given that investment has been agreed to support maternity safety and re-invest CNST MIS monies in 21/22, the Care Group Leadership Team would recommend that the Board of Directors discuss and provide a view in relation to the future approach to compliance with this requirement and the impact on future financial planning.

IEA 5 – Implementation of the Saving Babies Lives (V2) Care Bundle
A business case was approved in December 2020 detailing investment required to meet the above standards relating to SBLv2. There is a material risk in the ability to recruit the required Sonography workforce within the timescales attached and mobilise the enhanced services.

IEA 5 – Formal Risk Assessments of All Women at each contact with the service
Communication has been undertaken with staff and a regular audit put in place to monitor progress and improve compliance.

IEA 6 –Implementation of Consultant O&G Fetal Monitoring Clinical Leads
Short term action has been taken to extend the current Labour ward clinical lead role to include this on both sites however this poses a risk to displacement of other planned activities and further investment may be required or acceptance of redistribution of current available PA capacity to provide this role.

Recommendation

Trust Board of Directors are recommended the following:

- Note and discuss the content of the report and Assurance tool
- Note the key areas of assurance, risk and identified mitigating actions, including areas Identified that may require additional investment
- Strengthen the regular maternity quality reporting and assurance to Quality Committee and Trust Board
- Review and formalise the Maternity NED role, in line with the revised role descriptor issued
- To agree to receive a further update report in Feb 21 with outline action plan, further risk assessment and mitigation and potential future investment requirements.

Author: Jamie Todd, Care Group Manager and Freya Oliver, Associate Chief Nurse & Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: 08/01/2021

1. Introduction and Background

In December 2020, NHSE/I published the Ockenden Report which detailed a review of maternity care and subsequent failings at Shrewsbury and Telford NHS FT. The report contained a series Immediate and Essential Actions (IEA) of which all trusts that provide maternity care and services are expected to present and provide assurance to Trust Board by 15th February 2021.

It is to be noted that immediately following publication of the report, all providers were asked to respond giving urgent assurance in relation to twelve of the twenty five IEA's identified. This return was completed in the form of a letter from the Chief Executive and via the Local Maternity System. This response was given on the 21st December 2020.

The report highlights the importance of strengthening assurance and oversight of Maternity services at Trust Board Level.

2. Assurance Tool and Reporting Requirements

NHSE/I have provided a standardised assurance tool for Providers to use in self assessing services against the required IEA's. It is this tool that is included in this report and has been used for the purposes of providing assurance to the Trust Board of Directors. The completed assurance tool can be found at Appendix 1.

As highlighted above, the Trust Board of Directors is required to have presented and discussed the report and progress against the identified IEA's by the 15th February 2021. At a later date, yet to be confirmed in late February / Early March, the Trust will be required to provide evidence of assurance as contained within the submitted assurance tool.

The twenty Five Standards are broken down into seven categories as follows:

- **IEA 1** – Enhanced Safety
- **IEA 2** – Listening to Women and their families
- **IEA 3** – Staff Training and Working together
- **IEA 4** – Managing Complex pregnancy
- **IEA 5** – Risk Assessment Throughout pregnancy
- **IEA 6** – Monitoring Fetal Wellbeing
- **IEA 7** – Informed Consent

Assurance is also required to be given in relation to two further sections in the assurance tool; Maternity Workforce and Maternity Leadership.

2.1 Areas of Key risk / Gaps in assurance

The below gives an overview of the areas of key risk / gaps in assurance, mitigating actions and highlighting where future investment requirement may be required to become fully compliant.

IEA 1 – All Maternity SI's to be shared / discussed at Trust Board
A revised process has been instigated for all maternity SI's to be formally shared at Trust Board and will be in place from January 2021.

IEA 2 – Provision of an Independent Advocate for Women and Families
This is a new requirement to create senior advocate role to report to Trust Board and LMS. Job Description being created by National team, once advice and guidance on this role is issued by the National team it will be implemented. In the interim a senior member of the Midwifery leadership team is allocated to women and families to provide a family liaison role at the outset of any serious investigation into care. Additionally it is planned for the trust patient experience team to provide some further interim support to this function whilst further work is undertaken as detailed. It is likely that investment will be required to provide this role on a substantive basis.

IEA 3 – Consultant Led ward rounds twice daily (Day / Night)
Currently physical consultant led ward rounds occur at least twice a day on five out of seven days on both labour ward sites in York and Scarborough. On four out of seven days (York) and two out of three days (Scarborough) consultants currently lead labour ward rounds at least three times a day. Immediate action has been taken to implement consultant led ward rounds every night (8pm) seven days per week. This does however require the diversion of resource from other, planned activities in order to support. Sustainability of this action in the medium term, particularly at the SGH site, is a key risk due to the small size of the team and frequency / intensity of the requirement to provide more out of hours working. Therefore whilst assurance can be given in the short term with mitigating actions, further work is required to ensure sustainability in the medium term which will require an options appraisal and potential investment in the medical workforce, at the SGH site.

IEA 3 – Evidence of MDT training including the need to be 90% compliant for all MDT staff
In place and monitored by governance team. The LMS routinely receives verbal updates on multidisciplinary training (PROMPT) at safety working group meetings. However risk remains in the delivery against the 90% standard due to the impact of the COVID19 pandemic, particularly in the training of Anaesthetic staff and teams. Cross Care group work is currently ongoing to meet the required standard and regular progress updates through Care Group Board in place. This standard also forms part of the CNST assurance process and therefore failure to comply with this will also result in risk of losing the maternity Incentive premium rebate.

IEA 3 – Ring fencing of any external monies relating to maternity training and evidence of CNST maternity incentive rebate being invested in Maternity Safety
Assurance given that any external funding received for maternity training will be used solely for this purpose. Regarding investment into maternity safety, a business case was approved on 2 December 2020 committing to funding safety improvements relating to Saving Babies Lives V2 (SBLv2) care bundles to improve maternity quality and safety. Whilst this provides assurance for 2021/22 that significant investment has been agreed to support maternity safety actions and re-invest CNST MIS monies, the Care Group Leadership Team would recommend that the Board of Directors discuss and provide a view in relation to the future approach to compliance with this requirement and the potential impact on future financial planning.

IEA 5 – Implementation of the Saving Babies Lives (V2) Care Bundle
The Trust is working towards meeting all five elements of Saving babies Lives care bundles following the approval of a business case on 2 December 2020 to address scanning capacity and an additional midwifery fetal monitoring lead. The key areas of risk in 21/22 identified relate to the serial scanning of women identified to have higher risk factors and enhanced transitional care capability. As outlined in IEA 3, a business case was approved in December 2020 detailing investment required to meet the above standards relating to SBLv2. There is a material risk in the ability to recruit the required Sonography workforce within the timescales attached and mobilise the enhanced services. This risk is being managed via cross care group MDT implementation group and assurance given via Care Group Board and Operational Performance assurance meeting with the Executive team.

IEA 5 – Formal Risk Assessments of All Women at each contact with the service
National perinatal institute notes have a risk assessment section for booking and management review plan box for each antenatal contact. Snapshot Audit of compliance will be undertaken to gain immediate assurance against this standard however it is anticipated that compliance will be low. Communication has been sent to all staff to ensure all are aware of Ockenden report requirements and responsibilities for urgent clinical actions. Also confirmed that management plan including place of birth must be reviewed and revised at every contact. Antenatal appointments guideline already includes this requirement.

This audit will then be included in the regular audit cycle led by the maternity governance team.

IEA 6 – Monitoring Fetal wellbeing
There is a requirement to instigate a consultant Obstetrician and Gynaecologist to be the named, site lead for Fetal monitoring to complement the current midwifery site based fetal monitoring clinical leads. Short term action has been taken to extend the current Labour ward clinical lead role to include this on both sites however this poses a risk to displacement of other planned activities and therefore in developing a sustainable medium term solution, further investment may be required or acceptance of redistribution of current available PA capacity to provide this required role.

3. Next Steps

Following discussion and presentation of the assurance tool at both quality committee and Trust Board, the Assurance tool is required to be submitted to the LMS by 15th February 2021.

Further work will continue to develop the outline action plan, with associated timescales, progress the identified mitigations and plans, collate any further risk on the Care Group risk register and further quantify any identified financial requirement. It is then planned that a further paper with the above will be brought back to Trust Board for information and assurance in February 2021.

4. Detailed Recommendation

Quality Committee and Trust Board of Directors are recommended the following:

- Note and discuss the content of the report and Assurance tool
- Note the key areas of assurance, risk and identified mitigating actions, including areas Identified that may require additional investment, in section 2 of the paper
- Strengthen the regular maternity quality reporting and assurance to Quality Committee and Trust Board
- Review and formalise the Maternity NED role, in line with the revised role descriptor issued
- To agree to receive a further update report in Feb 21 with outline action plan, further risk assessment and mitigation and potential future investment requirements.

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

Maternity Dashboard in place shared with Trust board monthly- also provides information into regional dashboard. An LMS wide maternity data dashboard fed with provider level data is available and can be accessed via LMS PMO; the dashboard is discussed at LMS meetings regularly.	Performance is monitored through Care Group Board, trust quality and safety committee and Trust. Exception reporting is in place and development of action plans and interventions as required.	Governance processes within the Care Group and Trust ensure that information and action relating to performance and improvement is reviewed regularly alongside assessment of improvement trajectories and impact. Sharing of learning at Clinical governance forums, risk meetings and through the LMS governance structure supports trust and system learning.	Review and strengthen information presented at Trust Board	Senior Care group team and board level champion	In place	Mitigation in place as reviewed at Care Group Q&R committee , CG Board and Trust board

External specialist opinion for IP IUD,NND,NNBI,MD not In place	N/A	N/A	Work with LMS and Trust to develop process- needs collaborative LMS SOP and working	LMS PMO to advise re process	SOP and Process, time to provide reciprocal reviews	All cases reviewed during weekly local MDT case review meetings, through Trust Q&S meetings, using PMRT as appropriate, reported to MBRRACE and HSIB where criteria met

Currently SI reports are shared through Trust Board sub-committee	SI reports and action plans are used to drive change to improve safety, shared widely with teams	Ongoing review of incident trends and quality / safety indicators.	Mechanism agreed for all outstanding and future SI to be shared directly with Trust Board. LMS developing SOP for sharing with LMS. LMS will have SI reporting as a formal standing agenda item at LMS safety working group meetings attended by governance leads from all provider Trusts. An SOP has been approved and SI's will be tracked by the LMS and saved on Future NHS collaboration platform, with update alerts sent.	Action to be completed and in place by 31 January LMS PMO developed SOP		All cases meeting criteria reported to ENS and reviewed in PMRT. All cases meeting criteria reported to HSIB. Patient safety team monitoring through SI tracker

Perinatal Mortality Review group MDT meetings are in place on both sites and all Cases meeting the criteria have a PMRT completed. All cases meeting the criteria have been referred to ENS and HSIB	Learning and actions from PMRT are shared across the MDT; quarterly reports are shared with Trust Board.	Recommendation from HSIB reports are implemented and any necessary changes to guidance and practice made, shared in clinical governance forums. Trust attend LMS safety learning network meetings and share learning through this route, attendance at regional clinical network learning forums is also undertaken to share learning.	Continue to complete all reviews and share learning	In place	N/A	All cases reviewed through Trust process and PMRT MDT review where appropriate
MSDS data is being submitted by the Trust to the required standard to meet CNST	Data discussed at all CNST meetings currently every two weeks	Monitored through MSDS data dashboard	Continue to refine and submit data. Make amendments to Trust MIS to meet digital record standard	In place Data analyst leading Kevin Beatson end Feb 21	In place Development team resource	

The Trust will plan to implement all provider aspects of the perinatal clinical quality surveillance model in 2021and engage with the regional teams and ICS as required	N/A	Monitoring through care group and Trust governance processes	An outline implementation plan is to be produced on all provider level requirements. Joint working with the LMS and regional team to develop system and process	by February 2021 for immediate commencement in all areas possible	TBC	NED safety champion already in place, Trust Board already receive maternity dashboard monthly, full reporting to HSIB, ENS and MBRRACE is in place. High levels of engagement are in place with LMS safety groups and regional clinical network. HR involved where culture issues are identified. Services currently rated as good by CQC – historic RI rating on York maternity under effective

Maternity services assessment and assurance tool

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

Overarching LMS MVP, hub and spoke model with 3 MVP's covering Trust area	TOR and meeting notes from LMS meeting. LMS wide surveys of women's opinions. Widespread use of social media with two way communication.	Changes being made via Patient experience action plan shared with MVP	'Whose shoes' events to be undertaken once pandemic allows	MVP asked for further engagement ideas LMS approach	N/A	Continue to ensure attendance at all MVP meetings and communicate with women via social media, take actions based on feedback from women to improve services

When an SI is declared a senior team member undertakes the role of family Liaison	Evidenced contact with families	Feedback from families	Create senior advocate role to report to Trust Board and LMS. Job Description being created by National team, once advice and guidance on this role is issued by the National team it will be implemented.	Board level safety champion	Post to be created, funding required	consider offering families the opportunity to have an additional support person- Interim measures to include patient experience team filling this role prior to medium term solution.
Named NED (Lynne Mellor) already appointed as non exec Maternity safety champion who represents at board level	Bi monthly safety champions meetings in place, Future action notes to evidence attendance	Board understanding of Maternity issues, dedicated section on board papers on maternity safety	Ensure all aspect of role descriptor for non exec board safety champion are met. Consider if date time of meetings need to change to improve NE director attendance. Formalise requirements for board papers and submission process	Board level Maternity safety Champion	To confirm	Non exec champion In place, regular meetings with board level safety champion and care group senior triumvirate

NHS

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?

Mandatory MDT training in place, TNA being updated to meet requirements of core competency framework. Aim to meet compliance with CNST timelines	Monitored through governance teams for compliance percentages and full completion	Reported through Quality and resource committee and care group board	Ongoing monitoring and cross check TNA meets core competency framework. LMS process for sharing compliance to be developed. SBLCB eLearning to be added to learning hub profiles	Governance team to monitor monthly LMS to request a formal report three times a year	LMS template and SOP	In place and monitored by governance team. The LMS routinely receives verbal updates on multidisciplinar y training (PROMPT) at safety working group meetings.

Currently physical consultant led ward rounds occur at least twice a day on five out of seven days on both labour ward sites in York and Scarborough. On four out of seven days (York) and two out of three days (Scarborough) consultants currently lead labour ward rounds at least three times a day.	Attendance sheets demonstrating physical presence- audit findings	To be added to the annual audit cycle and monitored by clinical Governance meetings	SOP to be developed and audit to be undertaken to demonstrate compliance across 7 days SOP to be further developed to include escalation if consultant not present.	Clinical director by 15/1/20	Time for development of SOP's and audit	Consultant, entrustable training grade or experienced non-training grade Obstetrician physically present at every multidisciplinary handover meeting three times in 24 hours'

Any funding received directly for Maternity training will be used specifically for this. CNST MIS scheme funding will be ring-fenced for maternity safety improvements	Audit trail for any Maternity training funding will be maintained Audit trail for commitment of CNST funds and business cases.	Through care group Board and Trust board	Statement of commitment from Trust board regarding ring-fencing all external funding from CNST incentive scheme for maternity	CEO and Trust Board	Funding to be allocated in budget	A business case was approved on 2 December 2020 committing to funding safety improvements in relation to SBLv2 care bundles to improve quality and safety, this is currently being operationalised

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
All women meeting criteria for consultant led care have an allocated named consultant, a review in early pregnancy and an individual plan of care developed. Referrals are made to tertiary centres as required.	MIS can identify all have named consultant	Not currently reported- plan to develop regular reporting mechanism through care group governance structures	Once established York Trust will work with maternal medicine centres to develop and enhance current referral pathways	Clinical director lead for local SOP. Maternal medicine centre leads to develop referral criteria	Information regarding referral criteria to be developed by regional maternal medicine centres	Individual consultant review and individual plans made in agreement with women.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

NHS

National perinatal institute notes have a risk assessment section for booking and management review plan box for each antenatal contact – individual management plan area in notes	Document in management plan at first assessment, review and document at each contact and update management plan as required. Audit to be carried out to assess baseline compliance with documentation- any subsequent action plan required will be developed	To be reported via Quality and safety committee	Develop and undertake snapshot audit by 15/1/21- incorporate into audit plan for year LMS is working to provide a single maternity IT system which will enable risk assessment tools to be incorporated and shared with women	HOM and Dep HOM	Time and template, action plan as required	Communication sent to all staff to ensure all aware of Ockenden report requirements and responsibilities for urgent clinical actions. Also confirmed that management plan including place of birth must be reviewed and revised at every contact. Antenatal appointments guideline already includes this requirement.

The Trust is working towards meeting all five elements of Saving babies Lives care bundles following the approval of a business case on 2 December 2020 to address scanning capacity and an additional fetal monitoring lead	The Trust completes the regional compliance survey, progress is discussed as part of CNST meetings and an audit of compliance of the appropriate bundles will be undertaken in 2021	The regional compliance survey, through internal care group governance meetings	The Trust do not currently directly follow all risk based scanning criteria or undertake uterine artery Doppler scanning- the Trust is working towards compliance in line with CNST deadlines	Sonography clinical leads and senior care group management teams	Sonographers to undertake UAD scanning training Recruitment of additional sonographers Utilise all out of hours scan machine time to maximise capacity	Assessment of fetal growth assessment guidelines in place- These will be updated to include all risk based groups as soon as scanning capacity is available

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

Appointed band 7 fetal monitoring lead midwife post currently covering cross site. There is a named consultant fetal monitoring lead for each obstetric unit to work with the Midwife leads. MDT training programme developed and commences January 2021, e-learning in place for all staff now	Training schedules and performance against job descriptions.	Monitoring training compliance and CTG interpretation reviewed through maternity case review meetings weekly	Funding obtained for second Midwifery fetal monitoring lead post- currently in vacancy control process to advertise, then there will be site specific leads in place. The fetal monitoring leads will be core members of the LMS safety group. CTG reviews at LMS level to be undertaken quarterly.	HOM and Dep HOM- in progress and should complete by Feb 21	Funding agreed	Fetal monitoring lead working cross site in short term delivering training and monitoring compliance. Fetal monitoring reviewed on all cases referred through weekly maternity case review process and fetal monitoring lead involved to work with staff where any learning improvement is identified. General learning themes regarding monitoring shared widely via learning from emails.

NHS

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?

All women provided with a list of links to electronic information at booking to help provide informed choice, hard copies can be provided on request. Perinatal institute notes are used which also contain a wide range of information. All leaflets are available on Trust website and can be provided in foreign languages / alternative formats as needed. HCV LMS website is also a portal for women and families to access information to aid informed choice and the link for this and LMS partners is displayed on York Trust website. HCV LMS meet with provider Trusts and MVP to co-produce information that is shared with women and families.	Working link to website to be provided	Women supported to make choices outside guidance after receiving full information to make informed consent. Themes from complaints or claims. Work with MVP on survey to assess women's opinions on information.	Clearly display pathways of care alongside Links to information to assist choice. Update all information on website Work with MVP to develop survey of women's views if Trust website provides all necessary information to aid informed choice	HOM and Dep HOM – information on by 15/1/21- Discuss with LMS MVP chair a survey of women's opinions re website by March 2021	Support from MVP chair and LMS to develop and undertake a survey of women's impressions of information provided	Women all have individual care choices discussions with health professional and access to information via websites and leaflets

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

Development of clinical workforce planning underway in line with CNST requirement	Plans being developed with senior leaders from each speciality and will be shared with professional bodies as required by CNST.	Plans and progress will be shared with Trust Board and HCV LMS	Continue to develop workforce reviews and action plans.	Senior care group leadership teams	Resource and funding	Monitor and assess acuity across all services in a dynamic fashion flexing workforce and temporary workforce as needed. Utilise escalation guidance as needed.

Full Birthrate plus workforce review commissioned and commenced	Full report from BR+ to be shared with Trust Board	Implementation of the BR+ acuity app?	Continue to provide all required data to BR+ in order for full workforce analysis and provision of report anticipated to be with Trust Board in March 2021	Senior care group leadership teams Trust Board	Resource and funding	Monitor and assess acuity across all services in a dynamic fashion flexing workforce and temporary workforce as needed. Utilise escalation guidance as needed.

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Head of Midwifery is professionally responsible and accountable to the Chief Nurse who is an executive director as well as working within the senior care group triumvirate. The Trust has strengthened senior Midwifery leadership with the development of an additional deputy Head of Midwifery role. The Chief Nurse who is Board level Maternity safety champion is a registered Midwife and positioned to provide senior leadership and insight to the Board.

The Maternity service has developed numerous specialist Midwifery roles to date which include Antenatal and newborn screening, Perinatal mental health, Diabetes, infant feeding and bereavement and have an ambition to continue to develop further specialist roles in line with the public health agenda such as substance misuse.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Governance team monitor maternity guidelines to ensure in date, MDT guidelines group review and compare to NICE guidance, Clinical effectiveness team register benchmarking against NICE guidance	clinical governance meetings will be used to report this quarterly	Monitored by governance team and agreed by MDT guidelines group and approved through wider MDT teams	Once the increased scanning capacity and updated skills for SBLV2 care bundles is in place guidelines will be updated to follow NICE	Senior clinical team aim to be compliant by May 2021	Increased scanning capacity	Governance team monitoring guideline updates.

York Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

Board Assurance Framework – At a glance

Strategic Goals

- **To deliver safe and high quality patient care as part of an integrated system**
- **To support an engaged, healthy and resilient workforce**
- **To ensure financial stability**

Goal	Strategic Risks	Exec Lead	Quality of Resources	Original Risk Score	Residual Risk Score	Target Risk Score
Patient Care	1. Failure to maintain and improve patient safety and quality of care	**CN**	**Quality**	**25**	**25 ↔**	**6**
Patient Care	2. Failure to maintain and transform services to ensure sustainability	**COO**	**Quality**	**20**	**20 ↔**	**6**
Patient Care	3. Failure to meet national standards	**COO**	**Quality**	**25**	**20 ↔**	**1**
Patient Care	4. Failure to maintain and develop the Trust's estate	**FD**	**Resources**	**25**	**16 ↔**	**9**
Digital & Information	5. Failure to develop, maintain/replace and secure IT systems impacting on security, functionality and clinical care	**CDIO**	**Resources**	**20**	**16 ↔**	**12**
Workforce	6. Failure to ensure the Trust has the required number of staff with the right skills in the right location	**W& OD**	**Resources**	**25**	**20 ↔**	**9**
Workforce	7. Failure to ensure a healthy, engaged and resilient workforce	**W& OD**	**Resources**	**20**	**16 ↔**	**6**
Workforce	8. Failure to ensure there is engaged leadership and strong, effective succession planning systems in place	**W& OD**	**Resources**	**16**	**12 ↔**	**1**
Finance	9. Failure to achieve the Trust's financial plan	**FD**	**Resources**	**25**	**9 ↔**	**6**
Finance	10. Failure to develop and maintain engagement with partners	**COO**	**Quality**	**16**	**9 ↔**	**4**
Finance	11. Failure to develop a trust wide environmental sustainability agenda	**CN**	**Quality**	**20**	**12 ↔**	**1**
Finance	12. Failure to achieve the System's financial plan	**FD**	**Resources**	**25**	**9 ↔**	**6**

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Principal Risk: (1) Failure to maintain and improve patient safety and quality of care Causes – staffing vacancies, infection rates including Covid, limited capital available for remedial and development work Effects – staffing issues, ward closures, issues with old estate and equipment **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Nurse	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)

Trust Committee/Governance Structure including
Strategies, Policies & Procedures
Systems &Monitoring
- Incident Reporting, SIs/Never Event Reports, Claims, Quality Priorities
- CQUINs & contract monitoring
- Recording of escalation systems NEWS etc
- Medicines Management/EPMA implementation
- National Surveys, NICE, NSF & Clinical Audit
- Capital Programme
- Maternity CNST
- Performance & accountability (reviews/ dashboards)
Statutory and mandatory training
7 day working local adaptations
Lead medical examiner role introduced
Covid 19 intn/extn command structure together with specific SOPS, IPC BAF and risk assessed measures for management of beds and waiting lists
	- External inspections incl CQC Reports
	- Internal Audit Programme
	- CQC and Choices website feedback
	- SHMI
	- New Clinical Environment Risk Group implemented to oversee backlog maintenance spend risk management
	- National Survey Action Plans, Friends & Family Test
	- Reports incl Premises Assurance Model, PLACE/TAPE, Patient Experience, Pressure Ulcer & Falls, Mortality/Learning from Deaths, IPC, IBR, maternity, staffing, Health & Safety, Safeguarding Childrens & Adults
	- Quality Report
	- Patient Safety Walk Rounds
	- NICE, NSF and Clinical Audits/Effectiveness Reports
	- Learning Hub Data
	- 7 day audit – 7 day task & finish group & plan
	- Integrated Board Report
	- COO led monthly operational performance meetings with each Care Group
	- CEO led efficiency meetings with each Care Group
	- QIA of each efficiency scheme signed off by MD and Chief Nurse.
		- CQC Unannounced visit & Well Led responses and action plans (monthly monitoring at Board & Quality Committee) - the transitional regulatory self-assessment due to Quality Committee January 2021 will indicate further actions required to achieve compliance **(Jan 21).**
		- Implementation of 7 day working systems and controls
		  - Jnr Drs Contract (National)
		  - 2003 Consultants Contract does not facilitate 7 day working(National) **(current position review quarterly)**
		- Risk registers are not fully aligned - Full review of risk registers to ensure risks appropriately rated and managed **(April 2021)**
		- Governance structures have some gaps affecting the effectiveness of ward to Board communication - New Corporate Clinical Governance Structure implemented November 2020, however, further improvement work required at Care group level to improve processes. To support this a Governance Facilitator development programme is to be delivered to enhance care group knowledge of clinical governance **(Review June 2021)**
		- Quality of SI investigations identified as variable and learning not sufficiently embedded - Quality improvement project underway to redesign the incident management processes (including serious incidents and learning) **(July 2021)**
		- Staffing Vacancies PEM consultant Scarborough, medical staffing at Scarborough and nursing – East Coast Review looking at sustainability – **(quarterly review)**
		- C Diff rates at Scarborough due to estate issues/limited capital funds - Infection Control - NHSE/I Lead Review & Report – Capital prioritisation due to take place in Feb 21 at Exec Committee **(Apr 21)**
		- Under performance against key national targets and standards - Care Group improvement programmes & performance recovery plans

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	- Medical Examiner appointed - Local ownership of MCA/DoLS – matrons audit carried out - MCA/DoLS action plans/reaudit- took place in Nov 19 with action plans now in place & no significant concern raised. - Performance recovery plans - Performance framework (OPAMs) - Daily and weekly Covid 19 actions logs - Review at weekly gold CEO led group - Covid 19 dashboard - Submission of required Covid 19 returns for assurance	developed by each Care Group **(reviewed & updated monthly)** - Surge plan if social distancing ineffective – Surge plans in place **(Apr 21)** - Critical care capacity – establishment of Nightingale Y&H facility – transfer of care – internal surge plan and use of HCV ICS option **(quarterly review)** - Access & maintenance of adequate oxygen supply – oxygen guidance documents in place for each site – 2 flow monitors purchased **(review quarterly)** - Access to appropriate supply & distribution of PPE – compliant with national push stock system, daily national reporting, dedicated stores (Y&S), mutual aid in place, part of ICS emergency stock holding centre **(quarterly review)** - Increased risk of secondary deaths due to services not being accessed and impact of long waits for elective surgery. Clinical harm SOP in development to ensure capture and investigation of clinical harms. **(February 2021)** - Possible increased risk to children & adults in community due to social distancing - Safeguarding Team aware of risk to vulnerable adults & children – access to team for advice & support established during this period (**review Mar 21)** - Possible increased risk that some routine elements may be negatively impacted due to reduced reporting or staff absence

Principal Risk: (2) Failure to maintain and transform services to ensure sustainability <u>Causes</u> – Covid 19, Staffing levels, Capacity & Demand, Capital <u>Effects</u> – Sustainability, Service Constraints **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee & Governance Structure • Executive Directors Portfolios – Chief Operating Officer is the Trust Transformation Lead • Operational Performance & Assurance Meeting (OPAM) – escalation of key services issues that affect sustainability & service eg: performance, quality, workforce, finance & identification of improvement/ transformation opportunities • Care Group Boards (x6) - responsibility for the effective delivery of sustainable services • Business case management system for significant service change • Performance Management Framework - The Trust works in partnership to identify & deliver service transformation & sustainability; including: • HCV ICS, including Clinical Leads Network and Acute Care Collaborative. • Operational Delivery Networks eg: Stroke/ Critical Care • North Yorkshire and York System Leaders Executive • Joint Planned Care Board • HCV Cancer Alliance & Trust Cancer Strategic Board • Health and Care Resilience Board • SGH Services Review • Facilitated External review, eg: ECIST, Elective IST, GIRFT & Model Hospital • Health & Well-Being Boards • Local Resilience Forums • Contract Management Arrangements	A range of regular reports are provided to monitor delivery of our work. These include: - Integrated Board Report - Executive Committee Forward Plan and reports, e.g. SGH Services Review, Winter Resilience, Business Cases and Care Group Escalations Reports are shared with system partners as required. Minutes and action logs from partnership meetings are shared across the Operational leadership to ensure Trust actions are implemented. Humber Coast and Vale and Regulatory action plans, including: - Operational Plans - COVID operational plans, Phase2, Phase 3 - Scenario testing of surge plans - CQC action plans - Winter planning and Resilience plans: system escalation structures.	- Sustainable workforce in particular at the East Coast <u>Actions:</u> SGH Services Review and appointment of Programme Director to drive change and delivery. Post commenced in 23rd November 2020 **(Quarterly Review)** - Establishment of East Coast Leadership Team, Deputy Chief Operating Officer, Deputy Chief Nurse and Deputy Medical Director from 4th January 2021 (**Quarterly Review)** - Capacity across Hospital Estate and wider partnerships to deliver transformational pathways (financial constraints, capital constraints) <u>Action</u>: Engagement in system partnerships to explore options for capital monies to support estate reconfiguration, equipment opportunities and collaborative pathways, e.g. Emergency Department Capital Schemes **March 2021** - Trust wide clinical strategy (in development) Action: Clinical Strategy Programme Director commenced in post September 2020. **(Quarterly Review)**

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Principal Risk: (3) Failure to meet national standards Causes – Covid 19 pressures, increased demand, recruitment issues, capacity issues Effects – targets not met, increased risk of harm to patients, regulatory intervention, patient dissatisfaction **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer,	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust/Committee Governance Structure - Corporate Performance Team - Performance Management Framework – including Business Managers across the Care Group Structure and processes for escalation and resolution through Operational Performance Assurance Meetings and Executive Committee. - Commissioner and provider forums - Trust Operational Planning – Annual cycle supported by weekly and monthly monitoring - Winter Resilience & Emergency Planning Functions - Strategies, Policies & Procedures including operational plans - Training & Development incl. Capacity/demand Elements of assurance framework deferred ie: work plans, engagement with Internal Audit and 'routine' operational planning. In line with national guidance, usual reporting arrangements have been suspended. Current reports as per national requirements but minimal.	The Trust receives assurance through - Reports and the Integrated Board Report - Live, daily and weekly management information through corporate dashboards - Externally commissioned reports, e.g. EY - CQC action plans - Performance Recovery Plans - Winter Resilience Plan - Emergency Planning - including scenario testing. - E & Y Reports - External Benchmarking of systems and pathways - Internal Audit Programme - Operational Performance Recovery Plan - Winter Plan/System Resilience Plan - SAFER Local Delivery Plan - Planned Care Transformation Plan - Validation - Operational Plan - Learning Hub Data	- Sustainable delivery of access targets at the East Coast: Actions: - Programme Director appointed for Scarborough Services Review commenced 23rd November. **(Quarterly Review)** - Establishment of East Coast Leadership Team, Deputy Chief Operating Officer, Deputy Chief Nurse and Deputy Medical Director from 4th Jan 2021**(Quarterly Review)** - HCV HCP capital bid for SGH – business case approved & machines on site – Trust working to national timetable for submissions **(review quarterly)** - Continued challenges around achieving the ECS on a sustainable basis Action: - ECS Daily Monitoring (Ongoing daily Review) - Breach Review **(weekly)** - Ambulance handover action plan developed – improvement trajectory agreed with NHSI **(reviewed monthly)** - Delivery of long wait routine care as a result of the national pandemic: Actions: - Surge Plan actions (elective stand down SOP) to minimise and mitigate patient impact during wave 3. - Phase 3 recovery plan for elective care, supported by weekly monitoring **(monthly review to Quality Committee)**

Principal Risk: (4) Failure to maintain and develop the Trust's estate <u>Causes</u> - due to lack of resources including capital and staffing, volume of work required <u>Effects</u> – worsening of backlog maintenance issues, substandard estate, regulatory intervention **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structures o SLAs between Trust and LLP – contract management structure o LLP Committees/Governance Structure - Strategies, Policies & Procedures o Capital Programme o Estates Strategy o PLACE/TAPE Programme o Compliance Report Schedule o HCV Estates Strategy	- Compliance with P21+ and DH approved process for specific capital schemes - Condition Surveys - HCV HCP Capital Group Reports & Minutes - Internal Audit Programme - NHS Premises Assurance Model - Board/Committee Reports incl: Compliance, Capital, Sustainable Development, Health Safety & Fire - Full site backlog maintenance survey - Prioritised backlog maintenance register - Enhanced transparency of capital programme management via Executive Committee & Board.	1. Lack of capital to maintain/develop Trust estate – Pursuing discussions with ICS over access to supplementary PDC **(Quarterly Review) –** Commissioned RIBA 0, 1 and 2 reviews of key development issues in order to support business case development **(Quarterly Review) –** Seeking to place the Trust in the best possible position to bid for nationally released PDC funding **(Quarterly Review) -** Targeted and proactive use of Trust depreciation funding to remedy critical infrastructure issues **(Quarterly Review) -** Business planning process 21-22 has included a full Care Group and supporting Directorates assess of capital investment needs. This will be prioritised at Exec Comm on the 3.2.21 **(Feb 21)** 2. Work associated with realigning wards for Covid has meant some minor works have been deferred (although some work has taken place) 3. Some key projects aligned to the CQC plan have been put on hold ie childrens area in York ED - CQC Plan areas ie: childrens area in York ED will be delivered from emergency Covid 19 **(Mar 21)** 4. Capacity of the LLP to support the Covid 19 expanding work programme – Procurement of temporary capacity **(Jan 21)** 5. LLP ability to monitor full set of KPIs and provide assurance – procuring LLP KPI automated monitoring system (CAFM)**(Apr 21)** 6. Cultural acceptance of poor quality environment – Cultural work underway in LLP **(July 21)**

Principal Risk: (5) Risk of a failure to develop, maintain, replace and secure information and technology systems in a timely manner. <u>Causes</u> - increased demand , increased complexity, limited capacity (technical, workforce and financial funds) and capability (technical, workforce) <u>Effects</u> - data breaches, regulatory fines, loss of reputation, inefficient ways of working **Lead Committee:** Board Quarterly (last forma review – Jan 21) **Director Lead:** CDIO	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 4 Score: 12

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)

- CDIO appointment August 2020
- Statutory, contractual and quality reporting
- Care Group support being provided
- Dashboards and reports being produced
- Collaborative working with partners
- Inpatient clinical coding function being delivered
- Business continuity and disaster recovery plans being reviewed
- Information Asset Owners and System Owners being identified and appointed
- Reporting structure into Exec Committee, Resources and Board
- To continue to support
    - On-call Service
    - Internal monitoring/alerting systems
    - Third Party Monitoring
    - Ongoing User Awareness Programme
	- External & Internal Audit Reports
	- External review and Health Check
	- Information Governance Exec Group Reports
	- Board NHSI Declaration – Data Security & Protection Requirements
	- Learning Hub Data
	- DSP Toolkit Compliance
	- Information Asset Owner Register
	- Cyber Security Assessment & Action Plan
	- SUS Data Quality
	- Incident Management reporting and learning
	- CDIO immediate observations and recommendations – September 2020 to committees and board.
	- Coding audits
		Lack of capacity and capabilities in the team - Case for staffing increase to be discussed as part of the business planning process **(Apr 2021)**, Develop proposals for shared services and partnering across the region/ICS **(Apr 2021)**
		
		Lack of operational funds - Develop the case for staffing increase across critical roles (Jan 2021), Develop the case for external funds through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of capital funds - Develop the case to secure funding for essential services program capital scheme (Feb 2021), Develop the case for external funding sources through close working across the ICS, with NHSX **(Apr 2021)**
		
		Lack of prioritisation or strategic alignment of work coming into DIS - Deliver new Project and Portfolio Management approach to bring rigour to project delivery, set priorities and manage the pipeline of work into DIS **(May 2021)**
		
		Lack of CCIO, Digital Nurses and AHPs available capacity to work with DIS on delivery - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** - Develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way**. (Apr 2021)**

	-	Lack of Digital Leads or "Business Partners" embedded into care groups - Develop Digital Ready Workforce and Leadership Plan **(Apr 2021)** – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)** Lack of effective and standard change methodology or approach – Subject to funding develop proposals for modern change methodology to be introduced to the Trust to all change projects going forwards to ensure outcomes are achieved/benefits realised in the most effective way. **(Apr 2021)**

Principal Risk: (6) Risk of failure to ensure the Trust has the required number of staff with the right skills in the right location Causes – inability to recruit the levels of nursing/medical staff required especially on the East Coast, limited applicants available in some specialties, national policy on training numbers Effects – Compromised service delivery, limited capacity to open surge/esc areas, regulatory scrutiny **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Dir. of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 3 Severity= 3 Score: 9

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Workforce & OD Strategy & workforce redesign - People Plan - HCV HCP Workforce Strategy - Bank Management and Governance - Appraisal processes – Job Plans - Apprenticeship & Volunteering Programmes - Overseas Recruitment - Statutory and Mandatory Training - East Coast Medical Recruitment Programme - SLAM course - CleverTogether staff engagement forums and outcomes Covid19 specifically - Skills questionnaire to enable safe deployment of staff Homeworking enabled where possible 7-day swabbing service for staff and household members NHS Covid 19 App Health and Wellbeing measures to support resilience Race Equality Network	- Staff Survey/Staff FFT - National standards & visits - Trust Committee/Governance Structure - - ROA reporting to HEE - Internal audit programme - Programmes designed and evaluated by HEI and NHS Elect - SSW/FTSUG Monitoring Reports - Board & Committee reports - Data from E-rostering Data/CHPPD, Learning Hub, Exit Questionnaires - NHSI maintaining workforce safeguards - QIA for new nurse roles Covid 19 update Real time sickness data being captured through central 'hub' Staff requiring isolation to be signed off via OH and placed on medical suspension	- Work/life balance expectations of the future workforce - Objective Structural Clinical Exam (OSCE) - International Nurse recruitment **(Mar 21)** - Age Profile – Workforce Plan **(Oct 21) -** Health & Wellbeing Initiatives being implemented **(Jan 22)** - Workforce planning - Apprenticeship Steering Group Outputs **(Jul 21) -** Continue to develop Bank **(Dec 21)** - Effective utilisation of E Rostering Tool – Electronic E Rostering roll out **(Jan 23) -** Medical rostering system (not yet procured. BC **approved Sept 20**) - Implementation of electronic job planning - e-Job Planning **(Oct 21)** - HEE Policy – jr dr allocations - HCV HCP Workforce Action Plan **(Oct 21)** - Organisational Culture - Clever Together actions **(Mar 21) -** Revised Agile Working Policy approved, but needs embedding **(Oct 21)** - Medical Staffing gaps - East Coast medical recruitment project **(on-going)**

Principal Risk: (7) Risk of failure to ensure a healthy engaged and resilient workforce Causes – high levels of Covid related absence, constant pressure in the system ie: Covid, winter, flu Effects – Compromised service delivery, organisation culture, regulatory scrutiny, lowering of morale and wellbeing, limited capacity, vacancy rate across nursing/medical, increased staff attrition **Lead Committee:** Board Quarterly(last formal review – Jan 21) **Director Lead:** Director of Workforce & OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 2 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Occupational Health Service/EAP - Junior Doctor Forum & LNC/JNCC - Workforce & OD Strategy - Star Awards/Celebration of Achievement & Benefits programme - Recruitment and Retention Processes - Workforce redesign - Appraisal processes – Job Plans - Schwartz Rounds & RAFT - Emergency planning - Statutory and Mandatory Training - FTSU/SWG & Fairness Champions Covid 19 update: Psychological support increased – drop in sessions (now virtual) for staff working in cohorted areas. Tailored Schwartz rounds Headspace app being pursued Clear daily communication updating staff Staff testing for Covid 19 – Test & Trace Helpline and support sessions staffed by Clinical Psychologists RAFT/TiPi Apps to support mental wellbeing (Headspace, unmind and Sleepio). 7-day swabbing service for staff and household members Resilience Training	- Staff Friends and Family Test - Sickness absence/turnover analysis - Board & Committee reports - Trust Committee/Governance Structure - Data - E-rostering Data/Flexible working, health & Wellbeing, Learning Hub, Health Assured & FTSU/SWG monitoring - Staff Survey - RAFT evaluation Covid 19 update: Real-time sickness data collated via central ‘hub’. Support for Managers for virtual working	Work/life balance expectations of the future workforce Shift patterns and impact on Health & Wellbeing Actions to address the gap: Clever Together actions **(Mar 21)** Values and Behaviours implementation **(Sept 21)** Implementation of Agile Working policy **(Mar 21)** Continued Implementation of RAFT **(Nov21)** Implementation of Health & Well-being Strategy **(Dec 21)** Workforce Plan implementation **(Oct 21)** Safe Working Group Feedback initiatives **(continuous)** Line Manager Competency Training **(continuous)** Clever Together Programme **(Mar 21)** Impact of Lateral Flow Testing Programme/Test and Trace – Covid vaccine – (**Review Quarterly)**

Revised BAF approved in Aug 18 – current version 0.30 (Jan 21)

Principal Risk: (8) Failure to ensure there is engaged leadership and strong, effective succession planning Causes – FT Catchment area; new (and unfamiliar) application of talent management framework and workforce planning. Effects – Lack of appropriate strategy; poor culture; increased staff attrition; compromised quality of patient experience. **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Director of Workforce and OD	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 3 Severity= 4 Score: 12	Likelihood = 2 Severity= 3 Score: 6	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust Committee/Governance Structure - Workforce & OD Strategy - Gender Pay Analysis - WRES/WDES - HCV HCP workforce plan - Appraisal / Revalidation Processes - Board Development - Talent Management Framework - Progression and evaluation of internal leadership courses Covid Guidance for Managers for remote working	- Succession Planning Papers - Directors Portfolios - Team Structures - Learning Hub Data - Board/Committee HR Reports - Internal Leadership/Managerial Programmes - Revalidation data - WDES/ WRES action plan - NED development programme	Board Development Programme needs revising due to Covid - Board development **(Quarterly Review)** Shadow Board - this will recommence following Covid **(Quarterly Review)** Up to date Succession Plan - Succession Plan being developed **(Sept 21)** BAME representation at Board and in senior management – to be addressed when the next NED position becomes available **(2024) -** NED Development – (ICS) Programme starts **(Jan 21)** Previous values & behaviours not aligned/embedded – Embedding values and behaviours **(Sept 21)**

Principal Risk: (9) Failure to achieve the Trust's financial plan Causes – pressure from agency spend, system finance pressures, Effects – regulatory scrutiny **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working (stakeholders, LA's, Trusts (Harrogate, Hull, Leeds) (HCV Contractual MOU) - Shared Risk Contract - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) - North Yorkshire & York Leadership System - Primary Care Networks through CCGs COVID-19 Exceptional Measures: - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of efficiency requirements.	- External and Internal Audit Programmes - NHSE/I Reporting - External Audit - Value for money review - NHSE/I Use of Resources Review - Monthly Accounts & Reports - Operational Plan - Business Cases and benefits monitoring - Committee Papers - Capital Programme Reports and monitoring - Medium Term Financial Planning - East Coast Review	1. Continued recruitment difficulties placing financial pressure from agency and locum replacement staff resulting in pressure against the Trust's agency cap. 2. Additional staffing requirement from covid segregated areas and duplication of functions. **To address gaps 1 and 2:** Multiple Recruitment initiatives listed on strategic risk 6 – MD, CN & DoWF scrutiny & challenge of agency rates, structured review of long term commitments each week **(ongoing review quarterly).** - Premium implemented for bank staff 3. Failure to deliver system wide QIPP with financial pressure on the system partners and the Trust through the shared risk contract (temporarily suspended) 4. System affordability issues in relation to delivery of constitutional standards **To address gaps 3 and 4:** Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards **(Due Dec 20) – delayed (quarterly review)**. Work underway with ICS on understanding current financial positions and resource requirements going forwards. Details of Restoration and Recovery Plan submission awaited but delayed **(quarterly review)**

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Principal Risk: (10) Failure to develop and maintain engagement with partners <u>Causes</u> – lack of governance/structures, lack of system maturity <u>Effects</u> – lack of cohesion, lack of plans, NHSE/I intervention **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Operating Officer	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Scor RAG Rating – 5x5
	Likelihood = 4 Severity= 4 Score: 16	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 2 Score: 4

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
The Trust works through the Humber Coast and Vale Integrated Care System and associated governance structures. Support Corporate Operations this includes (not exhaustive): • HCV - Clinical Leads, Executive Group, Planned Care Board, Cancer Alliance and associated sub-structures, Acute Care Collaborative • North Yorkshire and York Systems Leaders Executive • Urgent Care Network • North Yorkshire and York Health and Care Resilience Board (Urgent Care) • North Yorkshire and York Joint Planned Care Board National pandemic response - engaged in the North East and Yorkshire Regional Cell and associated sub-structures, including Local Resilience Forums. Through Business as Usual arrangements, the Trust has regular communication and meeting arrangements with commissioners and regulators to negotiate and manage contractual issues to reduce the risk of financial penalties. This includes: - Contract management arrangements - Monthly performance meetings with commissioners - CQUIN quarterly reviews NHSE/I Quarterly reviews and deep dive assurance meetings through HCV.	The Trust receives assurance through - Appropriate level attendance at partnership meetings to act on behalf of the Trust - Minutes and action logs of the partnership meetings - CQC System Reports - NHSE/I action plans - Contractual reports to Resources Committee and Board - Integrated Board Report.	- Place Based Strategic Plans. <u>Action:</u> ICS Place governance structures and population health plans (April 2021) - System governance arrangements: <u>Action:</u> - Phase 3 recovery plans developed at place and Humber Coast and Vale level. Programme for recovery at place in development **(February 2021)** - North Yorkshire and York Finance and Performance Meeting established to lead on planning and delivery **(November 2021)** - Provider analytical networks established to support and inform the Acute Care Collaborative **(October 2021)**

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Principal Risk: (11) Failure to develop a trust wide environmental sustainability agenda Cause – lack of awareness/engagement/commitment Effect – Inability to achieve national targets, waste, inefficiencies **Lead Committee:** Board (last formal review – Jan 21) **Director Lead:** Chief Nurse	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 4 Score: 20	Likelihood = 4 Severity= 3 Score: 12	Likelihood = 1 Severity= 1 Score: 1

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	Assurance (Where our controls/ systems on which we are placing reliance, are effective)	Gaps in Control/ Assurance (Where we are failing to put control/ systems in place)
- Trust/LLP Committee/Governance Structure o Board Commitment o Travel and Transport Group o Head of Sustainability o Sustainable Development Group - Processes & Systems o Sustainability Development Assessment Tool o Sustainability Reporting Portal (measures Carbon footprint) o Sustainability Champions o Consultancy Contract Phase 1 and 12 month sustainable awareness development programme - Partnership Working o City of York Council o NYCC o York and North Yorkshire LEP o Humber Coast & Vale Sustainability Network Group	- Sustainable Development Management Plan/Green paper under development to comply with Standard Contract 2020/21 - Sustainable Development (SD) Reports/Papers - Transport Group Reports/papers - Compliance with NICE - Sustainability Annual Report - Trust Annual Report Sustainability Section - Carbon Savings figures - Savings Cost Benefit Analysis - Travel Plan - Benchmarking using SD Assessment Tool - Travel Survey - York Hospital selected as one of 12 in UK for Modern Energy Partners Programme to provide free sub-metering and pathway programme for buildings with aim of achieving 50% carbon reduction by 2032 - Funding secured for electric vehicle charging at York Hospital	- Engagement of staff incl Snr Management – develop engagement plan **(Dec 2020)** Sustainable Development Assessment Tool Action Plan **(Mar 20 62% - improve by Mar 21)** - Covid 19 impact on waste – Review waste monitoring data to determine impact of Covid 19 **(Dec 20) –** improve waste recycling for domestic black bag/catering waste (new tenders delayed due to Covid 19 work) **(anticipated post Jan 21**) - National Clinical Waste Provision Issue - NHSI monitoring nationally agreed (Mar 21) contract - awaiting further developments, National Waste Strategy to be published in Summer of 2020 (delayed)(**Review Jan 21)** - Travel Survey Analysis – Travel Plan being updated **(finalised Dec 20)** - Long Term Climate Change Act target 0 carbon by 2050 Delivering a Net Zero NHS document requires 80% carbon reduction on carbon emissions by 2028/32 - Green Plan with projects to achieve Climate Change Act Targets and Delivering a Net Zero NHS targets – reviewed annually **(Review Jan 21)** - NHS operational planning guidance 2020/21 requires all new builds to be net zero carbon standard (currently suspended due to Covid-19) - Proposed new SGH ED to be built to BREEAM excellent and new guidance awaited on building to net zero carbon standards (**Review Apr 21)** - NHS Long Term Plan targets 2019 & Standard Contract 2020-21- contract requires a plan by Mar 21 - Review of SD/Green plan **(Mar 21)** - Capital budgets not allocated for delivering a Net Zero NHS - Business cases: electric vehicle charging infrastructure, reducing estate carbon emissions; reducing waste/water, vehicle use & procurement impact & achieving Climate Change Act Targets **(Review Jan 21)**

Principal Risk: (12) Failure to achieve the system's financial plan <u>Causes</u> – financial pressures on organisations within the system, lack of capital/revenue, unforeseen expenditure requirements such as equipment failure <u>Effects</u> – ICS and regulatory scrutiny, loss of reputation **Lead Committee:** Board Quarterly (last formal review – Jan 21) **Director Lead:** Finance Director	Risk Level		
	Original Risk Score RAG Rating – 5x5	Residual Risk Score RAG Rating – 5x5	Target Risk Score RAG Rating – 5x5
	Likelihood = 5 Severity= 5 Score: 25	Likelihood = 3 Severity= 3 Score: 9	Likelihood = 2 Severity= 3 Score: 6

Controls/Mitigation (What controls/ responses we have in place to assist in securing delivery of our objectives)	**Assurance** (Where our controls/ systems on which we are placing reliance, are effective)	**Gaps in Control/ Assurance** (Where we are failing to put control/ systems in place)
- Governance Structure incl: OPAMs, CPEG, EDG - Annual Planning & Business Planning Processes - SFIs, Scheme of Delegation, Policies and Procedures - Collective Board Ownership - Legally binding contracts - Partnership Working - Shared Risk Contract - HCV & Partnership working ie: Contractual MOU - Engagement through System Delivery Board - System Medium Term Financial Plan - Care Group CIP Delivery Plans - Financial systems, cost controls and monitoring - Control Total Agreement (multi-year) <u>COVID-19 Exceptional Measures</u> - Temporary suspension of PbR with nationally set block contracts recognising cost of services. - Commissioner allocations adjusted to reflect increased provider funding. - Claims process for exceptional covid related revenue for Apr to Sep. Additional allocation for Oct onwards. - Capital bidding opportunities. - National cash process paying 1 month early to ensure strong cash position for all providers. - Temporary suspension of QIPP and efficiency requirements	- NHSE/I Reporting - Quarterly System Finance Meetings - Internal & External Audit - Monthly Accounts & Reports - Operational Plan - Medium Term Financial Planning - East Coast Review	1.Failure to deliver system wide QIPP with financial pressure on system partners and the Trust through the shared risk contract (temporarily suspended) 2.System affordability issues in relation to delivery of constitutional standards. 3.Pressure on non-York FT CCG contract expenditure. 4.Operational pressures for the Trust **To address gaps 1 to 4** - Development and refinement of a system wide financial recovery plan for Oct to Mar. Awaiting planning guidance & financial operating framework for Apr 21 onwards **(Due Dec 20) – delayed (quarterly review)** - Work underway with ICS on understanding current financial positions and resource requirements for Oct to Mar. Details of Restoration and Recovery Plan submission awaited but delayed. - Full engagement with the ICS to develop and agree longer term recovery plans **(expect to submit April 21)**

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Board Assurance Framework

BAF definition adopted by the Governance, Assurance & Risk Network (GARNet): 'the key source of information that links the strategic objectives to risk and assurance'.

All Trusts are required to prepare public statements to confirm that they have done their reasonable best to maintain a sound system of internal control to manage the risks to achieving their objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the Trust. The evidence to back up this Statement is supported by the Board Assurance Framework.

The Trust's Board Assurance Framework is based upon the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Board of Directors to resolve issues or concerns and to improve control mechanisms.

The risk scoring matrix (appendix 1) is part of the Trust's Risk Management Framework and will be used to score risks.
Risk Appetite (appendix 2) is part of the Trust's Risk Management Framework

Strategic Goals	**The planned objectives which an organisation strives to achieve**
Principal Risks	**The key risks the organisation perceives to achieving its strategic goals**
Key Controls	**The controls or systems in place to assist in addressing the risk**
Assurances on Controls	**Sources of information (usually documented) which service to assure the Board that the controls are having an impact, are effective and comprehensive**
Gaps in Controls	**Where we are failing to put control/systems in place**
Gaps in Assurance	**Where we are failing to gain evidence that our control systems, on which we place reliance are effective**
Risk Appetite	**The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives – appendix 2: Trust Risk Appetite.**

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Temporary governance arrangements in relation to the Covid 19 pandemic which follow national guidance

- The Trust has introduced a bronze, silver and gold command structure to co-ordinate efforts for the pandemic – all decisions are logged
- Bronze, silver and gold meetings are held every day with a weekly gold group which has replaced the Executive Committee during this period – Executive Committee planned to restart in June
- The Board and sub-committees are following the ‘reducing the burden’ national guidance and meetings have been limited to a one hour meeting which discusses Covid issues and then there is a section for papers which are for information.
- Any documents still requiring approval of the Committees/Board are covered under any matters of urgency – due to large number of items for approval in March, this was done by email (all emails retained) a paper detailing the approvals was taken to the April Board.
- The Board is introducing a bi-monthly workshop which is longer in order to discuss Covid issues in more detail – this is initially planned until September 2020
- Board and Committee Action Logs dates continue to be scrutinised to ensure that elements are covered or reviewed periodically
- Audit Committee in May streamlined to focus on year-end only – the July time out meeting will now be a normal agenda incorporating the time out elements
- The Council of Governors has been stood down, but communications are still being sent from the Chair and FT Secretary – in May 2020 a plan was agreed to look at how technology could be used to get the governors around a virtual table.
- Covid capital and revenue spend processes have been put in place

Appendix 1: Calculating Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring.

SEVERITY INDEX		LIKELIHOOD INDEX*		
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Severity - Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood - Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the risk score is determined it is the highest I risk score that must be referred to on the risk register**.

Appendix 2 - Risk Appetite Statement (Risk Management Framework - Appendix 4)

1. Quality & Safety - Delivering high quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. The trust has a risk adverse (Low) appetite to risk which compromises the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.

2. Patient Centred Care - This Trust has made a commitment to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services. The trust is risk adverse (Low) to enabling care without validating and verifying what outcomes are possible and desirable with all stakeholders.

3. Partnerships - This trust is committed to developing partnerships with statutory, voluntary and private organisations that will bring value and opportunity to the trust's current and future services. The trust has a risk seeking (High) appetite for developing these partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.

4. Financial Stability - The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose. The Trust is averse (Low risk appetite) to committing non evidence based expenditure without its agreed control limits.

5. Recovery - As a Trust we look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring the effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family. The trust is risk adverse (Low) to recovery that does not provide high levels of compliance with service user outcome measures.

6. Improvement and Innovation - Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The trust has a risk tolerant (Moderate) appetite to risk where benefits, improvement and value for money are demonstrated.

7. Leadership & Talent - The trust is committed to developing its leadership and talent through its Organisational Development and Workforce strategy. The trust is committed to investment in developing leaders and nurturing talent through programmes of change and transformation. The trust has a tolerant (Moderate) appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.

8. Operational Delivery of Services -The Trust is committed through its embedded strategy, governance and performance management frameworks to deliver the activity for which it has been commissioned. The Trust has an adverse (Low) appetite for failing to deliver the requirements outlined and agreed in commissioner contracts.

F

NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 January 2021
Implementing Continuity of Carer in Midwifery Services

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

To update the Board of Directors regarding progress on implementation of Continuity of Carer in line with maternity transformation and CNST MIS requirements

Executive Summary – Key Points

The attached update demonstrates York Trust is meeting the National requirement of 35% women booked onto a continuity pathway by March 21. The additional measure of actual received continuity is on an improving trajectory. Work to increase continues and following a full workforce review plans will be developed for further continuity teams on York site to meet the longer term goal of 51% by March 2022.

Recommendation

The contents to be reviewed and noted at QPAS and sent forward to the Board of Directors for information.

Author: Gillian Locking, Midwife Manager

Director Sponsor: Heather McNair, Chief Nurse

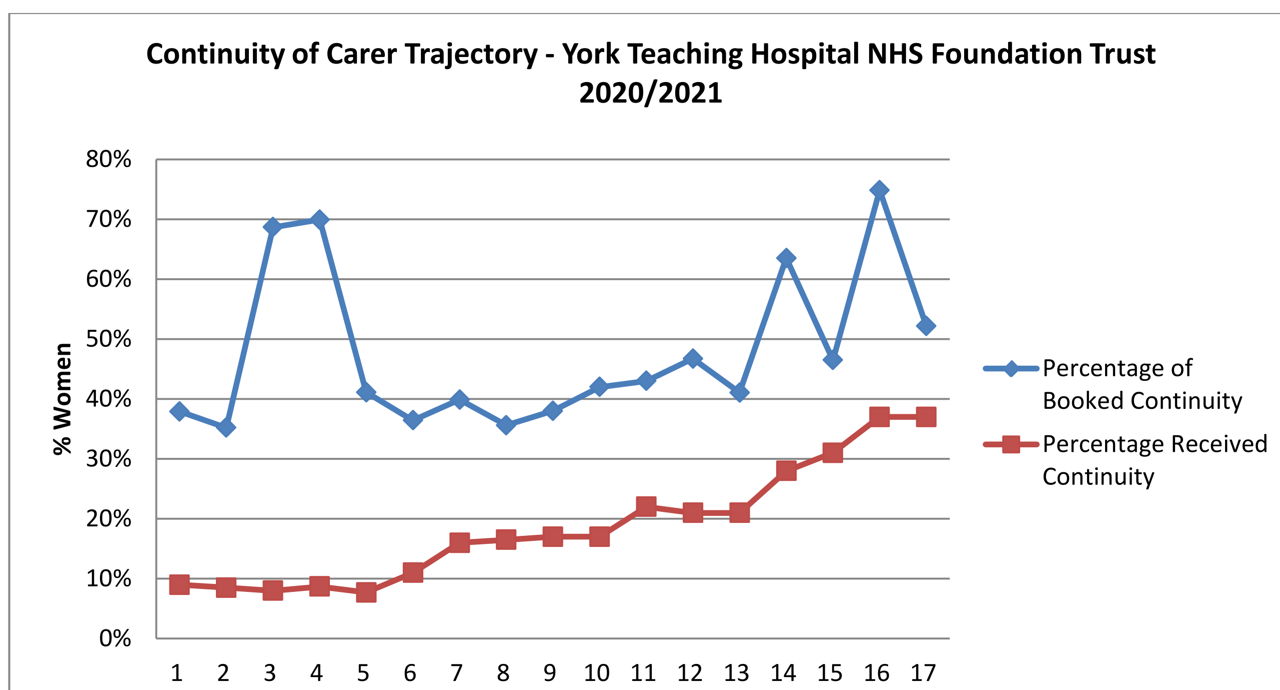
Date: 30 December 2020

1. Introduction and Background

Maternity Services in England have remained in the spotlight since the publication of Better Births in April 2016, the report of the National Maternity Review. The national Maternity Transformation Programme is the vehicle used to facilitate the implementation of the Better Births recommendations.

2. Detail of Report and Assurance

2020	SGH bookings onto CoC pathway	York bookings onto CoC pathway	Total bookings onto a continuity pathway(A)	SGH transfers onto pathway <29w	York transfers onto pathway <29w	Total transfers (B)	A + B	Total Trust wide bookings (C)	B + C	Percentage of women booked onto pathway	Total Trust Births	Percentage of Women receiving Continuity of Carer	Comments
January	185		185			0	185	488	488	37.9%	364	9%	
February	154	3	157			0	157	446	446	35.2%	329	9%	Sapphire team launched - not on call
March	166	29	195	100	36	136	331	482	618	68.7%	370	8%	
April	188	27	215	136		136	351	502	638	69.9%	326	9%	
May	139	18	157			0	157	382	382	41.1%	360	8%	
June	128	17	145			0	145	398	398	36.4%	338	11%	Sapphire team relaunch
July	168	19	187			0	187	469	469	39.9%	367	16%	Jasmine Team launch
August	137	14	151			0	151	424	424	35.6%	341	17%	
Septembe	121	18	139			0	139	366	366	38.0%	375	17%	
October	168	8	176			0	176	421	421	41.8%	381	17%	
Novembe	164	25	189			0	189	436	436	43.3%	264	22%	Malton Team Launch as on call
Decembe	160	21	181		25	25	206	441	466	46.7%	349	21%	1.0 WTE to aSapphire team with caseload
											349		
2021											349		
January	160	21	181			0	181	441	441	41.0%	349	21%	
February	160	45	205		75	75	280	441	516	63.5%	349	28%	2nd on call team - York site (Jorvik)
March	160	45	205			0	205	441	441	46.5%	349	31%	3rd on call team - Scarborough
April	160	70	205		75	75	330	441	541	74.8%	349	37%	3rd on call team - York Site
May	160	70	230			0	230	441	441	52.2%	349	37%	



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

Current Trust Position

Booked onto a continuity of carer Pathway Statistics – November 2020

Total Trust bookings for November = 436
Scarborough bookings = 164
Sapphire team bookings = 25

Percentage booked onto a CofC pathway for November = 43%
BAME booked = 30.1%
Postcode for top decile for deprivation booked CofC = 97%

Received Continuity of Carer Statistics – November 2020

Intrapartum care received = 22% (Oct 17%)
Intrapartum CofC received in Scarborough = 61.5% (Oct 45%)
BAME received = 20%
Postcode for top decile for deprivation received CofC = 19.5%

**Projected plans for 2021 are currently unapproved and will rely on a finance to create further teams in improve CoC care on York site. We will update with any progress.

3. Next Steps

Recruit Lead Midwife for Continuity of Carer.

Continue to strengthen teams and work with service users and Midwives to outline the direction of the teams.

Await Birthrate plus review before building a business case to facilitate plans for 2021.

We will continue to report our monthly progress to the Board.

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NHS
York Teaching Hospital
NHS Foundation Trust

Board of Directors – 27 January 2021
Medical Director's Public Report

Trust Strategic Goals:

☒ **to deliver safe and high quality patient care as part of an integrated system**
☒ **to support an engaged, healthy and resilient workforce**
☒ **to ensure financial sustainability**

Recommendation

For information	☒	For approval	☐
For discussion	☒	A regulatory requirement	☐
For assurance	☐		

Purpose of the Report

This report provides an update from the Medical Director in quality, safety and effectiveness.

Executive Summary - Key Points

The key point to note from this report is as follows:

- There remain a significant percentage of actions arising from national audits overdue for delivery. Work is underway with the care groups to address this position, however it is anticipated that this position will deteriorate further during the current COVID-19 surge as clinicians will have limited capacity to address the actions.

Recommendation

Board of Directors is asked to note the Medical Directors Report for January 2021.

Author: Caroline Johnson, Deputy Director of Governance & Patient Safety

Director Sponsor: James Taylor, Medical Director

Date: January 2021

1. Introduction and Background

The Medical Director's report provides an update in relation to clinical effectiveness, audit, policies, patient safety, duty of candour and risk registers.

2. Clinical Effectiveness & Audit

There are currently 3 overdue quality account audits; this has reduced from 4 the previous months. However, the number of overdue actions arising from the audits has increased resulting in 81% (114 out of 140) being overdue for delivery. In contrast the delivery of NCEPOD actions has improved considerably over the last month with the number of overall actions due for delivery reducing from 61 to 33. However, of the 33 actions 32 (96%) are overdue. In order to address this position the corporate team provide a monthly summary report for the care groups for review within their governance groups and the head of Compliance has met with each of the Governance Facilitators to ensure that they understand their role in ensuring delivery.

There are 8 NICE baseline assessments overdue, although 5 are awaiting care group sign off. Significant improvement has been achieved in relation to clinical policies with only 1 currently overdue. This was due for completion by the end of December 2020.

It is important to note that with the current surge of COVID-19 it is anticipated that there will be limited progress in relation to this agenda for the next few weeks, as clinicians and care groups will have limited capacity to focus on audits, effectiveness and policies.

3. COVID related harms

The Governance Team has written a draft standard operating procedure (SOP) for the capturing, monitoring and investigation of harms arising from delays caused by COVID-19. The SOP will be presented to the Risk and Oversight Group for discussion and approval.

4. Quality Improvement

The Improvement Team have moved under the portfolio of the Medical Director, line managed by the Deputy Director of Governance and Patient Safety. A dormant steering group has been re-established to develop a refreshed QI strategy which will be presented to the Quality Committee in Q1 2020/21.

5. Antibiotic Usage

The Pharmacy Antimicrobial Team Antibiotic Usage Summary Report Jan19 - September 20 is included for review as part of this report in Appendix 1.

6. Risk Registers

The interim Head of Risk Ivan Le Roux has now left the organisation. However, prior to leaving he completed a review of the corporate risk register, which is the subject of a separate paper on the agenda. There remains however, a great deal of work to do, to move several risk registers held on spreadsheets, to Datix and to embed a risk management culture within the organisation. Therefore, it has been agreed with the CEO to appoint a further interim for 4 months while more permanent options are explored. An interim will commence in mid-February and Ivan Le Roux had agreed to provide them with a full handover.

7. Recommendations

The Board of Directors are asked to note the updates within this report.

Appendix 1

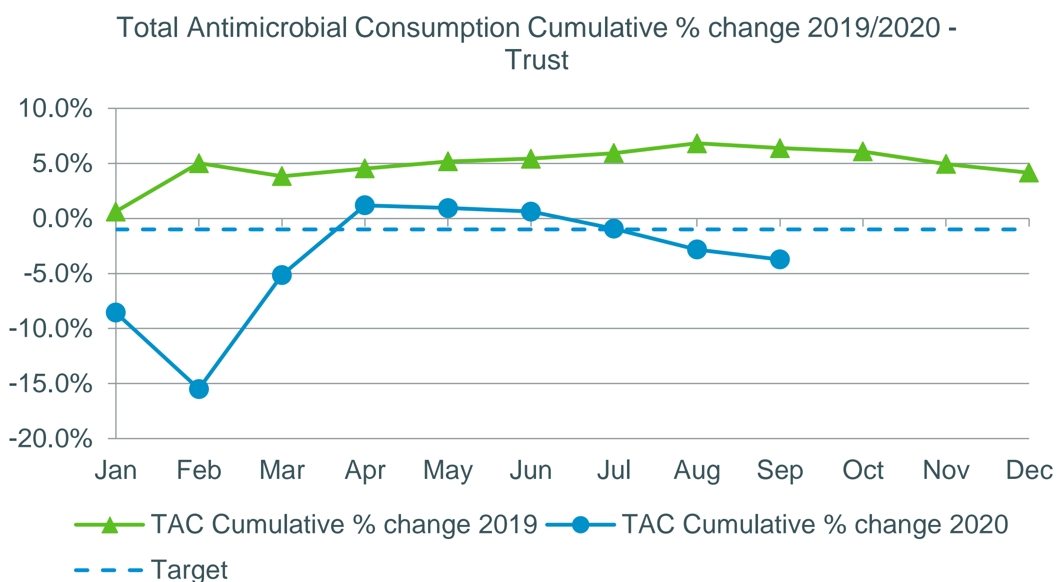
Pharmacy Antimicrobial Team Antibiotic Usage Summary Report
January 2019 to September 2020

This report details a summary of Trust antibiotic consumption data, this information was extracted from the Rx Info web site at the beginning of December 2020 and reports on antibiotic usage up to September 2020. (Please note the 10 week lag from the end of September to the December which is caused by a natural reporting delay and accounts for Trust prescriptions dispensed in community pharmacies).

Total antibiotic consumption data
% change in the cumulative totals comparing 2019 and 2020 up to and including September 2020.

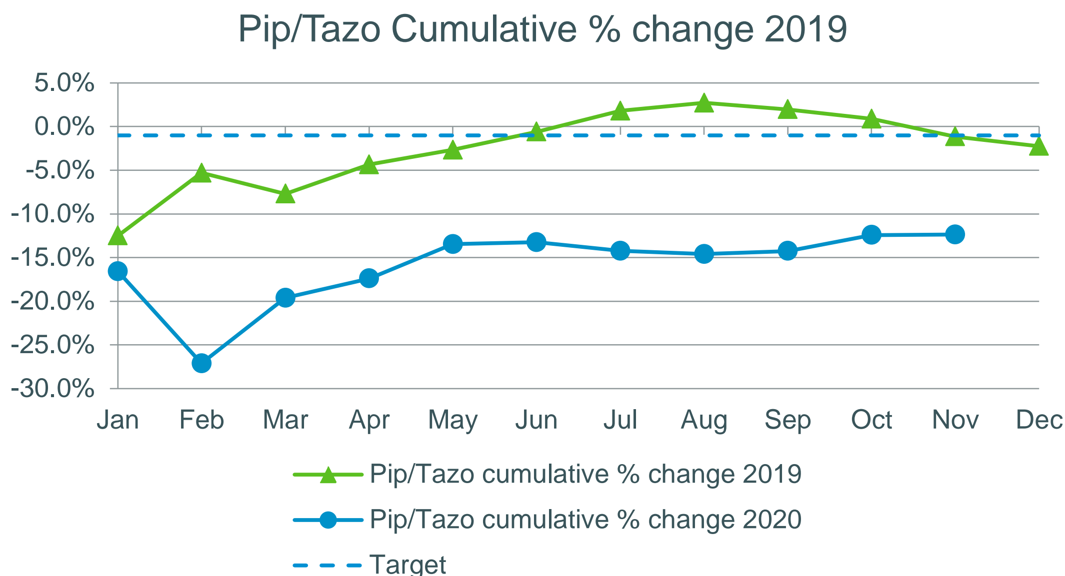
National Contract Targets – Trust wide
National contract target 1% reduction

Key Total Antimicrobial Consumption (TAC)



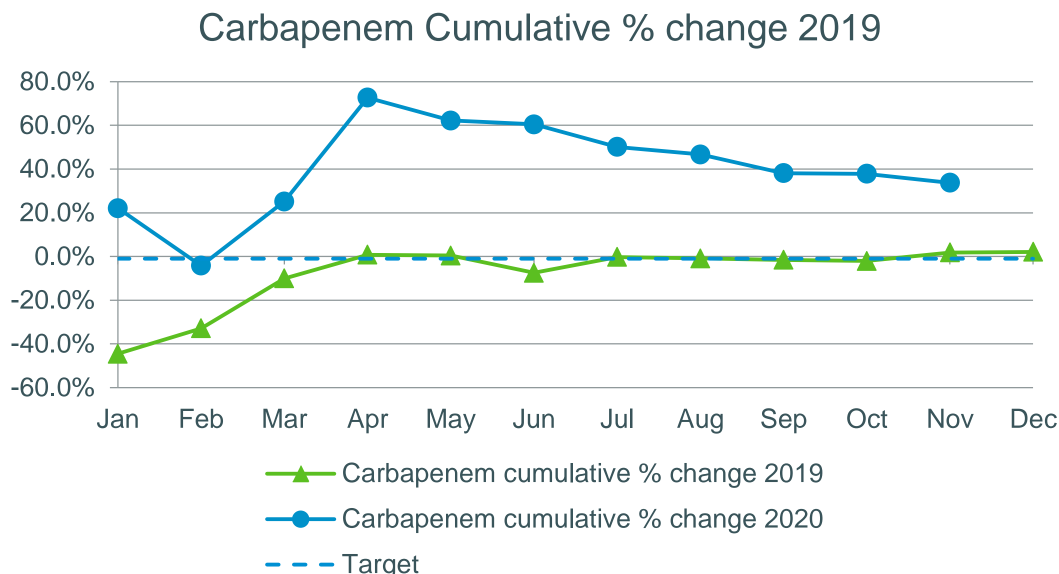
The volumes of antimicrobials grew between March and June as the Trust responded to the Covid crisis and split into hot and cold areas. This meant that antimicrobials were stored in more places, not that more patients received antimicrobials. The pharmacy team has worked hard at making sure that the stocks in those areas are tightly managed, as well as adjusting pack sizes so that patients only receive the quantities they require. This is an important issue in preventing antimicrobial resistance as it removes the temptation for patients to keep excess antimicrobials and use them when they are feeling unwell.

Consumption of Pip/ taz (Piperacillin/ Tazobactam) until the end of November 2020



The consumption of pip taz remains well below the previous years consumption.
A recent survey of Trust wide pip taz patients has shown that in Nov 20 compared to Nov 19, there is a 22% reduction in patients actually prescribed Pip taz. It is also encouraging to see that 69% of patients had their Pip taz stopped by day 4, compared to 64% in the previous year. The antimicrobial team are continuing to support the reviews of Pip taz through the twice weekly ward rounds.

Consumption of Carbapenems until the end of November 20



The impact of using Ertapenem as the first line choice of bacterial pneumonia associated with Covid during the initial wave continues to decrease as we have reverted to our usual choices for pneumonia.

ARK (antibiotic review kit) - has been suspended during December due to the outbreak of Covid on the York site and wanting to minimise footfall.

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Nominations Booklet
January 2021

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Nominations for January 2021

Amy Hope **Staff Nurse**	**Bridlington Hospital**	**Nominated by** **A colleague**

Amy is a really hard working individual.

Jenny Hughes **Occupational Therapist**	**Community Based**	**Nominated by** **A colleague**

Jenny is a committed and caring colleague. From the onset of the Pandemic she has acted as constant source of support to her team, taking on extra work and taking the time to check on how colleagues ar . She shows an unwavering dedication to her patients and role as an Occupational Therapist. Her skill and experience and just how hard she works have enabled countless patients to function with an increased level of independence and quality of life in the community. We are very lucky to have her as part of the community therapy team.

Sheryl Tattersall **Speech and Language** **Therapy Assistant**	**Community Setting**	**Nominated by** **Rachel Shearer** **A colleague**

Due to the limitations with face to face appointments in the COVID period, the Paediatric Speech and Language Therapy team has introduced 'teletherapy' so that Speech and Language Therapy could continue safely with children in both the first and second waves. Our virtual therapy approach was largely instigated by Cath Brown, Advanced Clinical Speech and Language Therapist, who was instrumental in supporting the team to get going with virtual therapy. However, I would like to nominate Sheryl Tattersall, one of our Speech and Language Therapy assistants, who has skilfully produced a wide range of innovative and interesting resources to support the whole team, often creating resources in her own time. Sheryl has shown huge adaptability and creativity in how she has enabled teletherapy to be accessible and fun for children. She has gone above and beyond her role in ensuring that teletherapy is accessible to as many families as possible, including researching apps to enable parents to access teletherapy resources on their personal devices. She has used her initiative and skill to ensure that teletherapy is fun and engaging for the children we work with, and has shown a huge openness to finding new ways of doing things. Sheryl's hard work has made it possible to keep delivering Speech and Language Therapy to children in an engaging way in these difficult times, and she has been amazingly helpful to the wider team in the resources she has produced.

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Fiona McHale **Secretary**	**Community Setting**	**Nominated by** **Tracy Means** **A colleague**

Fiona has tried to #raiseasmile for as many colleagues and friends as possible. Since the start of the second lock down, Fiona has videoed herself dancing to a variety of different songs, including some in fancy dress such as 'I want to break free' by Queen and posted these on Facebook for all to see. I can truly say they really do raise a smile at the end of a very busy working day. Fiona's plan is to do this until lockdown ends.

The Malton Hospital Estates and Facilities Team	**Community Based**	**Nominated by** **Usha Kante** **A colleague**

A gold star to the team in Estates and Facilities at Malton Hospital. Recently, The radiators weren't heating in Audiology rooms making the room difficult to work. One quick phone call, they came in a jiffy, recorded the job to be done, and even got a temporary heater to make the room bearable for us within minutes. Similar thing has happed in summer when the radiators were heating up unnecessarily and making the room too hot. they came to have a look within seconds of the call and fixed it for us. Never had anything sorted so quickly! It is amazing to see them care so much for their colleagues. We are very grateful. Well done.

Claire Cole and Lizzie King **Physiotherapist and Occupational Therapist**	**Community Based**	**Nominated by** **Fiona Skelton** **A colleague**

A lovely thank you letter received from a Patient of Lizzie and Claire's that I felt should be shared to show how much Patient centred interventions in their own homes are invaluable : "I would like to thank you from the bottom of my heart for your kindness and sympathetic approach to me and my various conditions. I have always been a great supporter of the NHS but you two have shown by your dedication and enthusiasm that it is not just a job but a life changer for your patients. Once again many thanks for all your help and be assured that your interventions have made the quality of my life not only easier but greatly improved. " Thank you both . The letter is reproduced with the consent of their patient Mrs Little who would like to nominate them both.

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The Therapies Team | **Scarborough Hospital** | **Nominated by Pauline Rabet A colleague**

The Therapy team has been amazing throughout the pandemic working incredibly hard to ensure patients were getting home safely in those difficult times. They have had to quickly adapt to a new way of working while trying to remain as holistic as possible and keep their patients at the centre of their practice at the best of their ability in such a restrictive climate. I feel proud to have been part of such an amazing and welcoming team.

Ruth Popham Discharge Liaison Officer | **Scarborough Hospital** | **Nominated by Pauline Rabet A colleague**

I would like to personally thank Ruth for her hard work and dedication. During the Pandemic I got the chance to work with Ruth on multiple occasions and she always demonstrated kindness and compassion. She would stay behind to ensure a patient could leave that day and would always think of the little things that would make a patient's journey as smooth as possible. Ruth would also take patients down to the discharge lounge herself which not everyone does! I think she's great at her job and a brilliant human being. Thank you Ruth. I'm proud of having worked with you. You deserve this award!

Victoria Spencer Administrator | **Scarborough Hospital** | **Nominated by Frances Woodcock A colleague**

Vicky has been a massive help to the Resuscitation Team in the work they do keeping our Advanced Life Support courses running at Scarborough Hospital. This course is essential for many of our medical and nursing staff who treat and manage acutely unwell patients and are part of our cardiac arrest teams. Continuing to run education courses through a pandemic has not been easy. Within the Covid climate, continuing to run theses advanced courses has presented numerous challenges. This has included keeping candidates and teaching staff safe through social distancing measures, juggling constantly changing candidates / teaching staff (some of whom withdraw at the last minute due to isolation, etc), keeping everyone hydrated and well fed, co-ordinating teaching and practical sessions whilst adhering to the latest social distancing and PPE guidance. Vicky has worked tirelessly with us to ensure we meet the requirements of the Trust in terms of social distancing in the work place, keeping us right on the requirements within the educational department whilst ensuring a high quality education experience for the candidates. She has worked with external bodies to ensure the courses run smoothly, managing candidate queries, organising the teaching faculty, writing and rewriting programmes, facilitating and invigilating the written exam and filing course returns. This is all on top of her regular job. Vicky always does this with a smile on her face and a willingness to help. Nothing ever seems too much trouble.

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Chris Williams | **Scarborough Hospital** | **Nominated by**
Anatomical Technician | | **Elizabeth Fox**
| | **A colleague**

The Mortuary in Scarborough is solely staffed by Chris, who always demonstrates kindness and compassion in his duties. Chris came in at the end of his week of annual leave to cover the Mortuary in Scarborough at very short notice to cover sickness. This enabled the Mortuary to continue to provide the usual level of service and allowed his colleague to go home knowing that the facility was looked after. Thank you Chris!

Sam Giwa, Karen Brown, Donna Kenney and Elaine Linsley
Ward sisters and Healthcare Assistants
Scarborough Hospital
Nominated by Julia Stevens
A Colleague

These ladies have been absolutely amazing my dad was admitted to hospital on 6th of November and was not very well at all. He has vascular dementia. My dad was moved to Lilac Ward then Cherry Ward because of contact with COVID then moved to CCU for 1 night, then to Chestnut Ward. The staff on the ward know my dad and I was happy that dad was put on there. Dad was on a closed bay so I could only have contact via my phone and the staffs phones. We had face time so I could see my dad the girls also sent me videos which I will cherish always. They have gone above beyond their job roles and I cannot thank them enough for the care and support they have given my dad. They kept dad happy and content. Dad also had his photo book that the dad and the staff could look through with dad. Dad was on Chestnut Ward for 9 days. Dad has improved. I so think that the lady's and staff deserve a mention and a massive thank you for all the hard work that you all amazing job.

Rachael Draper
Healthcare Assistant
Scarborough Hospital
Nominated by Debbie Hayden
A colleague

Rachel is a lovely caring person who is well liked by staff and patients. She also looks after her colleagues well by organising the birthday club where everyone receives a nice present and card and also a cake, she arranges flowers and cards to staff who are off work unwell, she bakes delicious cakes and brings them to work for everyone to enjoy - even if it isn't anyone's birthday and is just a very nice person. She makes sure that we are all alright mentally and physical and mentally, and never takes anything in return. Rachel was very ill earlier in the year with COVID, she still gets some effects of it, so therefore I think that if she received a star award it would cheer her up and make her day. She deserves this award.

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Phil Jones, Claire Grover and Michelle Trott
Associate Specialist, Lead Nurse and Healthcare Assistant

Scarborough Hospital

Nominated by
Chistabelle Kay Duffield
A patient

I attended A&E Scarborough at the request of my Doctor. The department was extremely busy. I was checked in quickly, seen by the first nurse quite quickly then sent to the doctor in acute assessment. This lady was very professional, extremely pleasant and showed great concern for my condition. She was very thorough and I was then sent back through A&E. A long wait later I was taken in for further assessment - again all staff extremely busy but showed care and treated me very well. Further into A&E the Doctor, Senior Sister and Radiologist all treated me with dignity and kept apologising for my wait. The Senior Sister made time to keep me updated as to my wait and made me feel respected and not just a number. It is not the best experience having to wait in A&E, I get anxious knowing others are ill around me, but these staff are amazing, working under extreme pressure and work load yet everything seemed to run like clockwork. A shortage of beds and cubicles was apparent which must put the team under so much extra strain and making their daily work area so restricted. A long day for me but longer for those working in those busy conditions. In addition everything was extremely clean within A&E, staff were constantly cleaning areas - which must also be so demanding in the current covid-19 situation. Thank you for my excellent care and well done everyone. Stay safe.

Kim Robinson
Midwife

Scarborough Hospital

Nominated by
Helen Gilbert
A colleague

Sickness on labour ward at Scarborough Hospital led to a staff shortage. Kim took it upon herself to come to Scarborough Hospital and offer to work her continuity shift which she should have worked based at Malton Hospital at Scarborough Hospital instead to increase staffing numbers and ensure a safe service was available for women. Kim is a newly qualified midwife and it's admirable to see her level of understanding of staffing in the service so early on in her career! Thank you Kim.

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Scarborough Children's Clinic and York Child Development Centre Teams | **Trust Wide** | **Nominated by Sharon Miles A colleague**

Since the beginning of the COVID crisis both teams have worked extremely hard to ensure that the needs of all children are being met. Initially, by ensuring that clinically urgent children who needed to be seen were able to be seen in a safe, face to face environment and also by converting any non-urgent appointments into telephone or virtual appointments to ensure children were still being seen without having to attend any of the hospital sites. Then more recently, both teams have worked on the restoration of services wherever possible, whilst also putting measures in place to ensure the safety of patients/families/carers and staff and adhering to all the COVID guidance rules. This has been a mammoth task which all members of both clinic teams have taken on board and worked together to find solutions. Both teams have shown a collaborative approach to dealing with the task, whilst thinking 'out of the box' to get services back on track.

Liz Costello Care Group Governance Facilitator | **Trust Wide** | **Nominated by Jo Mannion A colleague**

Liz has recently commenced a brand new role in the organisation as Care Group 5 Governance Facilitator . She has adapted to a completely different role (previously Lead nurse in the Children's Sexual assault service) to this liaison /administrative role without any clinical work or patient facing time, which I know she misses. She has made a fantastic start; already making a significant contribution to our Care Group quality agenda. She is very innovative constantly driving improvement and is a pleasure to work with.

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Julie Taylor | **York Hospital** | **Nominated by**
Advanced Specialist Nurse | | **Elizabeth Fletcher**
| | **A patient**

I got in touch with Julie at the start of this year when I was relocating from London to York and had no idea where to start in transferring my MS care and medication. I was so daunted by the prospect and received no guidance from my previous hospital. I left a garbled voice message and Julie got back in touch within an hour. She helped get me set up and put my mind at ease that my care would continue and help would be at hand. I've needed her again throughout the pandemic for guidance on Covid-19 and each time she has got in touch promptly with clear and helpful support and advice. It's these qualities - reliability, compassion and a genuine desire to help - which make all the difference. I've never had the chance to tell her how much it has helped me - and I'm sure it's only a small part of many brilliant things she does - but it made a world of difference to me.

Claire Kilmartin | **York Hospital** | **Nominated by**
Sister | | **Jenna Tucker**
| | **A colleague**

On the 24th June my little boy sustained a significant head injury which subsequently led to two rounds of surgery one at York followed by a Craniotomy at Leeds when a fractured skull was discovered in the first surgery. I am Children' s Therapy Team Manager at York but quickly found myself on the other side of the fence as a service user and Mummy. Needless to say I was extremely vulnerable, frightened and scared for my little boy. Every person we came into contact with on our York journey behaved extremely professionally and their care shone through, however Claire was amazing at more than one step in our journey. She provided me with unbiased emotional support when I needed it the most on the 25th June and proceeded to support when organising his follow up in a controlled and timely manner. Claire probably won't realise that her going the extra mile to support my family at such a difficult time meant a lot. Her care put us back in control of an impossible situation, empowered us to move forwards and reduced anxiety. Care Group 5 is passionate about outstanding care I'm proud to be a part of that and can safely say I have now received outstanding care from Care Group 5- Thankyou Claire

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A monthly award which recognises the achievements of staff and volunteers

Jim Ferguson and Arran Carney **Emergency Nurse Practitioners**	**York Hospital**	**Nominated by** **Jonathan Hanlon** **A colleague**

I am nominating Jim and Arran for a star award for the professional and caring way they dealt with a very sensitive safeguarding case. When assessing a child they recognised that there were serious concerns around how she sustained her injury and identified how vulnerable she was. The work that was carried out to find out her real identity and ensure she was safe was extraordinary. Both Jim and Arran displayed the Trust Values and as a team we are extremely proud of them. They followed the Trust safeguarding protocol while ensuring they maintained patient centred care. As a direct result of their actions the child is now safer with more safeguarding agencies involved in her care which may prevent other vulnerable children from being exposed to similar abuse.

Jenny Olivey **Specialist Physiotherapist**	**York Hospital**	**Nominated by** **Jo Whitmore** **A colleague**

Jenny has showed a great deal of dedication and leadership throughout the Covid period. Her role is mainly focused on the complex needs of ICU patients however, she has consistently delivered day to day guidance, skills sharing, training and support throughout the therapy team. She has worked incredibly hard to ensure quality patient care is delivered across the trust. It would be lovely to recognise and thank her for all the hard work she has put in over the last year.

Shirley Richardson and Ash Nicholls **Occupational Therapist and Physiotherapist**	**York Hospital**	**Nominated by** **Jo Whitmore** **A colleague**

Shirley and Ash have been supporting a patient who was being discharged to home under Fast Track status from ward 31. The patient presented with marked changes to his mobility and function, resulting in facing considerable lifestyle changes on discharge. The patient's wife was also undergoing serious medical treatment and has been facing a particularly challenging time. They provided emotional and practical support to both the patient and his wife who due to current restrictions had limited support and ability to assess the patient's condition. Both Shirley and Ash have worked beyond their role requirements including going to the patients home to move furniture and personal belongings to enable the patient to get the required equipment in to the home quickly . They have really demonstrated trust values in their dedication, compassion and hard work to meet the meet the patients and his wife's wish to return home.

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Nicola Bulmer **Sister**	**York Hospital**	**Nominated by** **Olivia Mouncher** **A colleague**

Prior to and during the Covid pandemic, Nic has been a wonderful ward Sister. Prior to becoming a Covid positive ward in March, many of the staff were struggling with anxiety and worry. Nic was with us every step of the way, supporting us, acting as a shoulder to cry on and cheering us up with gifts and thank you cards. She has taken us from a struggling ward, which couldn't retain its staff, to a Gold standard ward. As a Junior Sister, Nic has provided me with endless support and guidance and I honestly couldn't imagine having a better ward Sister. We all think she is wonderful and she really does deserve to be recognised for her hard work, many extra hours and dedication to the ward and team.

Louise Bowman **Nursery Nurse**	**York Hospital**	**Nominated by** **Stacey Needham** **A colleague**

Louise works with lots of families with children with life limiting and life threatening illnesses. She provides play and craft activities to explore emotional well-being. Specifically I am nominating her as she has worked very closely with a family whose 1 year old twin has just passed away from cancer. Louise worked to create memories of the child by organising photo shoots, ceramic and canvas artworks using the child's handprints and those of his siblings. She worked extra hours, on days off, and shot to Leeds General infirmary several times to complete artwork whilst the little chap was extremely poorly. In order to get the memories made. The family think the world of her, as do we as a team.

The team on Ward 34	**York Hospital**	**Nominated by** **Laura Wood** **A colleague**

One of our Cystic Fibrosis (CF) patients had an allergic reaction whilst starting home IV antibiotics. At the time of the reaction we were based at Clifton Park Hospital. She needed to be taken by ambulance to York Hospital. It is a difficult time for CF patients to be admitted to hospital with rising cases of COVID 19. Ward 34 did a three way bed swap in order to make a side room with en-suite available for the patient within an hour. Having a side room is essential for CF patients and having an en-suit means as little exposure to harmful bacteria as possible. With the extreme pressures the ward staff are facing at the moment they did a fantastic job at making this admission so smooth, safe and timely.

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Denise McNaughton **Admin Co-ordinator** | **York Hospital** | **Nominated by Jamie Todd A colleague**

Denise showed compassion and empathy when recently supporting a patient to attend her gynaecology outpatient appointment. The patient was elderly and required support to get to her appointment, Denise recognised the patient's additional needs and went over and above to meet her at the reception of the hospital and support her in attending her appointment. Denise always demonstrates the Trust values, but on this occasion showed a level of compassion and kindness that deserves recognition. Well done Denise.

Isabelle Jeans **Midwife** | **York Hospital** | **Nominated by Hannah Harness A colleague**

Izzie is a delight to work with and always goes that extra mile for her patients and is so polite and helpful towards her colleagues. This week Izzie has been looking after a COVID positive lady who's baby is on SCBU and she has not yet been able to meet her baby, Izzie has given this lady support, regular updates and lots of TLC. Caring for women appears to come easy for Izzie and she constantly gets positive feedback, I think it's only fair she gets the credit she deserves.

Mike Minihan **Staff Nurse** | **York Hospital** | **Nominated by Gemma Grainger A colleague**

Recognition for Mikes contribution in the support offered to students. Mike is the LEM for Paediatrics, he is an extremely thorough and contentious nurse and this is extended when supporting students. Mike is always available and goes over and above his duties. As the LEM Mike supports students in ensuring their placement runs smoothly, however this role can be sometimes be demanding as students require extra support to in addition to the expectations of the role. Mike treats everyone as an individual and takes everything in his stride; he always has a positive outlook.

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Dan Brown **Medical Equipment Engineer**	**York Hospital**	**Nominated by** **Duncan Fryer** **A colleague**

Theatres have just purchased 30 new patient trollies, these were delivered with the wrong type of O2 connectors. Dan immediately got his engineering head on, sorted the problem and made an attachment that meant we could fit a different O2 regulator to them. This enabled us to get the trollies into service as quickly as possible. Without Dan's input we would all be still sitting here scratching our heads.

Geraldine Lowes **Staff Nurse**	**York Hospital**	**Nominated by**

A lady was given the wrong appointment letter and paid £2.20 out of her money to park in the York hospital car park when her appointment was at Equinox House. This lady was very upset so Gerry give her £2.20 out of her own pocket the lady was delighted and said it made her day.

Helen Greenley, Lisa Young and Rif Rizvi **PPE Team**	**York Hospital**	**Nominated by** **Kevin Craven** **A colleague**

I have been involved with the PPE distribution / set up from day one and I have to say it has been a tough challenge especially when having to fit this in around my other work. Helen and her team had taken over from me and made many alterations, moved to other depts., created a better system for keeping all of the hospital and surrounding areas stocked up with PPE, it is a demanding and thankless job at times, rewarding too, but it has its moments. They are all doing this work on top of their own work and I feel these people deserve a medal, in this case a Huge Star to show the appreciation of their hard work, it is a continuing role at the moment with Covid19 playing havoc with everyone, and I would really like these people to be recognised please.

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Anne Hallam
Physiotherapy
Professional Lead
York Hospital
Nominated by
Jenna Tucker
A colleague

Anne is an exemplary professional lead. She has tremendous insight into professional needs and expectations alongside her ability to lend herself intuitively to the needs of individual staff members. She invests in staff wellbeing but her approach to this is empowering and thought provoking she spends the time to understand 'what makes you tick'. By doing this she has the ability to make you feel valued and inspire you to achieve. This year Anne has provided a particular sense of grounding to my senior team members at a time of significant turbulence. I know her support has really made a difference. In addition to this she has shown me compassion and empathy whilst encouraging me to look ahead in a time of personal crisis. Thank you Anne

Dan Taylor
Charge Nurse
York Hospital
Nominated by
Lucy Frain
A colleague

He has shown great leadership and knowledge and strength in his role on the Acute Medical Unit. He has worked hard with integrity and strength.

The Maternity Records Office Team
York Hospital
Nominated by
Denise McNaughton
A colleague

Katie Wiggins, Louise Atkin, Jill Taylor, Debbie Archer and Linda Powell have kept and are still keeping the roles in maternity records office and Ante natal reception covered under very difficult circumstances. Never do they complain, nothing is ever too much for them. They are working extra hours, moving their shifts around, sharing the cover of roles and generally keeping things going. They are the embodiment of the Trust values and I am proud to have them as part of my team. I just hope that this nomination goes some way to thanking them for all they have done and continue to do for the department.

StarAward

A monthly award which recognises the achievements of staff and volunteers

The Team on Ward 14 | **York Hospital** | **Nominated by Angela Stone A colleague**

I was admitted to A&E on Sunday 13th September with a suspected bowel perforation caused by a duodenal ulcer. After 48 hours in a "holding ward" to wait for Covid 19 result, I was transferred to Ward 14. During the following 11 days I spent on the Ward, I came into contact with all the staff on shift rotation but was, in particular, cared for by Linda, Kerry, Megan, Emma, Arran and Craig - all under the supervision of Sister Marieke. I apologise that I don't know any surnames but I wanted to send my gratitude and appreciation to the whole team who are working under incredible pressure during these unprecedented times.

Marcel Gatt Consultant | **York Hospital** | **Nominated by Angela Stone A patient**

I was admitted as an emergency on 13 September and was so fortunate to be assigned Mr Marcel Gatt as my Consultant. Not only was his care plan and communication of my diagnosis exceptional, I also felt like I was treated as an individual (never just another patient) and his attention to detail and the subsequent care extended by his Team was always prompt and caring. I am incredibly grateful and would like to extend my appreciation to Mr Gatt and his Team through the recognition of this Star Award.

Donna Sykes Operating Department Practitioner | **York Hospital** | **Nominated by A colleague**

It is hard to nominate just one person from the Operating Department Practitioner team when many of them are stepping up to cover shifts at short notice, covering other hospitals, staying late and missing lunches. Donna, a senior member of the ODP team has also come to work on her days off to arrange the seamless Thromboelastograph (TEG) changeover to a new system and volunteered to be an on call point of contact out of hours to troubleshoot and support the important blood testing system implementation.

The Star award nomination form can be accessed through the Star Award link on the website and Staff Room.

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