York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

26 May 2021

LNER lounge, York Community Stadium Leisure Complex, Kathryn Avenue, Monks Cross Dr, Huntington, York YO32 9AF

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Good Meeting Etiquette

KEY POINTS

- **Good meeting behaviour contributes to good meeting outcomes.**
- **Effective meetings need forethought and preparation.**
- **Listening, respecting your colleagues' right to express their views and making your points constructively are the cornerstones of good meeting etiquette.**

The checklist below includes activities you could go through at the start of your meeting. They give you a clear summary of what everyone should expect to be able to do, and how they can expect to be treated.

ASK YOURSELF, *HAVE I...*

- ✓ **read and understood the minutes and papers?**
- ✓ **checked the agenda?**
- ✓ **made notes on what I want to say?**
- ✓ **got written responses to anything I've been asked to address?**
- ✓ **arranged to be there for the whole meeting?**

TELL YOURSELF, *I WILL...*

- ✓ **actively participate ensuring I stick to the point, but do not dominate the meeting.**
- ✓ **really listen to what people say.**
- ✓ **compliment the work of at least one colleague.**
- ✓ **try to make at least one well prepared contribution but not repeat what someone else has said.**
- ✓ **remember it is about representing members and not bring personal experiences to the meeting.**

ENVIRONMENT

- ✓ **can I hear/see everything that is going on?**
- ✓ **is my phone switched off?**

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: 26 May 2021

By:

TIME	MEETING	LOCATION	ATTENDEES
09.00	**Board of Directors meeting held in public**	**LNER lounge, York Community Stadium Leisure Complex, Kathryn Avenue, Monks Cross Dr, Huntington, York YO32 9AF**	**Board of Directors**
12.00	**Lunch**		
12.45	**Board of Directors – Private**		**Board of Directors**

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

Date: 26 May 2021
Venue: LNER lounge, York Community Stadium Leisure Complex, Kathryn Avenue, Monks Cross Dr, Huntington, York YO32 9AF
Time: 09.00-12.00

All items listed in blue text, are to be received for information/ assurance and no discussion time has been allocated within the agenda. These items can be viewed in a separate supporting information pack (Blue Box).

	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Welcome and Introductions** To receive any apologies for absence.	Chair	Verbal	-	09.00
2.	**Apologies for Absence** To receive any apologies for absence	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda	Chair	Verbal	-	
4.	**Minutes of the meeting held on 31 March 2021** To be agreed as an accurate record	Chair	A	09	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log	Chair	Verbal	-	

York and Scarborough Teaching Hospitals NHS Foundation Trust

	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**Patient Story**	Chair	Verbal	-	09.10
7.	**Chief Executives Update** To receive an update from the Chief Executive • Recovery • Strategy	Chief Executive	B	19	09.25
8.	**Board Assurance Framework** To receive and note the revised Board Assurance Framework 2021/22	Chief Executive	C To follow	-	
Strategic Goal: To deliver safe and high quality patient care					
9.	**Quality Committee Ecalation Report** Items for escalation to the Board:	Committee Chair			09.55
9.1	• To receive and note the minutes of the meeting held on 20 April 2021		D1	23	
9.2	• To receive and discuss the committee escalation log from 18 May 2021		D2 To follow	-	
9.3	• Medical Directors Report		D3	-	
10.	**Safer Staffing Report** To note the report	Chief Nurse	E	33	10.00
11.	**Perinatal Clinical Quality Surveillance Report** (Ockenden) To note progress	Chief Nurse	F	41	10.05
12.	**Clinical Workforce Review - Maternity Incentive Scheme** To note and agree the proposed actions	Chief Nurse	G	51	10.10

	SUBJECT	LEAD	PAPER	PAGE	TIME
13.	**Infection, Prevention & Control monthly Report** To receive the report	Chief Nurse	H	59	10.15
14.	**Care Quality Commission – Update** To provide an updated position	Chief Nurse	I	83	10.20
	BREAK				**10.30**
Strategic Goal: To ensure financial sustainability					
15.	**Resources Assurance Committee Escalation Report** Items for escalation to the Board:	Committee Chair			10.50
15.1	• To receive and note the minutes of the meeting held on 20 April 2021		J1	101	
15.2	• To receive and discuss the committee escalation log from 18 May 2021		J2	107	
16.	**Integrated Performance Report** To note and discuss the performance of the Trust	Chief Operating Officer/Chief Nurse/Diector of Workforce & OD/Director of Finance	K1	109	10.55
16.1	• Integrated Business Report (blue box)		K2	-	
17.	**Operational Plan - final report** To approve the final plan for submission	Chief Operating Officer/Director of Finance	L	115	11.00
Strategic Goal: To support an engaged, healthy and resilient workforce					
18.	**Research Presentation**	Lydia Harris & David Yates	Presentation	-	11.20

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	SUBJECT	LEAD	PAPER	PAGE	TIME
Governance					
19.	**Code of Governance** To note the updated report	Chief Executive /Trust Secretary	M	123	11.40
20.	**Fit and Proper Persons Requirements** To note the Fit and Proper Persons Review	Chair/Trust Secretary	N	161	-
21.	**Reflections of the meeting**	All	Verbal	-	11.45
22.	**Any other business**	Chair	Verbal	-	11.55
23.	**Time and Date of next meeting** The next meeting will be held on 28 July 2021				
24.	**Exclusion of the Press and Public** '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.				

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Board of Directors
31 March 2021

Minutes of the York Teaching Hospital NHS Foundation Trust Board of Directors, held on Wednesday 31 March 2021, via Webex, commencing at 09.50am and concluding at 11.50am.

Present:

Non-executive Directors
Ms S Symington, Chair; Mrs J McAleese; Dr L Boyd; Mr S Holmberg; Ms L Mellor; Mr J Dillon; Prof. M Morgan; Mr D Watson.

Executive Directors
Mr S Morritt, Chief Executive; Mr A Bertram, Deputy Chief Executive/Finance Director; Mrs W Scott, Chief Operating Officer; Mr J Taylor, Medical Director; Ms P McMeekin, Director of Workforce & OD; Mrs H McNair, Chief Nurse; Mr D Roberts, Chief Digital Information Officer

Corporate Directors
Mrs L Brown, Director of Communication

In Attendance:
Miss J Hall, Interim Trust Secretary

The Chair welcomed everyone to the meeting.

21/14 Apologies for absence

No apologies were received.

21/15 Declaration of Interests

Prof Morgan declared an interested as he is the Clinical Consultant at HUTH.

21/16 Minutes of the meeting held on 27 January 2021

The minutes of the meeting held on the 27 January 2021 were approved as an accurate record.

21/17 Matters/actions arising from the minutes

No matters arising were discussed.
Action Log:
Action 19/68 Removed as this was no longer relevant

Action 19/63 remained under review
Action 20/11 Remain on the action log as work was ongoing
Action 20/25 Invitation would be extended to VJ to attend a future meeting (June/July)
Action 20/26 On agenda for April Board Time-Out
Action 20/40 IPC report to come to May Board as a half year report

RESOLVED
That the Board noted the items outstanding on the action log

21/18 Patient Story

HM introduced the patient story noting that there were two, one regarding maternity and one staff story. She introduced Freya Oliver, Head of Midwifery, who was leaving the to work on the East Coast. The Board thanked Freya Oliver for her contribution to the Maternity services. The second story related to two sisters training to be nurses.

The Board heard a story which had come to notice following a letter to the Chief Executive's office in February. The story related to a lady who lives in London who moved up to York during the pandemic to be nearer family during her pregnancy and birth. When she came in to give birth she was looked after by a midwife called Rachel who she praises highly. During Labour she mentioned to the midwife that when she was born she had problems with her tongue and had feeding problems, it took a long time for her to be diagnosed. When the baby was born Rachel examined the baby, she also was examined by a paediatrician also could not see anything wrong. During the night the Midwives spent a lot of time trying to help baby feed, Rachel had briefed the other Midwives including Angie who took over care in the morning and was also concerned. Baby was moved to SCBU and it was found that baby had some anatomical abnormalities in her mouth causing significant feeding problems. Mum can't praise the care she had enough, and acknowledges that the dedication of our staff prevented her daughter from becoming seriously unwell, with an undiagnosed condition. She described her experience at York as exceptional and wanted the Board to know.

The Board received a second story from Helen Hay involving two sisters training as nurses on the East Coast. The article would be appearing in the Scarborough post. The story focussed on two sisters experience of going on a paid placement in the trust. The title of the article is 'Coventry University Scarborough Campus nurse students step up to help the NHS'. The article would be shared with the Board when it was published. The article also included quotes from the nurses and the university. It was noted that nine of the nurses on the Coventry University Nursing course are being recruited substantively. The collaborative working between Coventry University and our nursing teams is of great value to the trust and the East Coast population in creating career opportunities for young people in nursing on the East Coast.

21/19 Chief Executives Update

The Chief Executive introduced his regular report, in particular providing an update on Covid-19 in terms of numbers in hospital across the Trust which had come down from 240 at the peak to 24 with 4 patients in critical care today. The focus post Covid was on staff and how to say thank you and importantly providing emotional support. The Board noted that a paper on Recovery would be presented to the Board at its meeting in April.

The Chief Executive provided updates on the recently published Planning Guidance 2021/22 which was for the first 6 months of the year (H1) focussed on expenditure for Covid-19 and recovery. He added that the centre were still in discussions on funding for the second half of the year (H2). He added that the Trust would produce its own plans

which would feed into the Humber Coast and Vale ICS plans for final sign-off. The Board noted that the Trust plans were due for submission at the end of April with the final ICS plan due on 6 May. The report set out the five priorities listed in the report and there was a sixth priority to work collaboratively across the system.

The Scarborough Urgent and Emergency Care Capital Scheme had received approval of the Outline Business Case from NHS England/Improvement, the Full Business Case would now be developed and submitted before the end of the year.

The Board were reminded that a lot of the ICS work will be done at Place level. Outline arrangements had been approved for York Health and Social Care Alliance which was co-terminus with York City Council boundaries. Simon referred to the Concord document appended to the report which required Board approval and sign-off. The Alliance would run in shadow form until 1 April 2022. Keith Aspen, Leader of the Council had agreed to be Chair and Simon Morritt elected Vice Chair. He added that the focus of the Alliance, in the early stages, was on out of hospital services and as of 1 April 2022 the Alliance would replace the CCG.

The Chief Executive further reported on the Government consultation on the future of local government in North Yorkshire for a single unitary authority. He added that the Trust would be responding to the consultation and supporting the proposal.

The Board were pleased to receive the notification that, in relation to the CQC recommendations, the Trust had officially been stood down from the Quality Board . A separate letter from NHSE/I had confirmed the Trust had moved from segment 3 to segment 2 of the NHS Oversight Framework noting that most Trusts were in segment 2.

The Board discussed the report, in particular, the good news stories, in response it was noted there was a Communications and Engagement plan which would include external PR. In response to a comment on the ICS and its focus, including staff and wellbeing, it was noted that any proposals for supporting staff wellbeing will require the ICS to sign-off any plans and hold us to account against delivery. In response to a question on the balance of power in the new arrangements, it was noted that later in the year there would be further guidance coming out.

RESOLVED
That the Board received and noted the report.

21/20 Quality Assurance Committee Chair's Report

The Chair of the Committee introduced his report which set out a number of matters the Committee had discussed at its meeting in March to escalate to the Board, this included an update on the work on the Ockenden Report which is a statutory requirement and the Trust was not yet fully compliant with, but working towards (it was noted the full papers were available in the information pack). The Committee was recommending to the Board to approve the safety actions 4 and 5 and for the Board to support the commitment to facilitate local in-person MDT training when this is permitted; a good news report on Community Services which highlighted how the team had worked collaboratively with outside bodies during the Covid pandemic to ensure best use of resources and innovative ways of working; and an update on the Clinical Summit in relation to patient safety concerns at Scarborough Hospital ED of the high number of 12 hour trolley breaches, a supportive meeting which recognised this was a system issue.

During discussion LB gave more detail on the Ockenden report and reminded the board of its responsibility around the maternity safety agenda. She added that the maternity

agenda was overseen by the Chief Nurse and supported by herself as NED Maternity Safety Champion. She added that reporting to the Board was through monthly reports including a Perinatal Surveillance Report, Perinatal Mortality Review report and Continuity of Carer Update all of which were presented to the Quality Assurance Committee. She added that nationally staffing, environment and culture had been identified as priorities. A staffing review was under way and a report including resource implications will be coming to Board in due course. Limitations in obstetric ultrasound was also an issue being looked at by the Trust. The recently published Planning Guidance highlighted that finance was available for maternity safety improvement via the ICS.

It was noted that a survey of Midwives in the Trust had taken place with 49.46% recommending the Trust as a place to work and 69.72% as a place to receive treatment. with the work being undertaken it was expected the results would improve over time. The Chair thanked LB for the update noting the staff views and felt assured with the updates. The Chief Nurse added that the £95m funding for maternity services will come via the LMS as part of the ICS, and the Trust would have to submit bids to win funding. In response to the question on the number of, and availability of, midwives to fill the posts, it was noted that more were required to comply with the continuity of carer requirements.

The Chief Operating Officer provided assurance to the Board on the key actions that had come out of the Clinical Summit on 12 hour trolley breaches which were now being taken forward, these included a clinical mapping process at Scarborough with an opportunity to refresh some pathways and include some of the learning from Covid and workforce challenges. She added that there were challenges on the East Coast in terms of workforce and capacity and conversations were around integrated services to deliver one Trust service to be delivered on 2 sites, Care Group 1 and 2 were working together on this and the action plan will be monitored via the performance review meetings.

RESOLVED
That the Board:

a) **Received and noted the report; and**
b) **received the update on the Ockenden recommendations and AGREED the recommendation from the Quality Assurance Committee to approve the safety actions 4 and 5 and SUPPORTED the commitment to facilitate local in person MDT training when this is permitted.**

21/21 Nursing Establishment Review - Update

The Chief Nurse introduced the report which provided an update on existing staffing deficits in the current funded in-patient ward establishments and reminded the Board that following the work undertaken last year a £5.8m gap for nurse staffing on inpatient wards had been identified. It was noted that the report had been discussed at length at the Executive Committee which had agreed the option for investment over 3 years and included support for investment in the priority wards on the East Coast at a value of around £2m.

The Board discussed safety issues and the impact on the bed base and the number of beds that should be open if staffing levels were below the requirements, in response it was noted there was a red flag system and in some areas bank and agency staff were used. There were systems in place to know day-to-day when staff levels were an issue. The Chief Nurse added that in terms of safety issues the Trust provided regular safety reports. The report was on pure nurse numbers and did not include other support. The Chief Operating Officer added that decisions to close beds only happen in extreme circumstances.

The Director of Workforce and OD discussed the recruitment of nurses to the East Coast and referred to the longer term solution of the link between Scarborough and Coventry University. She reminded the Board of the international nurse recruitment and the pipeline to recruit a further 180 nurses by the end of 2021. The Executive Committee had recently approved to continue with the programme for at least a further 12 months. In response to a question on the ICS's role in nurse recruitment it was noted that this was within the ICS remit and there was likely to be more mutual aid in the future – the LMS was referred to as an example and future direction of travel.

The Chair concluded and asked that all possible options were looked at to work towards the Trusts nursing establishment and that funding was made available.

21/22 Resources Assurance Committee

The Chair of the Committee introduced his report which set out a number of matters the Committee had discussed at its meeting in March and sought to escalate to the Board, this included the health and safety incident at Scarborough which it had been agreed will be led by the Audit Committee; the Terms of Reference and schedule of work; and safety at work following an assault on a member of staff and in light of the Sarah Everard abduction and murder to look at what could be done to improve the culture and safety of all our staff at work and around their commute. Other matters were being discussed later on the agenda.

In response to the discussion on safety of staff the Director of Workforce described the Trusts approach adding that incidents involving service users were reported on to the Datix system which was then picked up through the Health and Safety Committee. The Committee had discussed using the LLP to support with better lighting in dark in the carparks and advice on using public transport to commute to and from work.

The Director of Workforce gave an update on staff welfare and the Thank You to staff following Covid. It was noted this had been agreed by the Executive Committee and that £1000 would be given by 'Team' to be spent on what the Team want, the initiative supported the staff survey results on Team working. It was also proposed that at the end of the financial year there would be a further £1000 available for the Team that used their money in the most innovative way. The Board noted the Executive Committee had agreed to support and double the size of the psychological support being offered to staff particularly as staff sickness rates were increasing in relation to mental health. Work was ongoing to ensure there was good communication to staff. The Board welcomed the approach.

RESOLVED
That the Board received and noted the report.

21/23 Integrated Business Report

The Chief Operating Officer reported on the number of long waiters and provided assurance that the number on the waiting list was in line with the recovery plan submitted to NHSE/I in September 2020. The Board were further assured with the process in place to risk assess those patients and to ensure that they are constantly reviewed and reassessed in terms of clinical risk. It was noted this was a key priority area for Humber Coast and Vale ICS and referenced a piece of work called 'Waiting Well', which recognises the need to support patients who find themselves waiting for treatment. In terms of the recovery plan it was noted the Trust was performing well against the plan, over-performing in outpatients and slightly below target for day case, it was expected that

day case performance would improve from April 2021. The Board noted that this was a priority for the ICS as it had one of the worst performance areas. The Board would receive regular update reports.

The Chair of the Quality Assurance Committee noted that the Committee regularly received good assurance that patients were being managed. He asked if there was a better way of displaying data.

In response to a question on how people were informed of delays, it was noted that it is a national requirement to contact all patients via a letter. The Medical Director added that patients are written to every 6 months, he added that in the ICS there are approximately 30,000 people on the waiting list, discussions were ongoing in the ICS on different options to keep in touch with patients. It was further noted that the Trust was also sharing information with GP's.

MM commented on performance levels and activity despite Covid, and asked that the amount of effort that has gone on in by staff to achieve this level of performance be acknowledged.

The Director of Finance provided an update on the year end position, reminding the Board of the planned deficit of £5.5m due to annual leave and a shortfall in other income, both of which were allowable variances. Following a number of adjustments it was noted that the year-end position was expected to be in surplus.

RESOLVED
That the Board received and noted the report.

22/23 Draft Operational Financial Plan 2021/22

The Director of Finance presented the report which set out the draft version of the I&E plan for 2021/22 pending publication of the national planning guidance 2021/22. The Board noted that since writing the report the planning guidance had been published and work was being undertaken in conjunction with ICS and CCGs. The Board noted that early indications were that Trusts would have to deliver a balanced plan. Further details would be brought to the Boards April meeting for approval, prior to submission on 6 May 2021. He reminded the Board of the Nurse Staffing paper, discussed earlier on the agenda, confirming that the Executive Committee had agreed to fund this and the Executives had agreed to a deliver a small CIP to support this. He added that this was an unusual year as before the Board could approve the budget plan in April, Care Groups would be issued with an emergency budget. If there were any changes the Board required these would be amended. It was noted that the Chair of the Resources Committee had offered that the Committee, on behalf of the Board, would review the plans and provide assurance back to the Board for approval. The Chief Operating Officer further added she would also present the Operational Plan to the Committee.

RESOLVED
That the Board:

a) **noted the position and that a further report would be brought back to the Board at its meeting in April 21; and**
b) **agreed that the Resources Assurance Committee would, on behalf of the Board, review the Operational Financial Plan and Operational Plan 2021/22 at its meeting in April 2021.**

21/24 2021/22 Capital Programme

The Director of Finance presented the report which provided details of all the capital requests against the Trust's available resources. It was noted that the Executive Committee at its meeting on 20 January had identified £5m discretionary funding and agreed a 'back to basics' programme that would provide capital funding for essential backlog maintenance and improvements to the digital infrastructure. This had been supported by the Resources Assurance Committee. The paper presented set out the first release of funding and proposed a second review of priorities during quarter one. The paper sought approval of the four recommendations.

The recommendation of the Executive Committee was that £2m be released for digital improvements, £1m for backlog maintenance and £0.4m to continue the ward refurbishment programme. £1.657m was being retained for further consideration during quarter 1.

Discussing the report the following was noted:

- Referring to £3.150m in the table it was noted this was for existing loan repayments. It was noted that some were long term loans that were used to maximise the capital programme. He added that the financial regime FTs operate in allowed Trusts to create and deliver revenue surpluses to meet those payments, however in the current time, and if not delivering a surplus, the capital programme is used as a default for loan repayments. SH asked as the NHS moves towards being 'a system' is making operational surplus an acceptable position and do we need to rethink the degree to which we are comfortable to borrow against future repayments? It was noted that borrowing is no longer an option.
- The Chief Digital and Information Officer added that the only funding guaranteed for IT was from the £2m and the plans would be developed based on that number and not the necessary £4.3m.
- In response to a comment on projects that currently have no funding identified, the board asked if alternative means had been considered: in particular dialysis care and it was noted that there was a big strategic discussion taking place in relation to this.
- DW reminded the NEDs of the conversation with Stephen Eames who had intimated that there was money available for IT spend.

RESOLVED
That the Board:

a) **APPROVED the capital programme as set out in table 1 of the report;**
b) **Discussed and AGREED the recommendation from the Executive Committee that in addition to the commitments in table 1, a further £2m is released for digital improvements (against the requested £4.3m). £1m is released for essential backlog maintenance and £0.4m is released for continuation of the ward refurbishment programme and that £1.657m is retained for further consideration during quarter 1 of the new financial year; and**
c) **Project teams are established to scope the work in relation to: air handline at York Theatres, York SCBU, Scarborough Radiology backlog maintenance , dialysis capacity and the development of the child development centre at York, and in addition work continues to secure a development partner to provide HYMS teaching facilities.**

21/25 Draft LLP Operational Plan 2021/22

The LLP Managing Director introduced the report which had previously been agreed in principle by the LLP Management Group. DB added that the report was for the Board to note and that the figures would be updated in due course.

RESOLVED
That the Board NOTED the report.

21/26 Group Audit Committee Chairs Report

The Chair of the Committee introduced the Key Issues Report noting that this was now in a revised format. In particular the following was highlighted:

- the Committee's recommendation to the Board to approve of the YTHFM LLP Scheme of Delegation (item 15 below);
- supportive of the suggestion of a Risk Committee and the plans that risk was to sit with the new Associate Director of Governance position. The Chief Executive confirmed that an executive led Risk Committee chaired by the CEO, was being established, he added that risk was to be discussed at the Board meetings in April
- the escalation process from committees – it was agreed that JH and JMcA would work together;
- Robust action for managing our relationship with the CQC; The Chief Nurse described the process for escalating through to Board, and improving the visibility of this.

RESOLVED
That the Board NOTED the report

21/27 YTHFM LLP – Reservation of Scheme of Delegation

The Board received the report which sought approval of the LLP Standing Financial Instructions, Reservation of Powers and Scheme of Delegation. It was noted that the documents had been approved by to the Group Audit Committee at its meeting on 9 March.

RESOLVED
That the Board APPROVED the revised Reservation of Powers and Scheme of Delegation for the YTHFM LLP.

21/28 Health and Safety Policy

The Board received the YTHFM LLP Health and Safety Policy for approval noting the updates as set out in the report.

RESOLVED
That the Board APPROVED the updated policy.

21/29 Policies, Trust-wide Documents, and Service Level Documents – Development and Management Policy

The Board received and approved the policy.

RESOLVED
That the Board APPROVED the policy for use across the Trust.

21/30 Group Modern Slavery and Human Trafficking Statement

The Board noted the report and that this was an annual declaration noting the agreed statement would be signed by the Chair and Chief Executive and published on the Trust website.

RESOLVED
That the Board APPROVED the Modern Slavery Act Statement for publication on the Trust's website.

21/31 Standards of Business Conduct Policy

The Board received the Standards of Business Conduct Policy noting the revisions had been approved by the Executive Committee. It was noted that the revision referred to the publication of the registers of interest on the public website.

RESOLVED
That the Board APPROVED the revisions to the Standards of Business Conduct Policy.

21/32 Reflections on the meeting

Board Assurance Framework

Risk 5 was discussed in light of the boards conversations that day, in terms of funding and the impact this would have on the IT risk and subsequently the target risk of 12. In response the Chief Digital and Information Officer reported that he was revising the BAF based on affordability as well as revising he operational risks. He added that there needed to be a further discussion on what risk the Board was prepared to take.

DW referred to the Medical Directors report and the 214 overdue clinical effectiveness actions and if this was acceptable and what was needed to bring the number down? In response it was noted that during the pandemic this work had slowed, and JT added that there was a programme of work to address the backlog.

LM reflected that the Board had not had a detailed report on sustainability, this would be added to the Board work programme

The Chair added that it was hoped that the Board would meet face to face from its May meeting.

21/33 Any Other Business

No further business was discussed.

21/12 Items for information

The Board:

- **Noted the Executive Committee Minutes for information.**

21/13 Date and Time of next meeting

The next meeting will be held on 26 May 2021, venue TBC.

Outstanding actions from previous minutes – ® indicates that the action will be reviewed on that date, but may need a further date dependent on the Covid situation.

Minute No.	Action	Responsible Officer	Due date
19/130	The Corporate/5 Year Strategy objectives will be amended and brought to the Board for quarterly monitoring.	Exec Team	~~Oct 19~~ ~~Nov 19~~ ~~Apr 20~~ ~~Jun 20~~ ~~Mar 21®~~ July 21®
20/128	Mr Morritt to bring a QI/Values Launch proposal back to the Board in the New Year	Mr Morritt	~~Jan/Feb 21~~ July 21
21/26	Review escalation process from committees to Board.	J Hall, J McAleese	June 21

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Chief Executive's Overview

/ 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 provide an update to the Board of Directors from the Chief Executive on recent events and current themes.

/ Executive Summary – Key Points

The report provides updates on the following key areas:

- Covid-19 update
  - Current position
  - Operational recovery
  - Workforce recovery
- Launching our new values and behaviours
- Strategy development
- Quality improvement (QI)
- Working towards a healthy Bridlington

/ Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: 26 May 2021

1. Covid-19 update

1.1. Current position

At the time of writing we only have one patient in the trust who has tested positive for Covid-19, and numbers have been on the low side for a number of weeks. This is, of course, positive news. We know that we have to find a way to live and work with the ongoing presence of the virus, however as the vaccine programme continues its positive way forward and lockdown measures ease, it does finally appear that we can move into the recovery phase and away from the crisis response. We know that we are at a critical point whereby the impact of new variants is still to be understood, and there is the potential for the easing of lockdown to be delayed, however it does feel as though we have turned a corner and can move in to what will be our 'business as usual' way of working for the foreseeable future, focussing on our recovery as a priority.

1.2. Operational recovery

The final planned submission of our operational recovery plans, which will contribute to Humber, Coast and Vale Integrated Care System's overall plan, will be discussed as part of a separate agenda item.

1.3. Workforce recovery

The health and wellbeing of our staff is a top priority, and having will be essential to being able to deliver the operational recovery plans. We have thought carefully about how we can thank staff for their contribution throughout the last 18 months in way that is fair and fitting for everyone. We have launched our Great Big Thank You campaign, which includes the offer of a day off for everyone for their birthday, and £1,000 for each team to spend as they choose, primarily to support their wellbeing. Collectively this means we are recognising both teams and individuals, and are helping to support teams to rebuild and reconnect that may have been fragmented. This has been well received, and we have a number of other treats for staff as part of the campaign. We will be sending a keepsake to every member of staff to commemorate and recognise our trust's shared experience of the pandemic and everyone's personal contribution.

We also continue to focus on our wellbeing offer for staff and have invested in increased support for psychological health and wellbeing alongside a range of initiatives.

2. Launching our new values and behaviours

The revised values and behaviours were co-created with staff through the Our Voice, Our Future staff engagement exercise, and were supported and adopted by the Board in February 2020.

Their roll-out into the organisation has been delayed due to the pandemic, however I am delighted to report that they are now being launched and work is underway to being the process of embedding them. Embedding these fully will take some time, however it is a key component of driving culture change in the trust. Their rollout is supported by a wide-ranging programme of work to both raise awareness of the values and behaviours and to embed them into everything we do so that they are truly lived and demonstrated by everyone.

Following our session at the Board time out, the new values and behaviours have been shared across the organisation, and we have session planned with senior leaders to help them to understand their role in taking this work forward. We will also be identifying values ambassadors who will also receive support to help them in this important role.

3. Strategy development

Work is progressing in relation to strategy development, in particular with regard to the clinical strategy. We held a workshop with the executive committee to work through this in some detail, which included an extended attendee list of clinical directors and associate chief operating officers. This was followed by a session at the Board's time out at the end of April. The learning and feedback from these sessions has been distilled into themes, and a series of proposed responses to this feedback which will inform the amends to the draft strategy and next steps. In addition to this, work is being undertaken with care groups on their strategic ambitions at specialty level. Various follow up sessions are also planned throughout June. All of this insight and work will be shared at a strategy day towards the end of September, which will include the full Board. There are also a number of enabling strategies being developed which will support the delivery of the trust's strategic ambitions.

4. Quality improvement (QI)

A key component of recovery will be to be open about what we have learned from the pandemic and about what it has taught us about ourselves and how we work. Embedding this good practice will be an important part of moving forward. Staff have also told us that they would like greater clarity about how they can bring about positive change and how they can make improvements from small scale to wide-ranging change. We also know from feedback that we can do better in terms of how we learn from incidents, and from feedback from patients and staff. Launching our approach to Quality Improvement will send a strong message to our staff about recovery and the sort of organisation we want to be.

Our vision is to embed a culture of continuous improvement, whereby staff are empowered in collaboration with patients and carers to make ongoing improvements in their everyday work to ensure the delivery of the highest standards of care. A QI strategy group has been created to develop our trust-wide systematic and effective approach for QI. In addition to the expertise within the strategy group which includes a lay member, two consultant posts (2-3 PAs per week) will be recruited to in June to provide medical leadership for QI. Staff engagement sessions are also planned across May and June supported by an online survey to enable staff to contribute to the development of the strategy. The plan is to present the content of the proposed strategy to the Board in July 2021.

In order to enhance and grow the QI coaching resource and ethos, the Trust has recently partnered with Central London Community NHS Trust who have developed a QI coaching training package through the support of a Q Exchange grant from the Health Foundation. The 'QI Coach training package' is free of charge to use and it is envisaged that this will form a key enabler to creating an embedded culture of QI across the trust.

Following a successful pilot of a Quality Council model in Care Group 5, the improvement team will be promoting and supporting the wider use of Quality Councils. This approach enables front line staff to identify quality improvement projects that are supported to flourish through QI methodology, with supporting QI coaching provided by the improvement team. This enables teams to own their improvements and gain practical skills in QI.

5. Working towards a healthy Bridlington

This week will see the launch of a conversation between the health and social care system and the residents of Bridlington on developing plans for a healthier community. John Skidmore from East Riding of Yorkshire Council is leading this work on behalf of system partners, and our joint ambition is to create opportunities for change which ultimately lead to healthier lifestyles and improve the health inequalities of people who live in Bridlington and surrounding villages. There is a real opportunity to join up our resources to make them work more efficiently for local residents, to provide a broader range of services closer to their homes where it is safe to do so, and really make our physical assets busy community hubs. In the build up to the launch of the conversation, discussions have taken place with local politicians, the local health forum, and staff based in Bridlington. The conversation, which will run until mid-July, is a chance for local people to give their feedback about what needs to change as well as strengths and opportunities. I will keep the Board updated as the work progresses.

D1

NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes
Quality Assurance Committee
20 April 2021

/ Attendance: Stephen Holmberg (SH) (Chair), Jenny McAleese (JM), Lorraine Boyd (LB), Lynette Smith (LS), Bobby Anwar (BA), James Taylor (JT), Jill Hall (JH), Heather McNair (HM), Wendy Scott (WS), Caroline Johnson (CJ), Rhiannon Heraty (RH) (minutes)

/ Apologies for Absence: n/a

/ Minutes of the meeting held on 23 March 2021

LS confirmed changes to the abbreviation of ICS to IS on P10. Other than this the minutes of the last meeting held on 23 March 2021 were agreed as a correct record.

/ Matters arising from the minutes

There was a group discussion about the number of late papers. The Committee agreed that late papers can still be sent separately but that the revised consolidated pack should be emailed out prior to the meeting.

Action 87 – JT confirmed that the care groups are taking responsibility for statutory mandatory training for medical and dental staff. Statutory mandatory data is being uploaded into staff portfolios via the digital appraisal and revalidation programme and the consultant contracts have been updated to reflect pay progression only once job planning, appraisal and statutory and mandatory training has been completed. This will be formally presented to QPaS in May and will then go to Executive Committee for approval.

Action: SH/JM/LB to discuss movement of Board and Committee deadlines to the following week with SS

/ Escalated Items

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

Patient Safety

/ Medical Director's Report

JT gave an overview of the report and advised he had looked into the overdue baseline assessment NG056 and it was around NICE guidance that involves optimising care by reducing poly-pharmacy, multiple appointments and unplanned care. Tariq Hoth has now taken ownership of this and Shaun McKenna is leading work with the care groups.

The Committee was assured that we are within the guidance re Public Health England (PHE) post-SACT data.

JT confirmed work has started on a system redesign for SI investigations. There was a group discussion about recurrent themes and the need for more assurance that learning was happening and that the action plans were appropriate and delivered; CJ confirmed that this is the focus. CJ said we need to improve on identifying themes and trends and that work has started to allow theme categorisation on Datix. JT identified staffing as a long-term issue re patient safety as well as skill mix issues around innovative working. JM raised concern about work culture and HM said the actions agreed have not always been appropriate or manageable. Work is ongoing to change this but it will take time to show improvements so it is hard to give assurance at present. CJ said training is being organised to strengthen our current investigators using a QI approach. The Committee agreed it would be useful to have an ongoing sight of themes for assurance. JT added that he and CJ have discussed a database for SIs to identify themes and trends, and also that he will be recruiting for a senior clinical role to support the SI process and link with the care groups.

The Committee noted SI 2021/7006 as a never event and JT confirmed it is currently at pre-investigation stage. HM referred to SI 2021/4754 and said the family declined to send the case to HSIB and instead requested an internal investigation. We are arranging for an external investigator to come in and review this.

JT referred to Appendix 4 and said the reduction in the use of antibiotics cannot be benchmarked as this has been an extraordinary year, although there has still been a pleasing reduction.

Action: JT/CJ to include risk summary in next MD report re overdue clinical effectiveness actions

/ SI Trends and Incident Report Improvement work

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

/ QPaS – Escalation and Assurance Report

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

/ Infection Prevention and Control Report

HM gave an overview of the report and highlighted the key points as follows:

There have been issues around elective screening compliance for MRSA, which has been highlighted to the care groups but further improvement is needed.

MSSA themes appear to be a lack of ANTT compliance, the SOP not being followed and poor documentation - the IPC team are heavily involved in this. HM said this tends to happen more OOH either from locum staff or non-ward staff. There is guidance available for replacement of emergency-inserted lines but the issue is the lack of budget to ensure locum and agency staff have updated mandatory training, which is a risk. SH suggested all lines put in during OOH should be replaced and HM said there is more work to do.

There is more work to be done on GNBSI catheter care, which is on the IPC work plan.

The Committee was assured that there are no cleanliness issues in the clinical areas and ward sisters can raise issues with the LLP if required. The LLP are very responsive to this. In terms of the cleaning score dashboards it was noted that it only takes a minor change to go from green to amber.

Water safety continues to be a challenge, particularly legionella issues at Scarborough Renal Unit, run by Harrogate and this is being monitored.

Staff training continues to be an issue, particularly for medical staff. The Committee noted HM's main IPC concerns as:

- the IPC team being small and spread over multiple sites – their visibility in peripheral sites is low as a result
- C.Diff (001 strain) in Scarborough (SGH) – there is more proactive HPV being carried out but limited bed capacity means it is difficult to decant wards

HM said investment would mean the IPC team could be more proactive rather than reactive and JM said it was important not to dismiss asking for further investment. BA said it would be helpful to pull some IPC actions onto the CRR to give visibility on risk management.

/ CAS Alert Upate

The Committee was assured on the robustness of our CAS alert processes and noted it is a standing agenda item in the Quality & Safety Meeting. When a CAS alert comes through an MDT meeting around the particular alert is held to ensure full action tracking and CJ commended Liam Wilson on his work around this.

/ Update on Pre-natal Clinical Quality Surveillance (Ockenden) CG5

HM gave an overview of the report and highlighted the key points as follows:

We will not be compliant with CNST safety action 6 due to a shortage of both scanning capacity and sonographers. There were plans to outsource at a cost of approximately £0.5m with a London-based company but their proposal was for sonographers to travel to York on a daily basis to provide services. Due to previous experience (lateness, not being able to park, not being able to find the hospital) it was considered to be too risky a strategy that may not deliver the intended outcome. SH asked how much this will cost and HM confirmed £0.5m as a refund on the premium – this is money that the Ockenden report suggests should go to care groups to fund Ockenden developments.

The Committee noted a strong willingness to recruit more sonographers but there is a national shortage. HM said there will be a course to train midwives as sonographers in September and we may be able to outsource a small amount. WS said we are not the only Trust to have this problem and it is not due to financial constraint. We have considered how capacity can be created to do this work but unless additional capacity is created, it would be at the expense of other activity.

HM noted the additional paper (Clinical Workforce Review – to incorporate Maternity Incentive Scheme Standard 4) as a requirement for the Board to see our action plan around achieving standards.

Attention to the Board: SH agreed to escalate this to the Board for information

/ Implementing Continuity of Carer in Midwifery Services Report

The Committee received this report for information and noted that we are on trajectory.

HM confirmed the birth rate plus data should be ready for the next Committee meeting, which will help to inform the care group bid for what is needed to meet the Ockenden requirements.

Action: HM to include birth rate plus data in next report

Attention to the Board: SH agreed to escalate this to the Board for information

/ Nurse Staffing

HM gave an overview of the report and highlighted the key points as follows:

Vacancy levels in York (YH) are good (4.37%) but SGH is still a challenge (just over 13%). International recruitment has been delayed now that India is on the red list and it is unknown whether nurses can travel (50 are due in April from India) - originally they could if they were a key health worker and able to quarantine. The Committee also noted that the charge for mandated quarantine has now been passed onto Trusts.

The national drive to achieve 0% HCSW vacancy level is a work in progress – we are currently at an operational level of 1.37%. This requires constant oversight as it is a possibility we will lose staff once other job sectors reopen.

Health Education England (HEE) has requested a submission to coordinate tNA training for the HCV ICS. The Trust has contributed to this work, which will mean training posts can be supported through smaller private providers, such as nursing homes and hospices. The Committee noted this as positive news as often care home beds are empty due to staff shortages.

JM asked if there was any learning from redeployment and HM confirmed a survey has just been arranged to get feedback from staff that were moved as well as senior staff for their insight on what could have worked better. HM agreed to share the survey results once ready.

Action: HM to share results of staff survey re redeployment with Committee members

/ IBR Overview

SH asked for a 4AT screening update – HM said it ties into the dementia work but results are still poor.

SH asked for an update on 14-hour reviews as progress seems slow and one issue is that reviews are taking place but not being reported. JT said he has asked for individual surgical audits for assurance but will chase this up. There was a discussion about the fact that there are dual reporting systems – paper and CPD – which is a risk and the Committee noted that Dylan Roberts (DR) is working on a major strategic digital

programme to include single clinical records, although the anticipated delivery is 5-10 years. JT confirmed he and Donald Richardson (DR2) are working to make CPD as user-friendly as possible but feedback has been that it cannot keep up with ward rounds. JT said he had been assured by vascular surgeons that they have a consultant round 365 days a year and that every patient is seen but it is not on the system.

Action: HM to bring update on delirium assessment (4AT) to next Committee meeting

Effectiveness

/ Care Quality Committee Report

CJ gave an overview of the report and highlighted the key points as follows:

The CQC has asked for more info re mental health actions, particularly around embedding risk assessments in ED – we are currently at 79% compliance and work is ongoing to improve this, particularly on SGH site. The Core 24 service is now live and SOP's are being developed, which will then be fed into overarching mental health groups.

CJ met with the CQC last week to discuss the Transitional Regulatory Framework (TRF), which went well and they said they were assured by the document and our narrative. HM added that we requested feedback on the TRF so that we could benchmark our position but was told it was a national decision not to publish results. The Committee agreed that it is important not to get complacent around our position.

The Committee were assured that the CQC feature more on both the Executive Committee and Board of Directors agendas. It was agreed to wait until 27 April to see if the license breaches are lifted and then a paper will go to Board.

SH raised concern that the term SAFER is no longer being used and CJ said the feedback has been that it has become a top-down management performance tool. However, care groups are still using the SAFER principles and there has been good engagement with clinicians when patients are being put at the centre of care. The Committee noted that a number of organisations have stopped using the SAFER badge and are focussing more on what enables quality care.

/ IBR Overview

There was no further discussion needed around effectiveness.

Patient & Carer Experience

/ Dementia Strategy

HM gave an overview of the report and the Committee received it for discussion and as national and local context of our position. HM confirmed we have applied to charitable funds for a 12-month dementia nurse position as we cannot achieve the strategic goals without dedicated resources. There was a discussion about the wording and it was agreed that 'ambitious' would be removed from the strategy as the Committee felt this was misleading.

Pace of work is the biggest risk to delivery and it was agreed that once the decision on the dementia nurse role is confirmed, dates will be agreed to set the pace.

Action: HM to bring updated Dementia Strategy to Committee once dates are confirmed

/ IBR Overview

There was no further discussion needed around patient and carer experience.

/ Chief Operating Officer Report including Performance Update

WS gave an overview of the report and identified the key points as follows:

Demand is now approaching pre-Covid levels and on Monday 19 April YH ED had the highest number of attendances ever seen (345). There is a suggestion that limited access to primary care is an issue. Further work is being undertaken to explore this issue. GP referrals are back to pre-Covid levels but our performance levels are improving despite the challenges of waiting times and performance issues. The Committee noted this as positive news.

There was a discussion about Endoscopy diagnostics at modality level and the Committee noted the delay in overdue surveillance patients. Endoscopy is our most challenged diagnostic modality in terms of returning to normal practice due to overdue surveillance rates and having to stand the service down apart from acute cases for three months. This has resulted in a significant backlog. We have seen pre-Covid levels of fast-track patients referred through the service. Sleep services are also remodelling their services as patients that used to come in for group training now have to come in individually due to social distancing rules. The Committee noted the same issues with sonographer capacity as mentioned in item 11 and that prioritisation of maternity will put non-obstetrics ultrasound under strain. LB asked if there was any assurance or concerns re waiting list harms and LS said it was reassuring that there was a comparative amount of cancer diagnoses last year as in previous years for most tumour sites. The Committee also noted that FIT (Faecal Immunochemical Test) testing has been locally approved as a further mechanism to screen higher risk patients referred for endoscopy.

The Committee was assured by 0 12-hour trolley waits in ED in March and WS said it was due to redirecting staff efforts towards refocusing their efforts on patient flow. There are still ongoing issues re patient delays but these have significantly reduced compared to pre-Covid and we still have additional funding to facilitate discharge pathways.

There was a discussion around the move to emergency care facilities. WS confirmed that national standards were issued re the definition of a UTC, which is an integrated facility that can manage both minor injuries and minor illnesses. We are commissioned for minor injuries and Vocare is commissioned in York for minor illnesses, which meant we were not compliant as we were not delivering the service in an integrated way. The need to work more collaboratively is recognised and is subject of the ongoing work with Vocare. We as a Trust will still provide minor injuries care and likewise for Vocare re illnesses – this way of working allows us to offer an integrated directory of services to NHS 111 and other providers. The Committee noted that this is already the case at SGH site but that Vocare sub-contract with us for staff to work in the UTC on their rotas. The Committee acknowledged some internal opposition to this but also noted the local recognition that it is important to work in a more integrated way.

JT said the main objective is to reduce ED crowding and increase safety. This would be by offering an alternative to ED and move the large cohort of patients elsewhere to allow ED to manage the high risk work-stream and offer an alternative solution for minor illnesses and injuries. National funding may allow the future development of four community diagnostic hubs but for the next 12 months the contract and location will be co-located with ED.

Action: WS/LS to include further detail on Endoscopy length of waiters and what categories they fall into in next COO Report

/ Long Waits Report

WS gave an overview of the report and the Committee noted that NHSE/I are most focused on patients that are waiting over 52 weeks and P2 patients.

/ Board Assurance Framework

The Committee noted the report for information and were advised that there will be a 1.5 hour session at the next Board Time Out around risk management and trust-wide delivery as well as how the 21/22 BAF will look.

/ IBR Overview

There was no further discussion needed around performance and risk.

/ Consider other potential or new emerging risks

There was no further discussion required.

Item for discussion or escalation

/ Consideration of items to be escalated to the Board or other committees

The Committee agreed the following items for escalation:

- Medical Director – Never Event reported of wrong site treatment. Low harm but investigation ongoing
- Medical Director – Committee noted substantial improvements in SI investigations and development of action plans. Risk noted in relation to period of time expected before there was significant assurance that action plans were being completed and learning disseminated
- COO – Committee welcomed confirmation that the Trust had overachieved on delivery of Phase 3 Plan
- Chief Nurse – requirement to keep Board updated on progress for the following:
    - Update on Pre-natal Clinical Quality Surveillance (Ockenden)
    - Implementing Continuity of Carer in Midwifery Services Report

- Clinical Workforce Review - to incorporate Maternity Incentive Scheme Standard 4

/ Any other business

JT confirmed that the senior daily review audit for general surgery in ED is almost complete. JT noted his apologies for the next Committee and confirmed DR2 would be deputising, who can give an update on the utility of CPD. JT confirmed CPD will be used for at least 10 years in line with the digital strategy but will then be phased out should a single clinical record be agreed.

JM asked for more of a focus on community and WS agreed to include a quarterly narrative in the COO Report.

Action: JT to invite general surgical CD to May Committee meeting

Action: WS to include quarterly community update in COO Report from June 2021

/ Time and Date of next meeting

The next meeting will be held on 18 May 2021 at 1pm by teleconference. Dial-in details will follow

Action Log

Date of Meeting	Item No.	Action	Owner	Due Date
22.09.20	49	JT to bring sepsis report to Committee in c.4-6 months - date to be confirmed once data received	JT	May 21
22.09.20	52	HM to bring accreditation process report which relates to the Perfect Ward	HM	May 21
17.11.20	77	CJ to provide an update on SI trends and incident report improvement work	CJ	Completed
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	Completed
19.01.21	87	JT to bring finalised statutory mandatory training process to Committee once completed	JT	Completed
19.01.21	88	JT to link with LS to discuss medical staffing shortfalls and ask care groups to RAG rate specialty workforce to correlate with capacity	JT LS	Jun 21

23.03.21	96	HM to report back on status of line team and whether this needs escalation to the Board of Directors	HM	May 21
23.03.21	97	HM to include details of line-related infections in the next IPC report	HM	Completed
23.03.21	98	HM to provide corrected PPH thresholds for maternity dashboard	HM	May 21
20.04.21	99	NEDs to discuss movement of Board and Committee deadlines to the following week with SS	SH JM LB	May 21
20.04.21	100	JT/CJ to include risk summary in next MD report re overdue clinical effectiveness actions	JT CJ	May 21
20.04.21	101	HM to include birth rate plus data in next report	HM	May 21
20.04.21	102	HM to share results of staff survey re redeployment with Committee members	HM	TBC
20.04.21	103	HM to bring update on delirium assessment (4AT) to next Committee meeting	HM	May 21
20.04.21	104	HM to bring updated Dementia Strategy to Committee once dates are confirmed	HM	TBC
20.04.21	105	WS/LS to include further detail on Endoscopy length of waiters and what categories they fall into in next COO Report	WS LS	May 21
20.04.21	106	JT to invite general surgical CD to May Committee meeting	JT	May 21
20.04.21	107	WS to include quarterly community update in COO Report from June 2021	WS	Jun 21

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Board of Directors
26 May 2021
Nurse Staffing Report

York and Scarborough Teaching Hospitals
NHS Foundation Trust

/ 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 provide information and assurance to the Trust Board in relation to nursing and midwifery (safe) staffing levels for March 2021.

The report covers the requirement to submit the safer staffing metrics using Care Hours Per Patient Day (CHPPD). The March 2021 data is presented in Appendix 1 of the report. The Quality Committee should note that the collation and validation of the data remained challenging in March due to a number of wards changing function throughout the month in direct response to Covid-19, but this is an improving picture and the wards have now largely resumed substantive functions.

Assurance is provided that the daily assurance mechanisms delivered by the Matron of the Day are fully enacted on both sites. During March the conversion of red wards to amber wards was undertaken gradually, flexing capacity between the requirements as required; the nursing teams responded accordingly to ensure patient and staff safety and that service provision was optimised.

The Chief Nurse Team continues to work through a number of developments to support the strategic delivery of safe nurse staffing levels, updates are provided on the following developments:

- International recruitment
- Healthcare support worker recruitment
- Regional scoping exercise for tNA provision

A high level summary of registered nurse staff vacancy levels is provided for assurance, alongside recruitment activities.

/ Executive Summary – Key Points

This report provides assurance on how the Trust has responded to provide safe and effective nurse staffing levels during March 2021.

The three main risks associated with the Trusts response to COVID-19 in March were:

- Continuing dynamic management of wards and nurse staffing
- Managing the reintroduction of staff to their base area as required and provision of debriefs and support
- Management of staff unavailability and ensuring dynamic safe staffing levels maintained

Progress continues on the Trusts' 4 developments for nursing, listed below. The program of work the Trust is undertaking fully aligns to the new workforce expansion program which is overseen by the regional NHSE / I team.

- Trainee Nursing Associate Apprenticeship (tNA)
- International Registered Nurse Recruitment
- Registered Nurse Degree Apprenticeships
- HCSW recruitment to achieve 0% vacancy by 31 March 2021

The work to undertake establishment reviews across all adult in-patient areas is complete and has been presented. The associated investment in year 1 of £2.6M (1/2 year effect of £1.3M) was approved at April Trust Board.

Work will now be focused on the plans to

- re-align the budgets accordingly to be operational from 1 October 2021
- creating the capacity to revise the health rosters
- recruit to the vacancies the investment creates

Colleagues in Human Resources and Finance are briefed and a schedule of work will be established to deliver. The Deputy Chief Nurse has informed NHSE Regional Lead for Workforce in respect of the HCSW 0% vacancy monitoring as there is a low risk to flagging for HCSW vacancies whilst substantive recruitment is established.

In terms of strategic planning the next step will be to review and develop a proposal to support the second year investment aligned to the establishment review to ensure all the identified requirement is met in year 2 or minimally by year 3. However, it will be prudent to also plan to revisit the establishment reviews as the requirement may alter dependent on:

- The delivery of a Trust Clinical Strategy and associated plans
- The emergence of the ICS and potential review of services
- The potential impact of service re-provision in light of any learning from Covid-19

The Quality Committee should be assured that whilst the wards / units undertook delivery of elective work and continued to respond to Covid-19 infection fluctuations during March that nurse staffing levels were flexed and reviewed daily.

The Matron of the Day for both acute sites oversees delivery with escalation to Associate Chief Nurses and Chief Nurse Team as required. The delivery of safe nurse staffing remains dynamic and assurance is provided that the systems and processes in place are providing safe and effective patient care.

/ Recommendation

To receive the report.
To consider items for assurance / escalation to Trust Board.

Author: Helen Hey, Deputy Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: May 2021

1. Introduction and Background

The monthly Nurse and Midwifery Staffing paper complies with the National Quality Board, 2016 guidance and the NHS England, Operational Productivity and Performance report, 2019, Care Hours Per Patient Day (CHPPD) requirements for reporting.

The Trust has complied with the submission of CHPPD data and the March 2021 submission is attached in Appendix 1.

During March, the Trust is required to be as agile as possible in response to the requirements for patients attending the hospital with COVID-19 or symptomatic of COVID-19 (surge and super-surge demand).

2. Detail of Report and Assurance

2.1 Management of Nurse Staffing Levels in March 2021

COVID-19 continued to impact the operational organisation of wards and units throughout March 2021. Nursing teams, led by the Matrons, continued to adapt and respond to the requirements of patients and services. Ward changes in capacity and function continued.

The level of Covid-19 related activity and therefore the challenge throughout March started to reduce and gradually nursing staff were moved back to their substantive roles. It is evident that some staff have really enjoyed the challenge of Covid-19 and some have opted to remain in the areas they were deployed to; conversely some nurses have really struggled with the challenges for the past few months. There are a number of highly supportive mechanisms in place to help staff debrief; including a staff survey specifically for redeployed nurses being coordinated by the Care Groups. This is important work to support staff now, but also to ensure, as much as possible, if a third wave of Covid-19 impacts services in the future the team have taken as much learning as possible from the first two waves.

Nursing teams continue to respond and flex their delivery in response to the impact of COVID-19 the operational teams have supported this with the reduction in the aim to restore services as the number of people with Covid-19 presenting continued to be high through March. The requirement to continually flex the bed base for the senior nurses presents a daily challenge and the work of the Matrons and Associate Chief Nurses should continue to be noted.

2.2 Nurse Staffing levels, Associated Risk and Establishment Reviews

The Trust has submitted the planned versus actual (CHPPD) return to NHSE/I on time in March 2021 (Appendix 1). The Quality Committee should note that the data collection and submission remained complex due to the wards changing function and bed base within the month, sometimes on more than one occasion. The data has been reviewed and there are no specific risks to report associated with CHPPD. This data should be more static and valid from May 2021 as wards re-establish their substantive functions.
In respect of the fill rates in March 2021, whilst a number of the wards fell slightly below 80% on the York site the risk level was managed and can be aligned to the rapidly changing bed base and socially distanced beds, meaning that the ratio of nurse to patient was acceptable. The fill rates on the Scarborough site prima facie are more concerning, but there are a number of wards (Anne Wright; Ash) that have permanently amended bed bases or had temporarily altered bed bases due to Covid-19. Care Group 2 continues to

work through their budgets and staffing models and realign in accordance with their permanently amended bed base, this work needs to be progressed to ensure accurate data submission and has been discussed at the team operational meeting.

The Chief Nurse team has gained approval for £2.6M investment as a result of the establishment review paper with ½ year effect (£1.3M) in 2021/22. A program of work to ensure the plans are fully enacted from 1 October 2021 will now take place to ensure the budgets and rosters are aligned accordingly and to ensure the associated required recruitment is underway.

The associated risks, specifically temporarily increasing the registered nurse and HCSW vacancy rates will be reflected in revised risk registers and communicated externally as required. Progress against recruitment requirements will be monitored.

It is important for the Quality Committee to notes that whilst the Chief Nurse Team is delighted with the investment achieved in a challenging financial landscape; the overall request was for £5.8M. Therefore, further work is required in 2021 to re-visit the review and ensure the option for year 2 / year 3 investments is highlighted in 2022/23 financial planning. Any future review should encompass any changes to service provision that are as a result of the new Trust Clinical Strategy; the emergence of the ICS and any impact from re-provision of services as a result of Covid-19.

Table 1 – Nurse Vacancy Levels Trust wide and per site

Trust wide

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Trust wide	2,150.98	107.55	1,020.56	1,990.00	179.46	974.09	32.84	1.00	9.22	26.36		41.68	167.46	-70.91	14.01	7.79%	-65.93%	1.37%

York

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
York	1,511.63	87.39	680.01	1,444.85	112.29	660.69	23.19	1	6.14	17.36		32.56	72.61	-23.90	-7.10	4.80%	-27.35%	-1.04%

Scarborough and Bridlington

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Scarborough & Bridlington	639.35	20.16	340.55	545.15	67.17	313.40	9.65		3.08	9		9.12	94.85	-47.01	21.11	14.84%	-233.18%	6.20%

Table 1 details the March 2021 vacancy position for the Trust and for York and Scarborough / Bridlington sites. The Trust registered nurse vacancy position is stable at 7.79%, which is a slight decline on February 2021, 7.39%.

The significant work undertaken to achieve the operational 0% vacancy rate for HCSW was achieved with the actual vacancy rate of 1.37% being reported by 31 March 2021. The plan is now to sustain this achievement through 2021/22; the team are waiting NHSE/I instruction on how this will be monitored and have already flagged the impact the approval of investment aligned to the establishment review will have.

2.3 Development Work

As presented in the October report NHSE / I North East and Yorkshire Regional have commenced a piece of work to deliver the expansion program for nurses, midwives and allied health professions. This work is in response to the Governments pledge to increase the number of nurses by 50 thousand by 2024.

The Trust is satisfied that they have well-established and successful work programs aligned to most of the activity and will be engaging with the regional work to ensure the Trust is best placed to benefit from any regional program or support.

International Recruitment

The Trust continues to provide it's well-established and regarded international nurse recruitment program. The Trust continues to welcome Internationally Recruited nurses with 15 successful candidates due to arrive in April 2021.

The Trust has reviewed the pipeline and only had 1 Indian nurse in the pipeline. The Trust is following strict national guidelines in relation to 'red' countries and will continue to support the nurses who were expecting to arrive when it is safe to do so.

Health Care Support Worker Recruitment

In 2020, NHSE/I set a requirement for all Trusts to achieve 0% HCSW vacancy level by 31 March 2021. The Recruitment Team, have undertaken to lead centralised recruitment to achieve this ambition.

The Recruitment Team and nursing teams have delivered against this target. It is now vitally important that the Trust does not waste the output of this work with high attrition and to achieve this all the new recruits are enrolled on a comprehensive induction package which incorporates the Care Certificate. In addition, the Work Based Learning team is working to facilitate individuals' access to further education and highlighting apprenticeship routes to develop careers in healthcare.

Undergraduate Education and Support

There are two key developments to report.

As reported in February and March, the Trust welcomed 82 3rd year student nurses to commence in paid placements, in order to support Covid-19 related activity and staffing levels. The Clinical Fellows continue meet with the students to ensure they are supported and where appropriate have the best training and educational opportunities. The provision of the students in paid placements has provided some relief to the frontline nursing workforce; however, as Covid-19 activity subsides, where appropriate every opportunity is being used to enhance their training and experience in what has been an extremely disrupted years for nurses in training. This program concludes at the end of April when all the students will resume their student status until qualification.
This offer to the 3rd year students has been a significant success through wave 2 of Covid-19, when some practice placement providers removed the offer of any placement for student nurses. The Work Based Learning Team; Recruitment Team and wards and units should be congratulated for the support they have given to the learners, which has ensured that the majority of student nurses have managed to accomplish their required practice hours and qualify as planned this autumn.

Work has been concluded to determine the Trainee Nursing Associate requirements for the Care Groups for 2021/22. The nursing team are proposing to support 28 tNAs in 2 cohorts; one commencing in January 2022 and the second to commence in September

2022; utilising the provisions with both University of York and Coventry University at Scarborough.

This information will be shared with partners across HCV which should support smaller providers to join viable cohorts through 2022. The plan also ensures that the Trust can adequately support high quality placements for the tNAs who have had a break in learning and prevent the projected bottleneck for practice placements.

3. Detailed Recommendation

To receive the report
To decide whether further actions or additional information is required
To consider items for assurance / escalation to Trust Board

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Perinatal Clinical Quality Surveillance Update

/ 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 provide oversight from the Quality Committee and Trust Board of effective perinatal clinical quality as per the minimum required dataset following the Ockenden report and the supporting clinical quality surveillance report

/ Executive Summary – Key Points

CNST Saving Babies Lives v2 (safety action 6) outstanding concerns around scan capacity remain – paper with request to action plan this element sitting with the clinical network for decision.

Training compliance improving

One new HSIB case following intrapartum stillbirth

/ Recommendation

This report aims to inform the Trust Board of progress in relation to the Ockenden required minimum dataset around perinatal clinical quality

Author: Michala Little, Acting Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: May 2021

1. Introduction and Background

In response to the Ockenden report, a new quality surveillance model has been introduced to provide a consistent oversight at Board level in order to identify and address any arising issues. This will allow early identification of perinatal clinical quality concerns and actions to be taken

2. Detail of Report and Assurance

The minimum dataset will be reported monthly to board, as below.

3. Service User involvement

Service user feedback received: We engage with women and families in a variety of ways. As well as friends and family, pregnancy/birth debriefs and PALS, we have a Facebook page that is contacted frequently and attached to this, an 'Ask a Midwife' enquiry service. We are engaged with all three of our Maternity Voices Partnerships (MVP) and our LMS MVP lead; a culture of obtaining and sharing feedback is well embedded and features in our Care Group patient experience action plan.

Positive feedback received from service user who had a really positive antenatal, birthing and postnatal experience. Felt staff were caring, professional and made her feel safe and well cared for in all areas of her journey.

Positive feedback has also been received through family and friends- some direct quotes attached:

Concerns raised through PALS and complaints have been addressed directly and resolved.

MVP have been asked to gather information from service users around the quality of information we provide to them around pregnancy, birth and postnatal - is it accessible? Is there enough? What could we do to improve? This will support our work around the 7 IEAs from Ockenden.
Survey currently underway to determine take up of pertussis and flu vaccination in pregnancy – awaiting results from this in June.

4. Staff Safety Forum feedback

There were no specific concerns raised by staff in either neonatal or maternity areas during the walk around by Board level safety champion in April.
The sheet below details previous concerns raised and acted upon.

5. Safe staffing levels

Midwifery:
Escalation guidance is in place to cover any rise in acuity and dependency or shortfall in staffing levels. In April our labour wards did not need to enact this guidance, there were no closures. The escalation policy is currently under review.

Fill rates for Midwifery shifts at York site in April 2021 were 77.3% and for Scarborough site 74.6%.

Obstetrics:

Obstetric staffing rotas are closely monitored to ensure minimum safe cover for all maternity areas, with staff being moved across areas and locum cover being put in place where any gaps are identified. For the month of April there was one occasion where safe medical staffing was not met, due to a mistake in the booking of a registrar.

6. CQC Ratings

CQC Maternity Ratings – York Hospital – inspection 2015	OVERALL	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE
	GOOD	GOOD	REQUIRES IMPROVEMENT	GOOD	GOOD	GOOD

CQC Maternity Ratings – Scarborough Hospital – inspection 2015	OVERALL	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE
	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD

Preparations are underway to undertake mock CQC inspections across maternity, in anticipation of a CQC visit. The maternity self-assessment tool was undertaken September 2020 and this has highlighted areas of focus: saving babies lives v2 compliance, professional leads for quality improvement and human factors and auditing of daily safety huddles.

7. Coroner Regular 28 recommendations

CORONERS Regulation 28 recommendations made directly to Trust
There have been no new recommendations made to theTrust since 2016

8. Incident reporting

HSIB: **1** new case reported
0 new reports received

The HSIB case is in reference to an intrapartum stillbirth following a shoulder dystocia. Outstanding action plans for HSIB report circulated for comments. HSIB QRM meeting took place with positive feedback for our organisation.

Serious Incidents(SI): One SI ongoing for a baby transferred out for cooling after a difficult LSCS delivery - due at panel 20 May 2021.

Incidents declared as 'moderate harm' or above: One in April was graded as moderate harm – this was due to a missed treatment of anti D.

PMRT: Monthly PMRT meetings are held on both sites and any cases meeting the criteria are reviewed. The Q4 report will be submitted to board this month.

9. Training compliance

Scarborough	PROMPT	NLS	Fetal monitoring	SBLv2
Midwives	85% (81%)	92% (93%)	76% (77%)	68% (60%)
HCA/MSW	76% (71%)	N/A	N/A	N/A
Med Staff	58% (60%)	SCBU 90% (92%)	57% (55%)	21% (27%)
ODP	77% (68%)	N/A	N/A	N/A
Anaesthetist	100% (78%)	N/A	N/A	N/A

York	PROMPT	NLS	Fetal Monitoring	SBLv2
Midwives	92% (88%)	96% (94%)	76% (80%)	70% (66%)
HCA/MSW	82% (88%)	N/A	N/A	N/A
Med Staff	68% (71%)	SCBU 93% (65%)	57% (33%)	42% (39%)
ODP	84% (82%)	N/A	N/A	N/A
Anaesthetist	87% (87%)	N/A	N/A	N/A

Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	49.64% (place to work) 69.72% (place for treatment)
Proportion of Specialty Trainees in Obstetrics & Gynaecology responding with 'Excellent or Good' on how they would rate the quality of clinical supervision out of hours (reported annually)	100%

Plans to improve staff experience include the introduction of ward charters which define support and expectations around behaviour, additional ward manager training and the introduction of 'Greatix' to celebrate staff achievements. We have recently introduced Quality Councils in the Care Group and are progressing a maternity council; staff have been asked to contribute, they will receive quality improvement training and will progress ideas around staff and service user experience.

Progress continues to be made in relation to meeting the 90% training requirement for CNST since last month. Staff are given rostered time to complete, all PROMPT training has been virtual since the Covid 19 pandemic commenced. The 90% compliance element has now been removed from CNST but we continue to aim for this.
Fetal monitoring training rates are increasing with full compliance expected for end May in line with CNST timescales, in addition to the half day given for e-learning a half day face to face training for all staff commenced in January 2021.
E-learning for SBL care bundles was added to profiles in January 2021, compliance is variable month to month

10. CNST

There continues to be particular challenge around safety action 6 in terms of the additional scan capacity and subsequent review of the additional women that the pathway will determine are now 'consultant led'; work is ongoing with care group 4. A paper has been sent to the clinical network to support an action plan to extend the timeframe for compliance in order to support the recruitment and training of sonographers – awaiting a final decision as this will determine overall CNST compliance.

Safety Action	Compliance	Detail of each standard position
1	COMPLIANT	All cases eligible for PMRT have been appropriately reported and either have completed or ongoing reviews. Quarterly reports to board are submitted in an ongoing fashion
2	COMPLIANT	All required data for MSDS submitted. ISDN notice1513 awaiting confirmation of compliance - action plan agreed by board if not compliant
3	COMPLIANT	Transitional care pathways are in place across both sites and audit of all cases meeting criteria is undertaken monthly. Attain reviews for the Covid 19 period are complete and the action plan has been updated and shared with Maternity and neonatal safety champions, progress is reported via safety champions meetings
4	PARTIAL COMPLIANCE	A paper detailing compliance in relation to clinical work force and action plans for Anaesthetic standards, Neonatal medical and nursing workforce is being finalised to be sent to board in April 2021- approved action plans will then be shared according to CNST guidance with RCN and neonatal ODN. The Obstetric trainees aspect to this has been removed from March 2021
5	PARTIAL COMPLIANCE	The annual HOM report detailing all Midwifery workforce data was received by Trust board in March with a request for support for action plans (1:1 care in labour and 100% SN coordinator status). A second bi-annual workforce review paper will no longer be required as removed in March 2021 update - additionally the external Birthrate plus workforce review and paper has been received and will support the Ockenden funding bid.
6	PARTIAL COMPLIANCE	Work is ongoing with CG4 towards implementation of SBLv2. A business case was approved in December 2020 and funding to outsource scanning agreed in March – this was unfortunately withdrawn and a paper has been sent to the clinical network requesting further action planning agreement . There is challenge in organising increased capacity and out of hours work for review of scans due to additional women being Cons led. Ongoing audit work for other elements underway . Dedicated pre term birth clinics need to be on rota by June
7	COMPLIANT	MVP hub and spoke model in place, overarching MVP meetings have been maintained throughout Covid 19 with surveys being undertaken of user opinion. The service user chairs are remunerated and specific work is being undertaken to try to hear the voices of BAME women.
8	COMPLIANT	The 90% threshold for training compliance has been removed from March 2021 update, particular challenge remains around medical staff - compliance remains variable – being individually chased. We need to demonstrate ongoing and rising compliance with training. Board minuting of commitment to facilitate local in person MDT training once permitted is required.
9	COMPLIANT	Continuity of Carer updates against action plan have been submitted to Board monthly and the action plan revised to prioritise BAME women in next steps. UKOSS and MBRRACE Covid outcome reports have been benchmarked and action plans shared with safety champions. Monthly staff feedback sessions have continued throughout the pandemic. SCORE culture work is underway and the team are engaging with Matneo SIP and patient safety network learning events.
10	COMPLIANT	All qualifying cases have been reported to HSIB

11. Next Steps

To continue to provider this report monthly.

12. Detailed Recommendation

For the board to acknowledge and discuss the data required.

Maternity and Neonatal Staff Safety Forum			
Meeting date	Site	Host	Attendees
6.2.19	York	Sara C-H	None - walked around unit and asked staff if any issues
6.3.19	Scarborough	Sara C-H	2
3.4.19	York	Sara C-H	1 attendee - walked the patch
7.5.19	Scarborough	Freya O	
5.6.19	York	Sara C-H	No attendees. Walk around. No concerns voiced
3.7.19	Scarborough	Sara C-H	2 midwives
7.8.19	York	Sara C-H	1 attendee, no issues raised. Walk around.
4.9.19	Scarborough	Sara C-H	1 attendee , no issues raised. Walk around
2.10.19	York	Freya O	no attendees, walk around al areas and SCBU

Mat Neo Staff Safety Forum Action Log

Date	Issue/Risk Identified	Action Required	Lead	Target Completion Date	Date Action Completed	Required Evidence/Assurance
7.5.19	HCA discussed concern around trip hazards for both staff and mothers in postnatal areas as women bringing large amounts of luggage in.	To email all community team to remind women only top bring one bag and emind hospital staff to ask women not to leave bags and belongings laid around on the floor.	Freya Oliver	May-19	07/05/2019	email
6.3.19	When babies are transferred from SCBU to postnatal ward the SBAR does not give enough detail of feeding history. There have been several minor incidents and concerns at ward level on the York site, no datix or SI's	Design a feeding specific SBAR to use alongside SBAR for neonatal transfer. Take to Clinical Governance - SCH to do this.	Suzie Kinsella	Apr-19	Jun-19	New neonatal SBAR for approval at CG - NOV 12 2019.Feeding SBAR in place and working well.
3.7.19	Concerns voiced that two Sundays running a midwife has been taken from Hawthorn to support a busy labour ward leaving Hawthorn ward inadequately staffed. Midwives feeling unsafe. One midwife was taken for seven hours. Escalation plan not used.	Discuss with LW manager.Education needed re. escalation policy.	Susan Jackson (Gill Locking)	Aug-19	Jul-19	Discussed with coordinator on that shift. Email sent to all coordinators. On the agenda for next coordinators meeting. IOL times changing to alleviate pressure on Hawthorn at peak times. Agreement from HOM for extra support during section lists when staffing allows.
6.3.19	Concerns that the number of babies requiring at least a day case admission or overnight stay to CAU is high on the York site.	Deep dive into data. Look at reasons for admissions. Initial impression is that the issues are mainly breastfeeding related. Look at Scarborough data ? Same issues. If not, why not?	Suzie Kinsella	May-19	Aug-19	Evidence provided by IFC of recent audits. Email saved in Mat Neo Staff Safety Forum. 
06.11.19	Scarborough SCBU staff raised the issue of the resuscitaire placement in labour ward theatre. This has been moved to the anaesthetic room. Staff feels this affects patient experience and the safety related concern to this is that it takes longer to get the emergency trolley in the room and the new process is 'less smooth'.	Discussed at Safety Champions. HOM confirmed that this has been escalated to CG Director who supports the LW Manager decision to have the resuscitaire in anaesthetic room (IPC reasons)	Susan Jackson/Freya Oliver	Nov-19	Nov-19	HOM confirmed that this has been escalated to CG Director who supports the LW Manager decision to have the resuscitaire in anaesthetic room (IPC reasons)
06.11.19	Staff member concerned that a locum Consultant on Labour Ward had been blocked from working and then turned up and did a shift.	Discussed at Safety Champions. Broad discussion re. what are we saying about a practitioner if we block them from working.	Sara Collier-Hield	Nov-19	Nov-19	On this occasion an Obs Consultant made the decision that the staff member should work with LW co-ordinators to escalate if any concerns.

3.4.19	Staff on G2 concerned about their levels of activity and acuity. Remarks about time spent answering the buzzer. Number of visitors too high / difficult to police, especially other people's children. Discharge computer work taking more than should be as often antenatal details not entered. Three staff suggested more support workers could be part of the solution	On-going monitoring. Staff SCORE culture results due June 24th. Consider role of volunteer. Look for local solution to buzzer issue.	Debbie Sharp	on-going	Dec-19	New Sister in post. Meeting planned with core staff Sept 17th 2019 to get ideas. Volunteers in place 3-4 lunchtimes a week. Working well and viewed positively by staff.
5.2.20	Staff nurse at York SCBU concerned about being moved to ward 17 to cover short term sickness etc and not orientated to the area.		Vikki Smith	Mar-20	Feb-20	Vikki has worked with the clinical educator on ward 17 to develop a solution. All new employees to SCBU spend time on the ward as part of their paediatric preceptorship.
3.4.19	CPD, the maternity computer records (that only midwives have access too) and the inpatient care record in maternity is disjointed. This leads to: 1) Failure to act on high MEWS scores to recognise the unwell pt. 2) Minimal communication with GPs regarding pregnant patients admitted and discharged with medical problems – no adequate eDNs, no record of medication discharge with pt, no record of investigations carried out. This adds to the problem of GPs not willing to continue the care / prescribe medications. 3) Discrepancy between national guidance / our own guidance and CPD assessments e.g VTE		Sara Collier-Hield/Freya Oliver	On-going		Nov 19. Meeting with Kev Beatson, Donald Richardson and Magda Borucszowska re. new Maternity records standard. Linking up to LMS and digital plans for the future.
7.5.19	No staff attended- walk around of unit staff raised concern around SCBU staffing, what is happenning in relation to current cot reduction and recruitment. Explained rationale for cot reduction and gestation raise is around safety, awaiting RCPCH report with staffing model suggestions for whole service.	N/A- await RCPCH report	Directorate team	Jun-19	Mar-20	cot capacity restored, staff recruited. Medical cover beeing reviewed as part of ASR
7.8.19	Junior Doctor planning at August (and other) handover periods. Inadequate cover.	Rota planning in advance.	Jamie Todd (or team)	TBC	Jun-20	rota being reviewed in ongoing fashion and locum cover sought as needed
2.10.19	Staffing concerns raised re levels and also staff being moved to new areas without orientation	Discussed all vacancies recruited to , awaiting pin dependent starters. D/W senior team possibility of 1-2 orientation shifts if moving to a new area where not worked for significant period.	Freya Oliver	Oct-19	Mar-20	orientation plan , clinical skills midwives aware
2.10.19	ADU staff raised concern regarding ability to get bed out of door for emergency transfer to Labour ward	Being looked at by Matron following issue, difficult to widen door access but may consider replacing beds with trolleys	Debbie Scott	Dec-19	May-20	trolley in place
2.10.19	SCBU staff raised concern baby tagging system cannot be used as tags and bands not suitable for preterm babies	To contact company again as they were developing a prototype for preterm babies	Vikki Smith	Sep-20	Dec-20	SCBU working with x tag medical and looking to try a new product in March 2020. Paused due to Covid email regarding this, prototype avaioable w/c23/11. supplier has delivered prototype and now in use

8.1.2020	Midwife concerned re. low staffing levels in Malton team and now embarking on providing continuity of carer.	review of rotas and recruitemnt	Michala Little	Mar-20	Jun-20	email
	Concern raised escalation policy not clear or easy to follow	to be reviewed and coordinator involved in development	Susan Jackson	May-21		20/7/20- in draft to circulate for comments. Additional work undertaken to draft to add medical staff escalations, current guideline
13.3.20	concern raised about staff absence due to covid and staff not being tested	to be reviewed at trust level	Heather McNair	Mar-20	20.3.20	staff testing in place initially for family member but affected staff added 14/4/20
	partogram not working well	New partogram needed	Susan Jackson	Oct-20		5/1/21continuing to use national PI partogram- to reconsider if further developemnt needed
26.5.20	Anonymous whistleblowing letter received by CEO- citing issues around culture, recruitment, visibility of managers,	actions in cells below	as below	as below	Nov-20	
3.6.20	action around issues raised from culture survey	restart paused work around culture survey. Introduce kindness champions	Michala Little	Nov-20		culture work commencing jan 21
	SCBU environment concerns	minor works forms being actioned	Vikki Smith	Sep-20		update awaitied jan 21
	Mimimum 30 hours for band 7	already resolved for labour ward- can be 22.5	susan Jackson	complete		
	rotation of band 7 posts from ward	discuss with senior team, survey staff in post to understand impact to them	Freya Oliver	Dec-20		
	Visibility of managers	Staff drop in sessions, appointments for new starters with HOM, daily walkaround	Freya Oliver	Jul-20	Jul-20	diary for staff surgeries and walk arounds
	Recruitment process	senior team review	Freya Oliver	Jul-20	Jul-20	agreed all band 7 or above substantive posts to be advertised externally
	Culture and raising issues	Senior care group management to discuss	Freya Oliver	Jul-20	Oct-20	managerial cross site precence and utilising
4.7.20	no attendees					
5.8.20	concern around lack of support from TVN's regarding complex would care	to raise with TVN service	Heather McNair	Aug-20	6.8.20	H McNair discussed with Sam haigh
09/09/2020	no attendees					
28/10/2020	shower facilities on ward too small for pregnant women	escalate to estates as very dated and need replacement	Freya Oliver	Apr-21		
28/10/2020	staffing concerns on SCBU due to recruitment delays, sickness and shielding staff	plan in development and utilising long term agency	Sal Katib	Dec-20	Dec-20	
02/12/2020	walkaround no issues raised					
21/01/2021	walkaround all areas SGH- no issues raised					

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Clinical Workforce Review – to incorporate Maternity Incentive Scheme Standard 4

/ 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 is intended to update the Board on the clinical workforce review, the required action plans and to inform the board of the compliance in relation to Maternity Incentive Scheme standard 4.

/ Executive Summary – Key Points

The obstetric medical workforce aspect of standard 4 has been removed from CNST in March 2021.

The Trust is currently non-compliant on the East Coast with ACSA standard 1.7.2.5 which requires all elective caesarean section lists to have dedicated anaesthetic, obstetric and Midwifery staffing.

The Trust is non complaint with BAPM standards for medical staffing in neonatal units and with neonatal Nursing staffing on York site. Action plans are proposed within this document to address the shortfall; approval of these action plans will enable declaration of compliance with standard 4. Copies of the action plans have to be submitted externally to the RCN and neonatal network following Trust board approval.

/ Recommendation

The Board is required to formally minute and agree the proposed action plans.

Author: Freya Oliver Head of Midwifery and Michala Little Deputy Head of Midwifery

Director Sponsor: Heather McNair

Date: 14 April 2021

1. Introduction and Background

Workforce provides a critical part of the Maternity safety standards and as such regular reviews and the development of subsequent actions plans where standards are not met is required. The Ockenden review requires the review of clinical workforce and for the Trust to support action plans to meet compliance with National standards. The required aspects from safety standard 4 are covered below. Trust board is required to sign off the action plans within the document and they will then need to be shared externally.

1.1 Obstetric medical workforce

The Obstetric workforce standard and action has been removed from CNST in March 2021. We will continue to monitor our obstetric workforce requirements and escalate any concerns and action planning via the safety champions to Trust Board.

2. 2.1 Anaesthetic medical Workforce

STANDARD
1.7.2.1 A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

EVIDENCE REQUIRED

The Rota should be seen to allow obstetrics to take priority where the duty Anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. CNST, NHSLA or equivalent evidence and audits should also be provided.

The Trust currently meets this standard in both York and Scarborough. There is an Obstetric Anaesthesia handbook which includes this policy which is given to all trainees, locums and consultants at point of induction. This is also emailed to them for reference. Additionally consideration is being given to a bespoke obstetric Anaesthesia session on induction day. The handbook is also available on staff room and hard copy in clinical areas.
In York there is a dedicated Anaesthetist 24hrs a day, in Scarborough there is an Anaesthetist named as the obstetric Anaesthetist but they do have other responsibilities. However they will be able to delegate care of their non-obstetric patient to the other on call Anaesthetist or call the on call consultant in out of hours. Rota's are available as evidence this is the case.

STANDARD
1.7.2.2 Obstetric units have, as a minimum, consultant cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed).

(GPAS REFERENCES)
9.1.14 As a basic minimum for any obstetric unit, a consultant Anaesthetist should be allocated to ensure consultant cover for the full daytime working week (that is, ensuring that Mon-Fri, morning and afternoon sessions are staffed). This is to provide urgent and emergency care, not to undertake elective work.

Where the standard refers to a consultant Anaesthetist, it is acceptable for SAS doctors whom this process has agreed can practice without consultant supervision, to fulfil this role (see Note 4).

At York Hospital this standard is met in that there is a dedicated anaesthetic consultant covering delivery suite for the full daytime working week Monday to Friday. In Scarborough the standard is also met, but if not all full daytime sessions are covered by an anaesthetic consultant, an SAS doctor whom this process has agreed can practice without consultant supervision, is available.

STANDARD
1.7.2.5 Where there are elective caesarean section lists, there are dedicated obstetric, anaesthesia, theatre and midwifery staff.

This standard is met on York site, we have dedicated elective caesarean section lists, and the consultant is immediately available. Rota for York reflects this.
At Scarborough being a smaller site and only having one obstetric theatre there is one dedicated Anaesthetist on obstetrics for the elective lists, if an emergency obstetric procedure is required often the elective list is put on hold to do the emergency case in the one and only obstetric theatre on delivery suite. If an elective C-section is already underway and an obstetric emergency occurs at Scarborough there is another Anaesthetist doubled up (who is covering the emergency bleep) available, they would have to open up a second obstetric theatre in Scarborough's main theatre suite, there are no dedicated Obstetric or Midwifery staff for this list- the action plan below has been developed to address this.

Issue to be addressed	**Planned Actions**	**Strategy to achieve**	Lead responsible	Timescale
Anaesthetic staffing	Ensure Rota always has a second consultant or SAS grade Anaesthetist available should a second theatre be required for Obstetrics. Ensure second ODP is also available	• **Rota coordinator to ensure second Anaesthetist and ODP available at times when elective lists are running** • **Consider development of business case for additional ODP and Anaesthetist for all elective sessions**	Lead anaesthetic consultant	December 2021
Obstetric staffing	Review Obstetric job plans to achieve either consultant or SAS grade dedicated staffing	• **Business Case agreed to support additional consultant level funding** • **Recruitment of additional Middle Grade SAS doctors to support dedicated medical staffing for section lists**	Clinical Director Obstetrics	July 2021

Midwifery and support staffing	Await outcome of BR+ workforce review and allocate dedicated staffing for elective lists	• **Include requirement for dedicated elective staffing in paper to board regarding findings of Birthrate plus.**	Head of Midwifery	July 2021

STANDARD
1.7.2.6 The duty anaesthetist for obstetrics should participate in delivery suite ward rounds including multidisciplinary handovers.

EVIDENCE REQUIRED
A copy of the Rota to demonstrate duty consultant availability at a time when delivery suite ward rounds are taking place.

The Trust meets this standard at both York and Scarborough Hospital in that the duty Anaesthetist attends the multidisciplinary team handover meetings every morning, we have signed documentation for this. The anaesthetic Rota's reflect the availability of anesthetics at the time of Labour ward rounds.

2.2 Neo natal Medical Workforce

CNST Standard: The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level

The BAPM guidance for junior medical staffing of neonatal units requests different levels of staffing to be met in York and Scarborough. York is a Local Neonatal Unit This requires immediately available at least one resident tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7 and immediately available resident tier 2 practitioner dedicated solely to the neonatal service during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week.

Scarborough is a Special Care Unit. This requires a resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. A resident tier 2 who would be expected to provide cover for co-located Paediatric services but be immediately available to the special care unit is also required.

York meets the tier 1 requirements but does not currently meet the requirement for a tier 2 practitioner dedicated solely to the neonatal service during the periods of peak activity in a co-located Paediatric Unit e.g. between 09.00 – 22.00, seven days a week.

Scarborough staffing currently meets the BAPM junior medical staffing standards.

The following action plan is to address the non-compliance at Tier 2 level in York. The standard is met Monday – Friday 09.00 – 17.00. Outside of these hours there is one Tier 2 doctor to cover the neonatal unit and Paediatric unit. Mitigation between 17.00 – 22.00

Monday – Friday and 09.00 – 15.00 Saturday and Sunday is provided by the on-call consultant being resident in the hospital and immediately available.

Issue to be addressed	Planned Actions	Strategy to achieve	Lead responsible	Timescale
ODN reviewing level of neonatal units across the region (this may impact staffing level required)	Input into ODN review and enact recommendations.	Attend ODN meetings and feedback updates to management team Review medical staffing recommendations once ODN have agreed these	Sunny Sandhu Vicki Hemming / Sunny Sandhu	Dec 2021 (Note: NCCR is 5 year plan)
GIRFT local review awaited	Engage with local review when scheduled to gather further information about level of staffing required.	Await review recommendations and action accordingly	Vicki Hemming / Sunny Sandhu / Jamie Todd / Freya Oliver	June 2021
Review activity data to determine peak hours	Review activity data for Paediatrics, ED and neonatal unit	Request data from IT systems and information for discussion	Victoria Hemming / Sunny Sandhu	Feb 2021
Review Tier 2 Rota	Can Tier 2 Rota be adjusted to provide doctor for neonatal unit for all peak hours	Discussion and review with Rota coordinator	Sunny Sandhu	Completed already – unable to achieve
Staffing numbers	Business case if current Rota cannot be adjusted for extra staff needed at Tier 2 to meet standards	Await outcome of NCCR and GIRFT review before progressing	Jamie Todd	December 2021
NIPE	Review role of NIPE trained midwives and if they could provide cover for postnatal ward on regular basis	Increase number of NIPE trained Midwives Increase WTE midwifery staffing to allow for this change in role	Head of Midwifery / ANNB screening coordinator	reviewed and unable to achieve within establishment- would require business case

2.3 Neonatal Nursing workforce

A review of the neonatal workforce on both York and Scarborough sites was undertaken by the neonatal Network in February 2020 using the CRG workforce (Dinning) tool. The outcome of that review was that Scarborough site met the standard required. York site showed a deficit in registered staff of 3.08 WTE, a deficit of trained in qualification in specialty staff and a surplus of non registered workforce.

The action plan below has been developed to support workforce remodeling and meet BAPM staffing standards on both sites. Some aspects of the work have already been enacted.

Issue to be addressed	Planned Actions	Strategy to achieve	Lead Responsible	Timescale
Neonatal Health Care Assistants band 2	To align with workforce review and have 0.0 WTE band 2 Health Care Assistants	Expressions of interest internally for band 3 transitional care support workers. Not replace band 2 health care assistants with natural wastage	Sal Katib Vikki Smith	April 2022
Neonatal transition support workers band 3	To meet the need of the service with 5.6 WTE band 3 transitional care support workers	Internal expressions of interest from band 2 workforce followed by external advert if post not filled. Funding already approved through business case.	Sal Katib Vikki Smith	June 2021
Band 5/6 Neonatal Nurses	To recruit 3.08 WTE band 5 neonatal nurses	Funding from reduction in band 2 healthcare assistants in budget and other cost savings from within the care group where possible	Sal Katib Vikki Smith	April 2022
Trained in qualification in specialty staff	Increase number of staff with Qualification in Specialty by at least 0.4 WTE	Three members of staff currently enrolled.	Vikki Smith Nicola Lockwood	April 2022
Band 7	To increase by 0.2 wte with clinical educator and enhanced nursing role.	Uplift of current band 6 to include these roles with enhanced nursing qualification	Nicola Lockwood Vikki Smith	June 2021

3. Next Steps

Complete and enact the above action plans to develop clinical workforces to meet the required external standards

4. Detailed Recommendation

The Board is requested to formally minute the detail in this report and **APPROVE** and **SUPPORT** the development of any required business cases regarding proposed action plans around workforce.

Freya Oliver Head of Midwifery and Michala Little Deputy Head of Midwifery

April 2021

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York and Scarborough Teaching Hospitals NHS Foundation Trust

Board of Directors
26 May 2021
Infection Prevention and Control Monthly 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

The report provides surveillance information on healthcare-associated infections for April 2021. The report also highlights assurance of actions being taken to reduce healthcare associated infections (HCAIs) in accordance with the Health and Social Care Act (2008).

/ Executive Summary – Key Points

- There have been a total of 7 Community Onset Healthcare Associated (COHA) + Hospital Onset Healthcare Associated (HOHA) *Clostridium difficile* cases for the month of April 2021.
- There have been 0 Trust-assigned MRSA cases for the month of April 2021.
- There have been 5 MSSA Trust-apportioned cases in the first month of 2021/22. There were 5 Trust-apportioned cases in the month of April 2021.
- There have been 2 further cases of *C.difficile* ribotype 001 at Scarborough hospital identified in April 2021. This signifies an on-going issue with *C.difficile* within Scarborough Hospital.
- Cesarean section Surgical Site Infections in Labour ward at York has prompted investigations into the root cause

/ Recommendation

The Boar of Directors is asked to note the current position in respect of HCAI and associated activities and for their support of the actions being taken.

Author: Paul Rafferty, Deputy Chief Nurse (Scarborough); Astrida Ndhlovu, Lead Nurse IPC (York) & Andy Whitfield, Lead Nurse IPC (Scarborough)

Director Sponsor: Heather McNair, Chief Nurse

Date: 08 May 2021

1. Introduction and Background

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, *Methicillin Resistant Staphylococcus aureus* (MRSA) and *Methicillin Sensitive Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to three Gram negative bacteria *(Escherichia coli* (*E.coli*)), *Klebsiella* species and *Pseudomonas aeruginosa)* and other important healthcare-associated infections for the month of April 2021. The report also highlights environmental cleaning and staff training in relation to HCAI management. Any outbreaks and adverse incidents that occurred in April 2021 are summarised in this report.

2. Surveillance data

2.1 Clostridium difficile

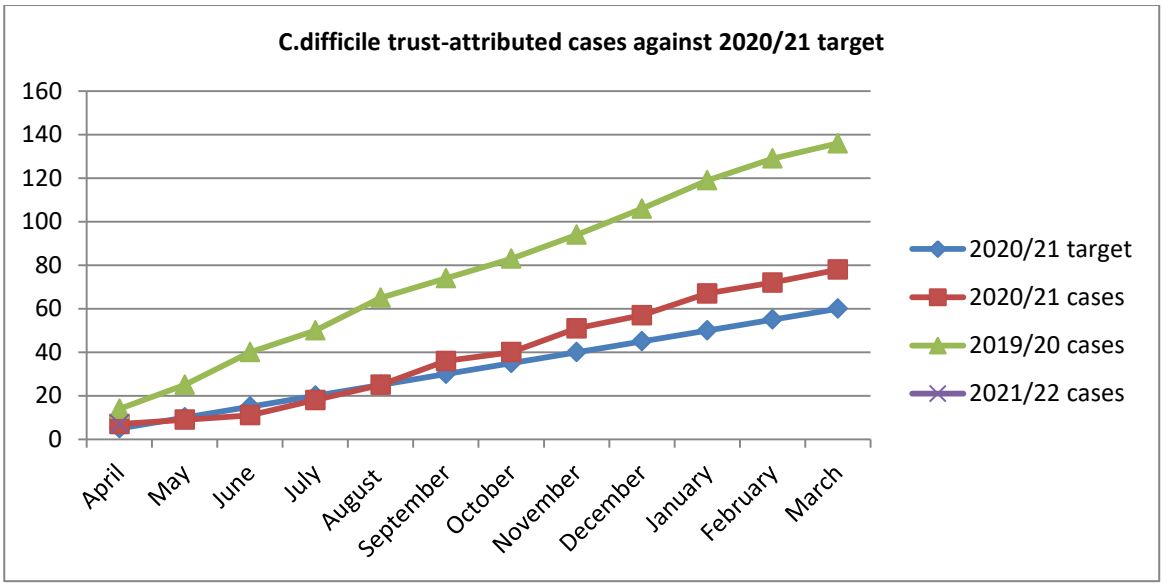
The *Clostridium difficile*-associated diarrhoea objective for 2021/22 has not been set. The Trust has had a total of 13 cases of *C.difficile* in April 2021; of which 6 were community-onset healthcare-associated (COHA) and 1 healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. These are classed as Trust-apportioned.

A *C. difficile* action plan detailing control measures that have been put in place in response to the previous *C. difficile* outbreak in Scarborough has been developed (appendix 1); and is monitored through TIPSG and the *C. difficile* control group. In December 2020 PHE agreed to declare the *C. difficile* outbreak in Scarborough closed following a significant period of no cases. However, there have been 12 further cases since January 2021 with 2 most recent cases reported in April 2021. This signifies an on-going issue with *C.difficile* transmission and has prompted a review of the C.difficile action plan with a review of completed actions and adherence to recommendations. To date 18 actions have been completed. Three actions remain but there is a plan to ensure these remaining actions continue. If agreed at the next control group, 14 new actions will be added to keep the momentum with this project. The meeting schedule is being reviewed to ensure maximum attendance, the frequency of the meeting will also be reviewed – this currently remains monthly.

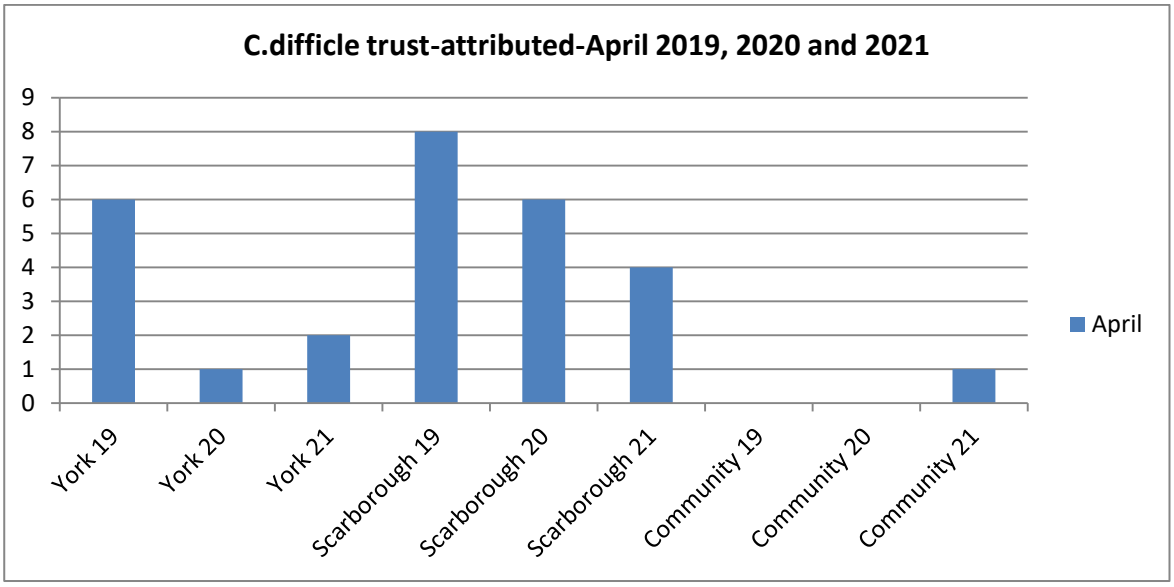
There has been a strong link to Chestnut ward of the *C.difficile* Ribotype 001 cases implicated in the outbreak. On 29/04/2021 a decision was made to decant Chestnut ward to enable some cosmetic works to be done and to carry out a full chlor-clean and HPV. In order to facilitate Chestnut ward to be run down, some patients were moved to Coronary Care Unit (CCU) beds where relaxation of social distancing of beds was agreed with the Chief Nurse; with necessary mitigations put in place.

Further refurbishment work followed by a deep clean and HPV on Chestnut ward will be carried out in May 2021 when Ann Wright ward is ready to be used as a decant space. This will be a rolling program that will also prioritise other wards that did not receive HP in 2020/21.

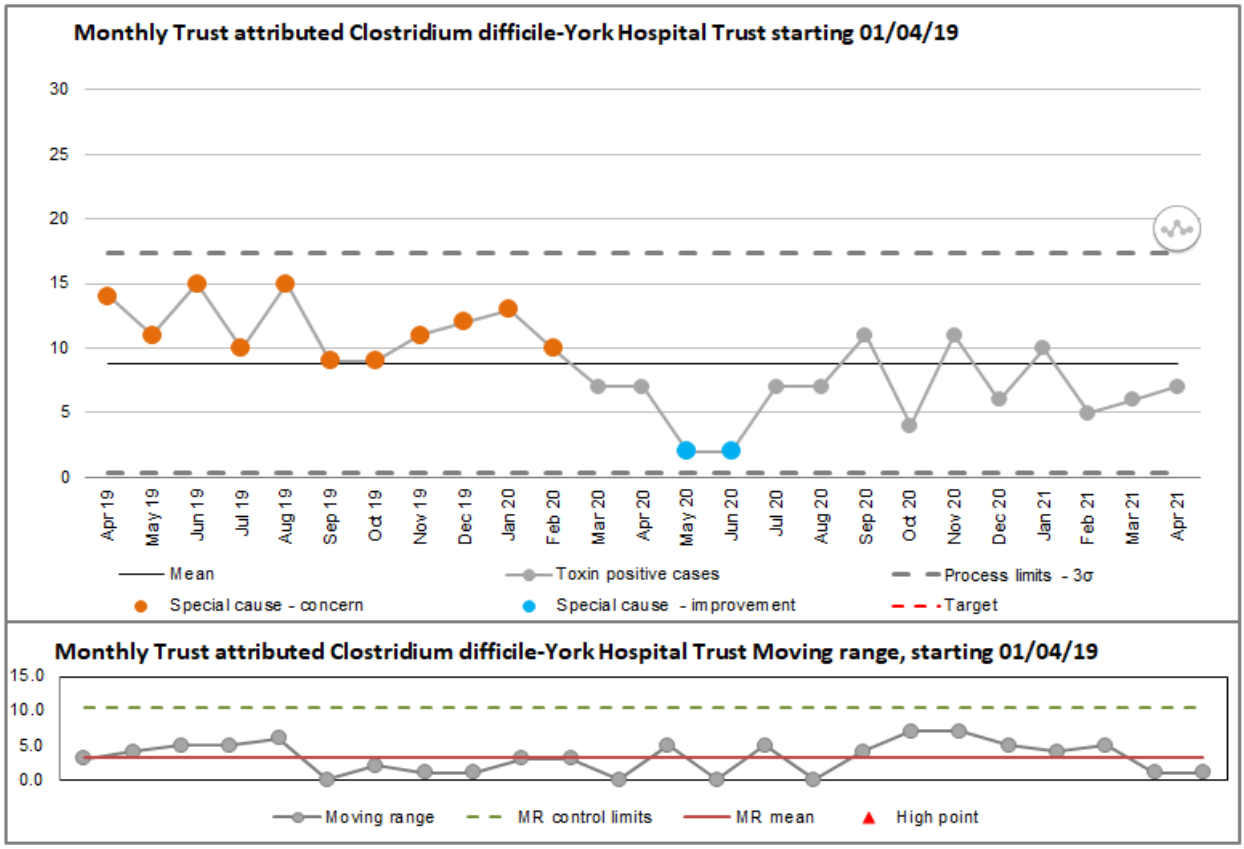
Post Infection Reviews (PIR) are undertaken for all Trust-apportioned *C.difficile* cases. A process of reviewing and conducting PIRs through Care Groups was developed in 2020/21. This process is intended to highlight action plans on Care Group dashboards, enhance learning from PIR outcomes and sustained improvement in practice.



Graph 1. Trust-attributable *C.difficile* toxin positive cases against 2020/21 target



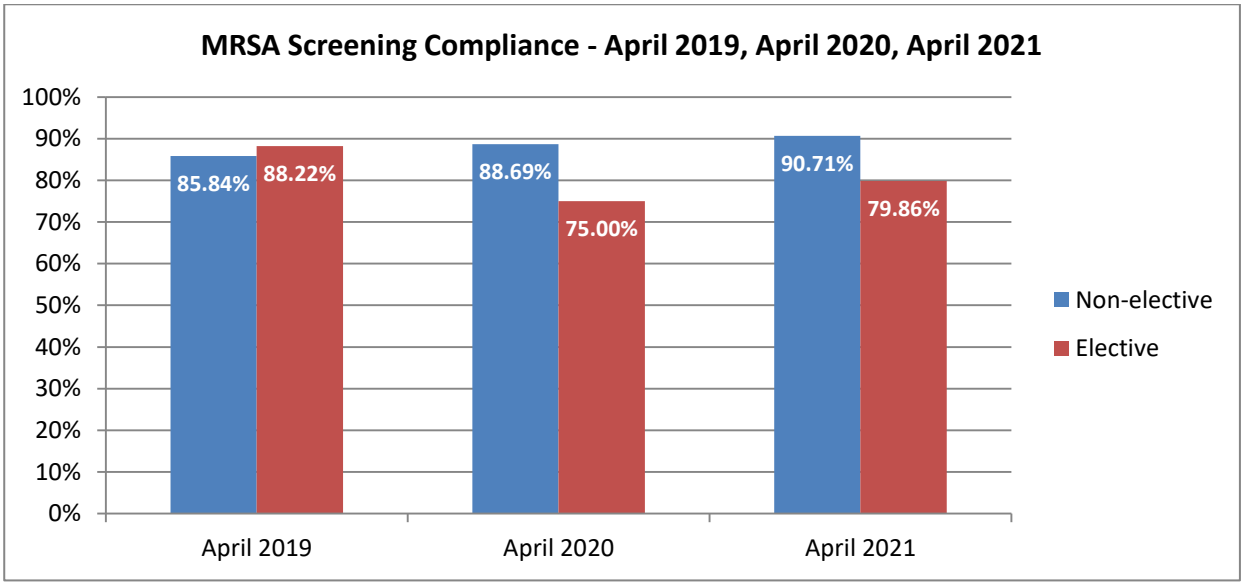
Graph 2. CDI performance comparison-April 2019, 2020 and 2021



Graph 3. Monthly Trust attributed *Clostridium difficile* April 2019-April 2021

2.2 MRSA bacteraemia

The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There has been 0 community MRSA bacteraemia and 0 Trust-assigned cases in April 2021.



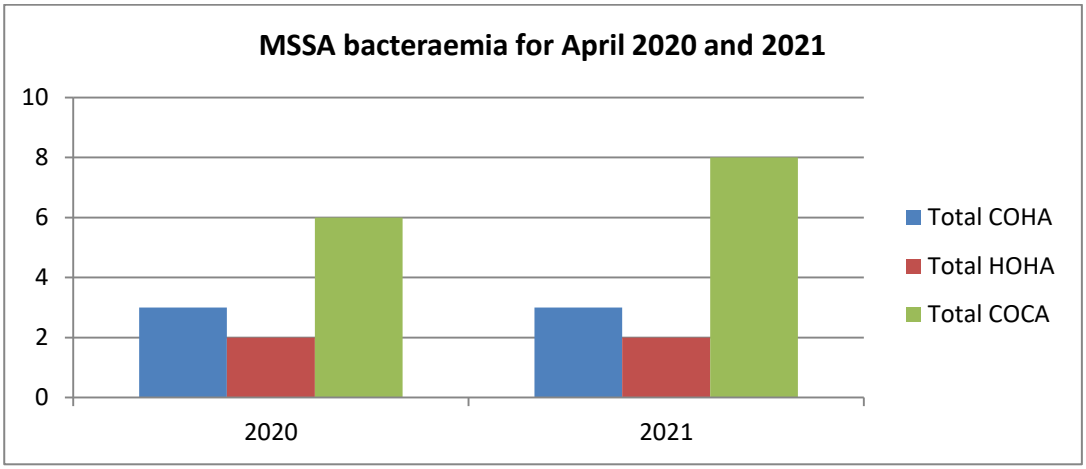
Graph 4. MRSA screening compliance for Elective and non-elective (April 2019, April 2020, April 2021)

MRSA screening compliance for non-elective patients improved for 2020/21 compared to 2019/20 although there still remains room for improvement. The average compliance for non-elective screening is around 91%. Elective screening has consistently been lower for the 12 months of 2020/21 compared to 2019/20; with an average of 82% screening compliance to March 2021. The low screening compliance for elective patients has been escalated to Care Group 3 Clinical Governance meeting and to the senior sisters meeting in 2020/21.

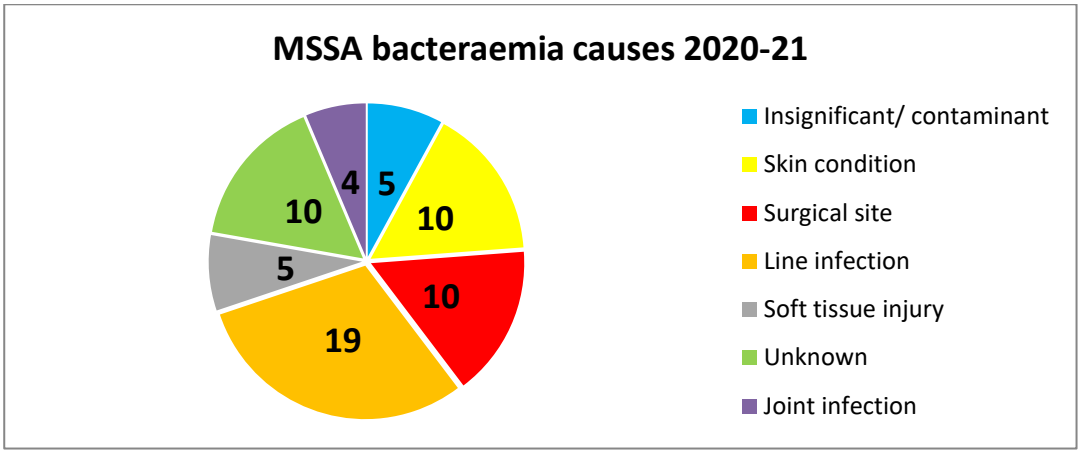
The concern of the MRSA screening compliance for elective patients was highlighted to the Information Team in April 2021 to try and understand what overall data is being included. This will continue to be monitored.

2.3 MSSA bacteraemia

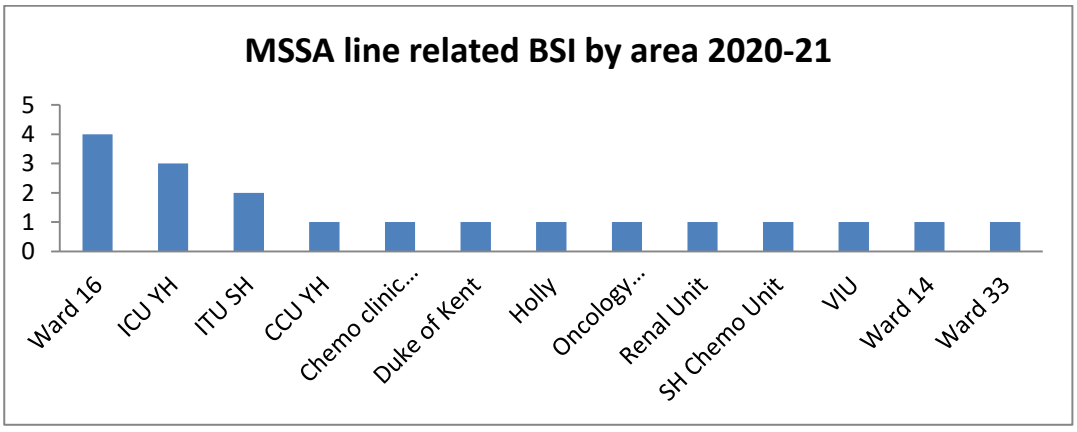
There were 12 cases of MSSA bacteraemia in the first month of 2021/22; of which 5 were classed as Trust-apportioned. There is no external target for MSSA bacteraemia, and the Trust sets an internal target benchmarked against previous performance.



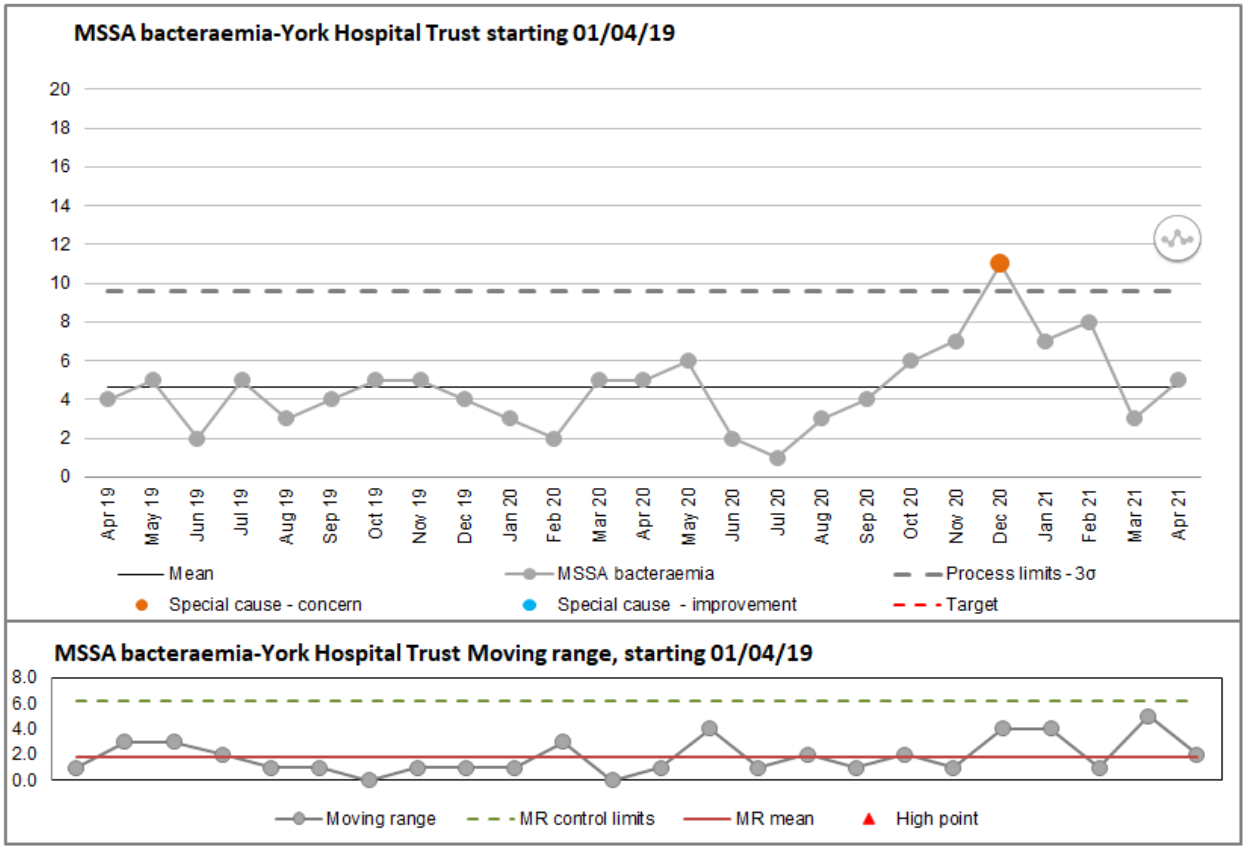
Graph 5. MSSA bacteraemia cases April 2020 and 2021



Graph 6. Thematic analysis for MSSA bacteraemia



Graph 7. MSSA bacteraemia by clinical area



Graph 6. Monthly Trust attributed MSSA April 2019-April 2021

The Trust continues to sustain Aseptic Non-Touch Technique (ANTT) practical training to ensure appropriate management of invasive devices. A self- declaration of ANTT practical sign off facility was developed in August 2020 on the Corporate Learning and Development (CLaD) platform for staff who have undergone clinical skills practical competency training to ensure a true reflection of staff training compliance. The aim is to achieve and sustain 95% and above training compliance in practical ANTT across the Trust.

ANTT practical and theory courses were removed from staff required learning along with the essential skills subjects. The Trust Executive Committee made the decision that only those subjects currently listed as 'Core' subjects on the Learning Hub would form required mandatory training. This is a risk to the organisation given the year end incidence for 2020/21 of 63 cases; 29 of which were related to invasive procedures.

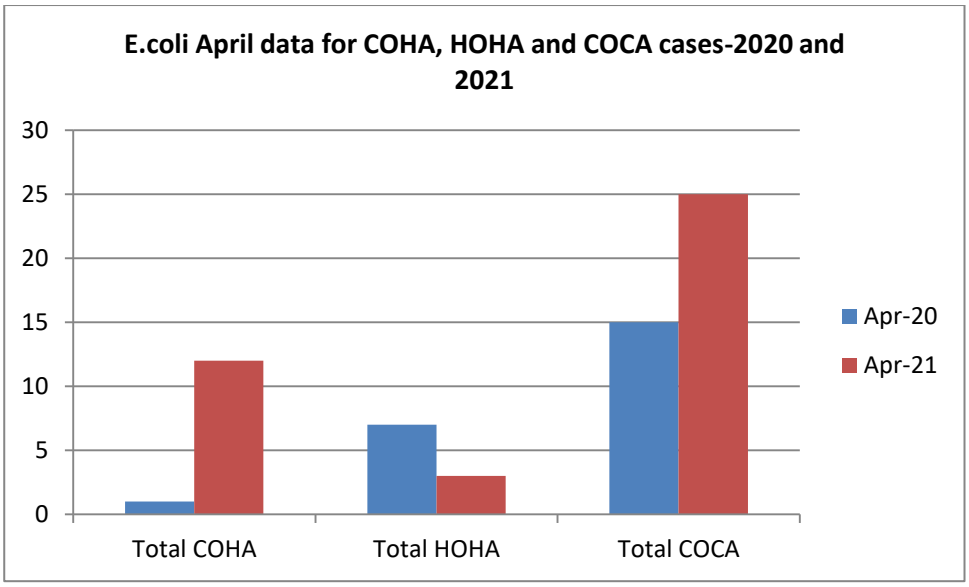
2.4 Gram Negative Blood Stream Infections (GNBSI)

Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

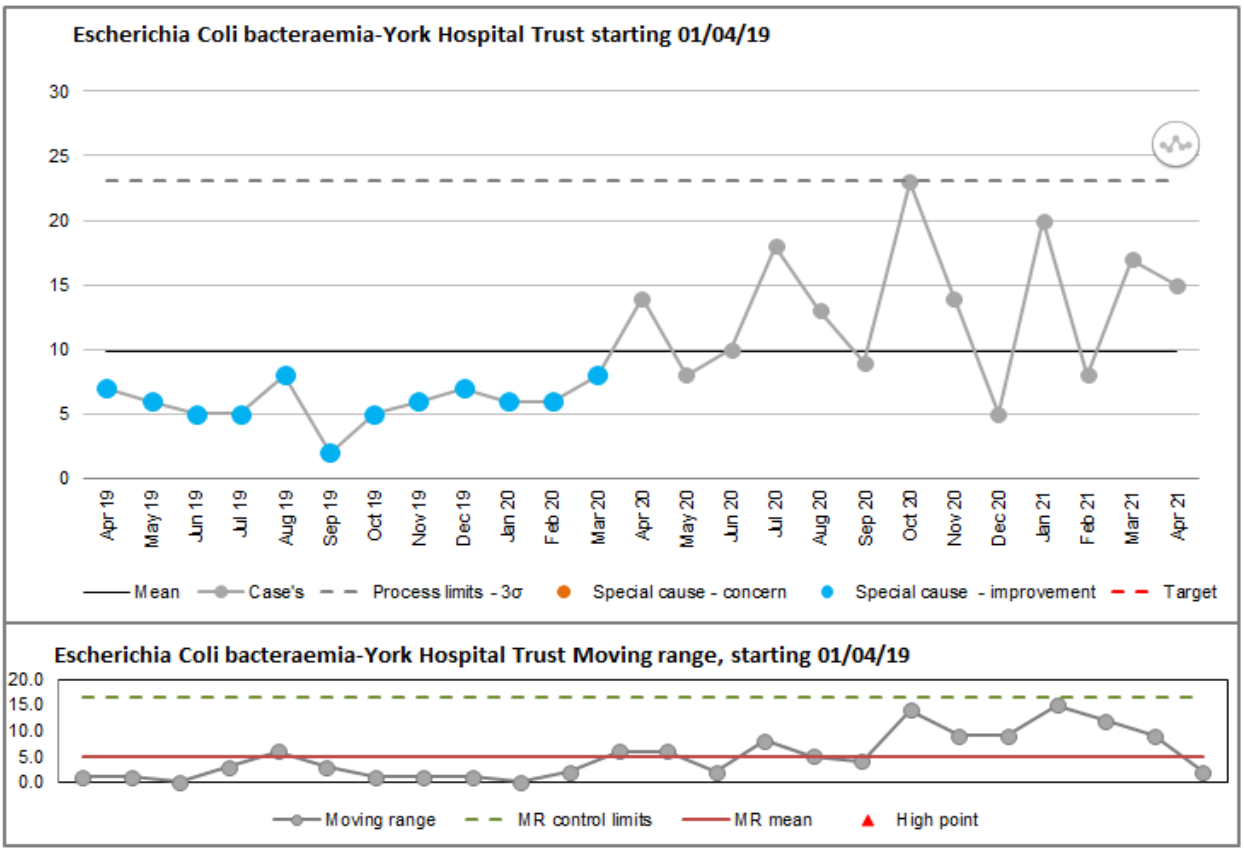
In April 2021, the Trust reported a total of 55 cases of the three GNBS organisms which are part of national surveillance. Of these, 23 cases were classed as Trust-apportioned as defined by the Department of Health (*E. coli 15; Klebsiella sp. 5; Pseudomonas aeruginosa* 3).

The Trust was seeing small reductions in the incidence of hospital-associated *E.coli* bacteraemia in the first 6 months of 2020/21 but there has been an increase in the *E.coli* incidence from October 2020. This could be related to the fact that the Trust also saw a reduction in bed occupancy from the start of the financial year due to the COVID-19 pandemic compared with last year for the same period.

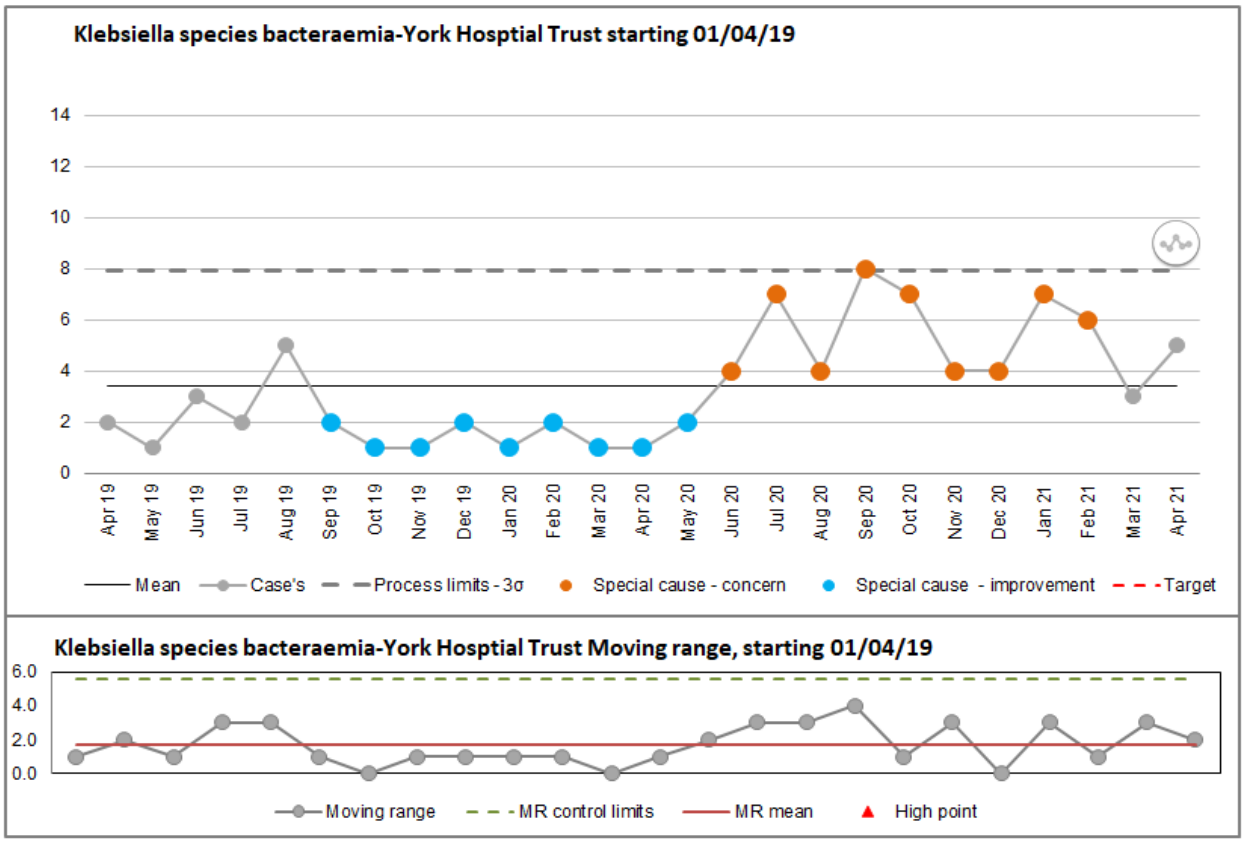
The Trust's annual plan for 2021/22 aims to continue ongoing reduction of healthcare associated GNBSI and includes introducing initiatives around promotion of hydration, urethral catheter care audits and training and education for staff.



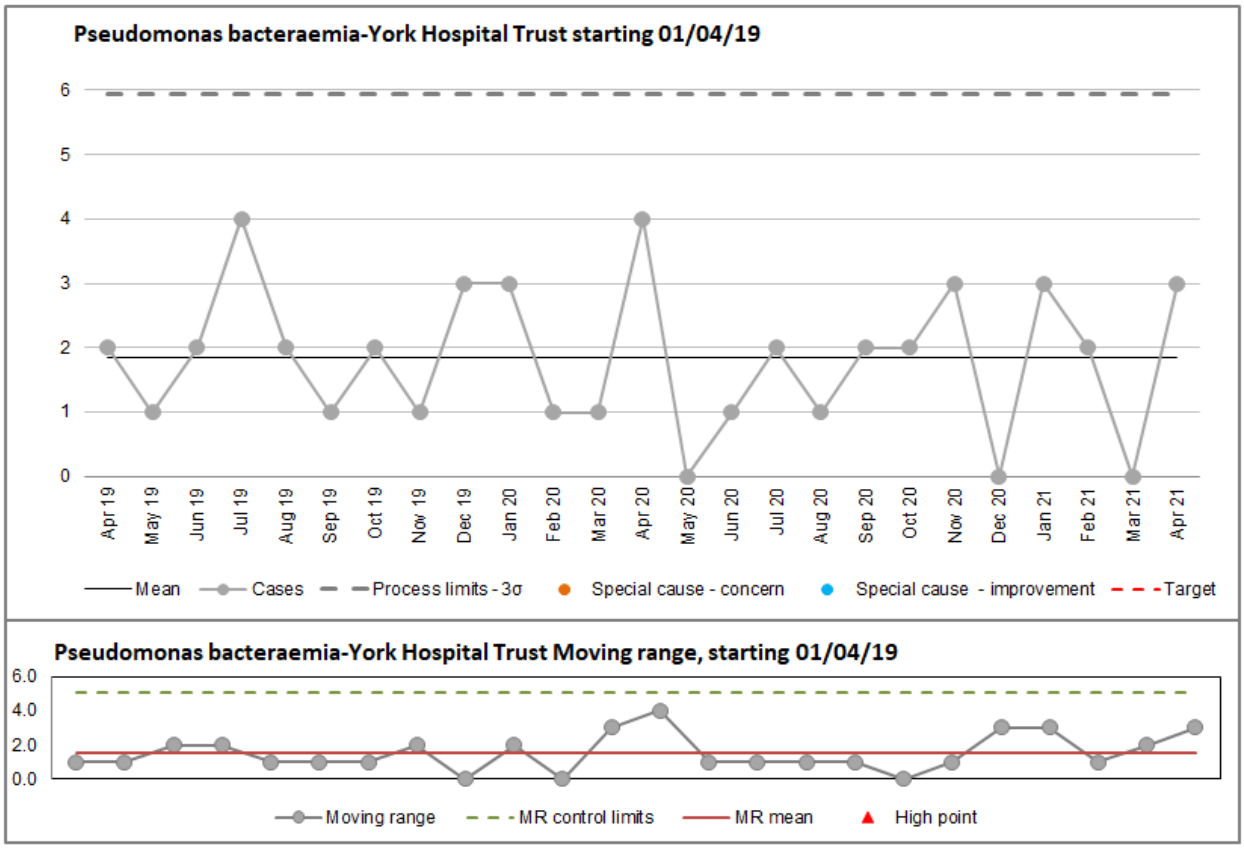
Graph 7. *E.Coli* bacteraemia by attribution April 2020 and April 2021



Graph 8. Monthly Trust attributed *Escherichia Coli* bacteraemia April 2019-April 2021



Graph 9. Monthly Trust attributed *Klebsiella species* bacteraemia April 2019-April 2021



Graph 10. Monthly Trust attributed *Pseudomonas* bacteraemia April 2019-April 2021

2.5 COVID-19

The incidence of COVID-19 has been declining over the past 2 month with cases per 100,000 people in the last week 24th to 30 April reporting cases around our surrounding region as follows:

Region	Cases per 100,000 of the population
National average	17
York	20
Scarborough	17
East Riding of Yorkshire	29
Hull	38
Selby	67
Harrogate	19

A COVID-19 outbreak is classed as two or more cases which occur in the same clinical or non-clinical area within a 14 day period. The definition includes asymptomatic infections and infections among staff.

The internal Track and Trace team supports the investigation of staff and patient cases. Trust guidance has also been produced to strengthen governance around investigation and management of hospital-acquired cases, clusters and outbreaks; as per national and regional recommendations. From January 2021 the internal Track and Trace team have been contacting discharged "contact" patients to make them aware of being in contact with a COVID-19 positive individual and to ensure they understand the need for isolation and to monitor for any symptoms.

The IPC teams have undertaken audits during January 2021 and April 2021 using the "Checklist and monitoring tool for the management of COVID-19" published by NHS England/Improvement (NHSE/I) in December 2020; a summary of these audits have been produced for both sites to provide assurance of compliance with key actions. The Trust has been successful in securing regional funding for IPC and has been used to purchase Sani Stations for all main entrances at York and Scarborough sites. The Sani Station were installed on both sites in March 2021. These are branded to the Trust, a visual representation can be found in Appendix 2.

NHSE/I resources and guidance 'Every Action Counts' that was produced in March 2021 has been adopted by the Trust through development of banner posters located at all main entrances including community sites. These posters are to provide visual and written information of COVID-19 precautions to all service users.

Risks

Social distancing remains the cornerstones of the government's policy for containing the COVID-19 epidemic. Rising admission numbers (bed occupancy of 13,126 in April 2020 vs 21, 494 in April 2021); and services restarting at full capacity is making adherence to social distancing of patients challenging.

To mitigate this, Quality Impact Assessments (QIA) are being undertaken by Care Groups. The overarching approach has been previously reported and agreed at the Quality Committee in September 2020 to protect patients whilst meeting operational demand. Care Groups have been asked to ensure there is a process for continual, dynamic risk assessment of social distancing in practice. There has been a renewed drive to deliver social distancing on all wards across the Trust. This is being led at Care Group level and reporting to Silver for any issues that require escalation. Matron's and Ward Managers

complete a Trust agreed weekly social distancing audit with any escalations to the Associate Chief Nurse within Care Groups.

The challenges experienced of not being able to maintain social distancing of patients across the Trust were highlighted to Public Health England (PHE) and the Clinical Commissioning Group (CCG) in 2020/21.

Visiting has been restricted across the Trust to essential visits only in light of the relaxation of social distancing. It is recommended that this is maintained until the additional beds are removed and that the use of the extra beds is kept under review with every effort made to remove them as soon as possible.

In a paper to Gold Command in March 2021 a summary of the options available in regards to revising the Trust's approach to visiting was presented; with the preferred option being to gradually reduce visiting restrictions in a planned manner, across all Trust sites; and in line with the government's roadmap to recovery plan.

The lack of a robust decant programme to facilitate proactive terminal cleans and HPV across the organization is an identified risk for *C.difficile* reservoirs and on-going transmission from the environment for the Ribotype 001 in Scarborough. *C.difficile* meetings will be continued to ensure implementation of recommendations and escalation to TIPSG. All general adult in-patient wards at Scarborough Hospital received pro-active HPV cleaning during 2020 with the exception of Lilac Ward. An annual program has been developed by the Patient Flow Manager for Scarborough Hospital to roll out from May 2021; this is being reviewed and requested to be brought forward due to recent incidence and a focus on the Emergency Department and Lilac Ward are being discussed.

3. Outbreaks and incidents

There were no outbreaks of any infection reported in April 2021.

All Outbreaks of COVID-19 that affected the Trust during the eight of the COVID pandemic were reported to the NHSE/I using their online portal and followed up to 28 days as stipulated by PHE as the end of an outbreak if no further cases are identified. A summary of all the outbreaks from November 2020 was submitted to the Patient Safety team to be able to accurately apportion harm and ensure Duty of Candor has been exercised where required. All outbreaks are currently closed.

Thirteen cases of *C.difficile* Ribotype 001 have been cultured in stool samples since September 2020 in Scarborough. Following an agreement with PHE to close the *C.difficile* outbreak in Scarborough in December 2020, nine further cases have been identified; with the most recent case from 29th April 2021.

A proactive decant and HPV plan has been drawn up with the aim of commencing by May 2021 as a *C.difficile* reduction strategy. The IPC annual plan for 2021/22 will focus on various education and training methodologies and platforms and highlighting *C.difficile* as a priority.

An incident involving a patient with Cabapenamase Producing Enterobacteraese (CPE) occurred on ESA and ward 14 at the York site. Eight other patients who were identified as contacts in the bays where the positive patient was placed. An incident meeting was held to discuss duty of candor, screening of contacts, environmental cleaning and appropriate placement of patients. Further escalation has been made to the Information Team to

ensure the alert system for infections are easily identified by clinical staff. This action remains outstanding.

Cesarean section Surgical Site Infections (SSI) in Labour ward at York site has prompted investigations into the root cause. Preliminary investigations involving a walk-round by the IPC team has revealed concerns with the poor state of the maternity theatre environment. Recommendations have been made and actions will be followed up through care group engagement. Also see appendix 3.

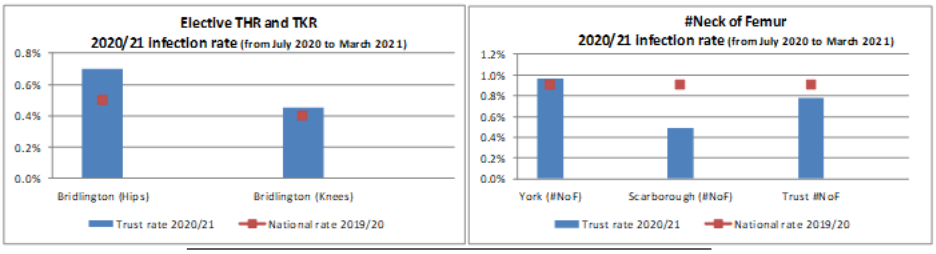
Three orthopaedic surgical site infections have been identified for the period of January and February 2021 for patients who had their surgery whilst an inpatient on Kent ward in Bridlington Hospital. Post infection reviews are underway to establish cause and the IPC team has undertaken visits in April 2021 to assess practice and support staff.
No Infections have been reported for April 2021.

Actual number of infections - refers to month of inital surgery

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Year total
Bridlington (Hips)	x	0	0	0	0	0	2	0	0	2
Bridlington (Knees)	x	0	0	0	0	0	0	1	0	1
York (#NoF)	0	0	0	1	0	0	0	0	2	3
Scarborough (#NoF)	0	0	1	0	0	0	0	0	0	1
Trust	**0**	**0**	**1**	**1**	**0**	**0**	**2**	**1**	**2**	**7**

Infection rate to date (number of infections/number of operations)

	Bridlington (Hips)	Bridlington (Knees)	York (#NoF)	Scarborough (#NoF)	Trust #NoF
Trust rate 2020/21	0.70%	0.45%	0.96%	0.49%	0.77%
National rate 2019/20	0.5%	0.4%	0.9%	0.9%	0.9%



Graph 11. Orthopedic surgical site surveillance data-July 2020 to April 2021

4. Environmental cleaning

The Trust continues to monitor monthly cleaning scores through the Cleanliness Monitoring team and any concerns escalated to TIPSG.

Concerns have been raised regarding the consistently amber cleaning scores on the York site particularly in the very high risk areas. Assurance from the Facilities department has included completion of a root cause analysis to ascertain some of the finer details and corrective measures to enable areas to improve their cleaning scores.

The first Environmental Monitoring Group (EMG) meeting was held on 14th August 2020. This was followed by a review of other groups that look at environmental issues and process mapping of how these groups could come together. A follow on meeting was scheduled in April 2021. Exception and risk escalation from the EMG are expected to be through and the main functions of the group being:

- To review the measures that the Trust has in place to monitor the patient environment in relation to cleanliness and general state of repair
- To review performance against local and national cleaning standards
- To agree priorities for cleanliness and refurbishment of wards and departments

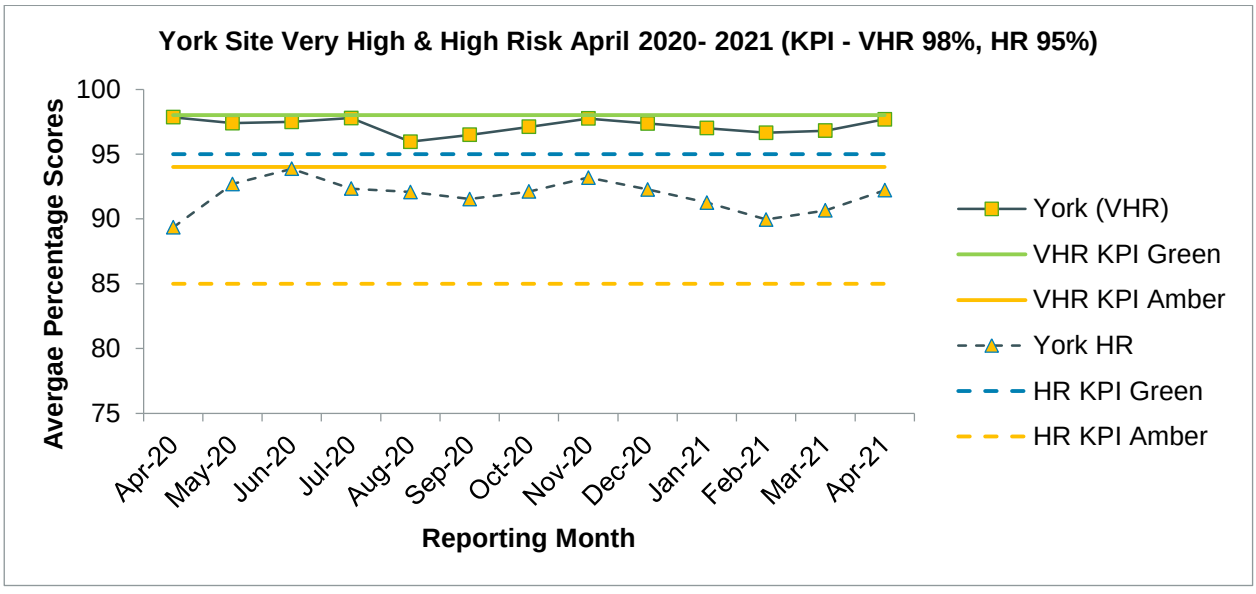
The Trust introduced an electronic system of auditing the environment on 4th September 2020 as part of an integrated audit of care elements through a computer application (app).

The IPC team monitors the weekly and twice weekly and share any issues for escalation at TIPSG.

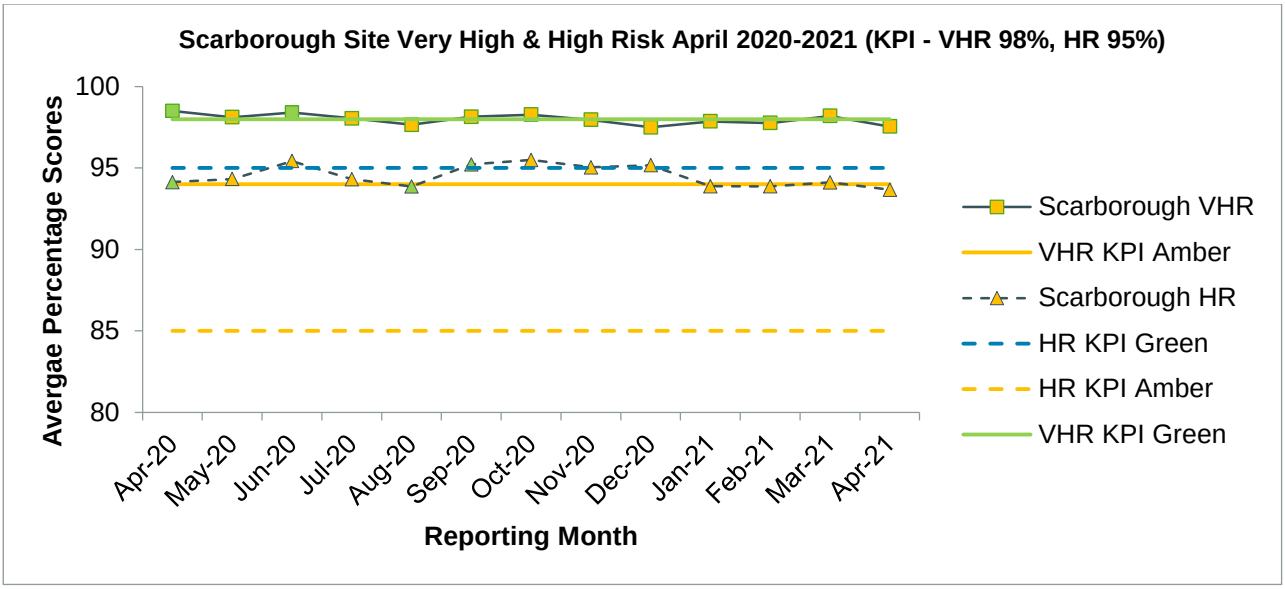
Date	York	Scarborough	Bridlington	Selby
Apr-20	97.85	98.51	99.40	96.47
May-20	97.39	98.11	98.63	97.44
Jun-20	97.49	98.41	97.73	96.22
Jul-20	97.78	98.04	98.84	97.38
Aug-20	95.96	97.65	99.00	96.95
Sep-20	96.49	98.14	98.61	96.10
Oct-20	97.10	98.27	98.15	99.01
Nov-20	97.75	97.96	98.59	97.38
Dec-20	97.36	97.49	98.88	97.40
Jan-21	97.00	97.86	98.43	98.28
Feb-21	96.65	97.76	98.24	99.54
Mar-21	96.81	98.19	98.75	98.80
Apr-21	97.69	97.54	98.90	98.24

Table 5. Cleaning scores for very high risk areas April 2020 to April 2021

All very high risk areas cleaning scores are above the amber Key Performing Indicator (KPI) of 94%.



Graph 11. York Site Very High & High Risk April 2020-2021



Graph 12. Scarborough Site Very High & High Risk April 2020-2021

The Deputy Chief Nurse for IPC has arranged a regular, monthly meeting with the Head of Facilities (LLP) to discuss any issues and increase collaborative working between IPC, the Trust and the LLP.

5. Water Safety

On 1st September 2020, a high count of Legionella was identified from water outlets of out-patient areas at Bridlington hospital. Preparation for major works on water pipes commenced in September 2020 and major mechanical work were completed in October 2020. The confirmed resampling results showed that all areas have come back clear with the exception of 3 outlets; which all showed significant reduction in counts. The Trust's water safety plan was followed for the mitigations for the level of identified risk for these remaining 3 outlets to address localised issues. Enhanced flushing and further remedial works were continued in October 2020. Outcomes of the work being carried out are shared at TIPSG and the Water Safety Group.

In October 2020 a high count of Legionella was identified at the Harrogate renal unit.

Room No.	Room Description	Outlet	Result	
H07	Consultant/Treatment room	HWB	225 cfu/l (pre-flush hot/mixed water)	Confirmed result – sample date 8/10/20
H08	Clean utility	HWB	250 cfu/l (pre-flush)	Confirmed result – sample date 14/10/20
H20	Staff rest room	HWB	25 cfu/l (pre flush-hot/mixed water) 50 cfu/l (post-flush – hot water)	Presumptive result – sample date 23/10/20
H01	Dialysis bay	HWB	25 cfu/l (pre flush hot/mixed water)	Presumptive result – sample date 23/10/20

Table 6. Legionella results for Harrogate Renal Unit October 2020

The hot water system seemed to have been affected. The Estates team from Harrogate undertook a chemical disinfection and flushing of the system with minimal operational disruption.

In January 2021 a water outlet in the isolation lobby in ICU at Scarborough hospital failed the 6 monthly routine *Pseudomonas aeruginosa* sampling. This tap was completely removed alongside the associated pipework and replaced with a brand new outlet and

pipes. It was returned back to use after passing 3 *Pseudomonas aeruginosa* water samples.

In February 2021, 10 colonies of *Pseudomonas aeruginosa* were identified in a water outlet of the main kitchen at Harrogate Renal Unit. Repeat samples for testing were collected on 26/02/2021 and a flushing regimen of the tap put in place. Pre and post flush samples after one week showed no growth.

On 9th April 2021 the routine Legionella samples in Lawrence ward kitchen at Bridlington hospital passed on the cold pre and post at 25 and 75 cfu/1000ml, but the hot pre and post failed at 575 and 500 cfu/1000ml). The outlet was put out of use and started on a 7 day flushing regime. Further Legionella samples were taken around this area to determine whether there was further spread in the system. Results are still pending.

6. Staff training

On 9th April 2021 the IPC team at the York site received a one day in-house training in Water Safety organised by the Health and Safety team. The training is in line with the Health and Safety Executive (HSE) recommendation for anyone who is responsible for water safety in a healthcare setting. The same training is scheduled to take place for the Scarborough IPC team in May 2021.

IPC mandatory training Trust-wide compliance is 91% for level 1 and 89% for level 2. The low IPC mandatory training compliance is highlighted to managers through prompts from CLaD; and by the IPC team to all relevant teams using various forums such as care group meetings.

The IPC level 1 face to face training presentation has been revised and submitted to the Work Based Learning team for 2021/22.

Other planned staff training programs based on the IPC annual plan for 2020/21 were challenging to achieve due to priorities being given to managing COVID-19 across the Trust and staffing challenges within the IPC team. However, with reducing rates of COVID and improved staffing within the IPC team, training using different platforms will be resumed in 2021/22.

7. Next Steps

- Continue to integrate the IPC team into care groups to improve engagement with clinical teams and improve outcomes for reducing HCAIs; in particular *C.difficile* and blood stream infections.
- Develop cleaning competency tools with a focus on commode and bed cleaning as a *C.difficile* reduction strategy.
- To embed into practice the amalgamated post infection reviews (PIRs) into the DATIX system to enable local learning within care Groups from PIR outcomes.
- Develop training packages that facilitate IPC training for staff within clinical areas to enhance good practice.
- Ward based training in PPE to enhance staff and patient protection against transmission of COVID-19 and other HCAIs.
- Offer assurance for actions taken against relaxing social distancing of patients by monitoring of mitigations through audits conducted by clinical teams.
- Participate in the planning and implementation of the decant and proactive HPV program.

- Working with the tissue viability team to relaunch annual mattress and bed audits.
- Audit invasive device management with a focus of reducing HCAI bacteraemia related to invasive devices.
- Develop the annual plan for 2021/22 with focus on any issues that were not implemented in 2020/21 due to the COVID pandemic.

8. Detailed Recommendation

The Quality Committee is asked to note the Trust position of HCAIs; and to gain assurance from the actions within the *C.difficile* action plan.

The Quality Committee is asked to acknowledge and support initiatives to reduce other HCAIs.

The IPC mandatory training compliance for medical and dental staff is low. The Quality Committee is asked to seek assurance that Care Groups are addressing this locally so that the Trust is assured that there is plan in place to ensure medical and dental staff are compliant with IPC training requirements to maintain safe clinical practice.

Although the outbreaks of COVID-19 among patients and staff have reduced the IPC team advises that the Quality Committee acknowledges the risks of inadvertent transmission of COVID-19 to staff or patients as a result of relaxing social distancing within clinical environments. The committee should also seek assurance that the mitigations are in place to reduce the risk of COVID-19 transmission on wards where social distancing is not possible.

APPENDIX 1. *Clostridium difficile* action plan

ACTION PLAN FOR:	Reduction in Clostridium Difficile Cases at SGH/BDH	DATE:	07/05/2021
OVERALL STATUS:	10 of the last 17 hospital attributable C.diff cases at SGH/Bridlington have been Ribotype 001 (59%)	OVERALL RAG:	

RED	Unlikely to be completed without additional time or resource	Amber	Likely to be completed but may require addition resource or time	Green	Due to be completed with no additional resource or time required

	Issue	Date added	Action	RAG	Owner	Review Date	Measure of Success	Escalation Required	UPDATE
1	**Estates:** Wash hand basin not at every ward entry point	n/a	Request quote from LLP for the installation of a wash hand basin at the entry point to every ward on the Scarborough/Bridlington sites.		A Whitfield	31/07/2020	A Wash hand sink is installed at every ward entry location on the SGH site.	YES - Escalated to PR/H McN	**07/05/21 - awaiting official confirmation of monies from HMc/PR/TF . Initial meeting held with estates regarding design of sink** 09/03/2020 - £ 26K allocated for sinks at entrances to wards at sgh. Remains issue of where to site the sinks - need to revisit with a walk around with estates - ACW 28/09/20 - issue of where to site sinks. Space is limited and there is a concern that the basins will get smashed or knocked of the wall when moving beds. The door edges around the wards have clear damage where they have been struck by beds and the basins will be more even prone to damage. 24/08/2020 - Third party contractors have assessed the work and we await the quotation. In terms of an indicative cost whilst we await the quote, £3000 per sink is an acceptable figure. J Wilshire will speak to the contractor to see if the quote can be expedited.
10	Improve Antibiotic prescribing	n/a	ARK Project – Relaunch/ reinvigorating the project		D Mawer/ Anita Chalmers	31st May 2021	An increase of the proportion of antibiotics stopped within 72 hours.		**6/5/21 - project to be Launched 1st June 2021 on site. E-learning in place** 13/04/21 - update to follow from DM 9/3/21 - D Mawer to revisit as Covid work subsides
11	Reduce Intra-ward transfers throughout the Trust	n/a	Intra ward transfer reduction project and associated documentation launched		S Kelly	31st May 2021		YES - Escalated to PR	**04/05/21 - Project to be re-launched. Original Paperwork obtained PR to speak with Freya O/Michael Mawhinney** 13/04/21 - SK/ACW to meet w/c 19/04/21 9/3/21 - PR/ACW to revisit as COVID allows 5/10/20 - Challenging at present due to COVID operational pressures
22	Delays in stool Sampling (2)	NEW 04/05/21	Simplify Stool Sampling Flow Chart		ACW	31st May 2021	New Sampling Poster in use across Trust	NO	**04/05/21 - Draft poster developed. Awaiting agreement on changes required**
23	Hand Hygiene - numerous dispensers not working - soap and alcohol gel	NEW 04/05/21	Move to hand operated Hand dispensers (Currently battery) (Soap required for C.Diff but all types of dispensers need replacing)		ACW	31st May 2021	All battery operated dispensers removed and replaced on	NO	**04/05/2021 - Newly added. Numerous dispensers not is use. Battery replacement appears to be main issue. There was a move to go to Hand operated ones pre COVID. To re-explore possibility**
24	Hand Hygiene - Discrepancy between ward audits and IPC	NEW 04/05/21	IPC Peer review Hand Hygiene Audits		Astrida Ndhlovu	31st May 2021	5 x Peer Review HH audits carried out a month	NO	**04/05/21 - Newly added**
25	Hand Hygiene - Particular issue surrounding 5 moments identified	NEW 04/05/21	Improve training		Anne Tateson/Jane Tulley	31st May 2021	Improvement in IPC Hand Hygiene Results	NO	**07/05/21 - HH training voa GOJO to be repeated Attendance was 40 + on first session** 04/05/21 - JT has been providing additional training on Chestnut and Cherry wards. AT has arranged GOJO to provide free training on HH for staff on HH day (5th May)
26	Hand Hygiene - improve education	NEW 07/05/21	Development of Hand Hygiene Tool Box Teaching		TBC	TBC	TBC	NO	**07/05/210 - to be agreed/identify lead**
27	Patient Beds not Cleaned to a high enough standard after a patient is discharged	NEW 04/05/21	Bed Cleaning Compentencies to be developed		TBC	TBC	TBC	NO	**07/05/2021 - Lead to be identified to develop compentancies**
28	Improve Commode Audit results further	NEW 07/05/21	Recent improvements across site - IPC to develop commode cleaning competencies		TBC	TBC	TBC	NO	**07/05/21 - Lead to be identified**

29	Inconsistancies in the use of sporical wipes to clean commodes when C.Diff has not been identified	**NEW** 07/05/21	To explore the standardisation of the use of sporicidal wipes for all commodes - all the time		TBC	TBC	TBC	NO	**07/05/21 - To be agreed at IP**T
30	Improve Education of C.Diff amongst staff	**NEW** 07/05/21	Development of C.Diff Tool Box Teachong		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed/identify lead**
31	Ensure C.Diff care standardised	**NEW** 07/05/21	Development of new C.Diff care plan		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed/identify lead**
32	Numerous ward Refurbishments required	**NEW** 07/05/21	Numerous ward Refurbishments required		TBC	TBC	TBC	NO	**07/05/2021**
33	Poor condition of ward environment	**NEW** 07/05/21	Re-launch environmental audits and walk arounds involving Ward leaders		TBC	TBC	TBC	NO	**07/05/2021 - TO be discussed at IPT**
34	Cleanliness of Environment	**NEW** 07/05/21	Introduction of Cleanliness standards meeting		Paul Rafferty	31st May 2021	Meeting Established	NO	**07/05/21 - first meeting due 13th May 21**
34	Increase prevalence of 001 strain - ?community	**NEW** 04/05/21	TBC - possible period of sampling all loose stools and ribotype on admission. There are some circumstances on our current stool sampling flow chart where this would not occur		TBC	TBC	TBC	NO	**07/05/2021 - To be agreed at IPT**

18 items closed/completed (see completed tab)

Completed actions

ACTION PLAN FOR:	Reduction in Clostridium Difficile Cases at SGH/BDH	DATE:	07/05/2021

OVERALL STATUS:	10 of the last 17 hospital attributable C.diff cases at SGH/Bridlington have been Ribotype 001 (59%)	OVERALL RAG:	

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	Issue	Date added	Action	RAG	Owner	Review Date	Measure of Success	Escalation Required	UPDATE
2	**Estates:** Unclear which areas of SGH site	n/a	Undertake/update review of locations suitable for HPVing		J Pownell	31/07/2020	Up to date list of suitable areas for HPVing.		Survey completed on Monday 10th August at SGH and on Tuesday 11th at York
3	Currently have a reactive model with regards to HPV Program	n/a	Identify a decant facility for SGH and BDH		D Thomas	24/07/2020	Identify an area to use as a decant facility.		Ann Wright Identified as a decant area whilst awaiting potential work to be done to convert into 11 siderooms.
4		n/a	Develop Proactive HPV plan for SGH and BDH		A Whitfield/ S Kelly	31/07/2020	Have an agreed plan for the proactive HPVing of all areas at Scarborough hospital.		Plan published - 1st ward area Beech being completed w/c 31/8/20
5	**Estates:** Lack of isolation facilities	n/a	Work up plans to increase sideroom capacity		D Thomas	August	Increase of Sideroom capacity onsite from siderooms		Bid Successful - awaiting tender
6	Estates: Decontamination of beds	n/a	Complete Decontamination of Beds program at SGH and Enterprise Bed Upgrades		A Whitfield	24/07/2020	All beds have gone through Decontamination and upgrade program of work.		19/10/20 16 out of original 423 left to do (96% complete). 13 in York, 2 in Bridlington, 1 in Scarborough 5/10/20 64 out of original 423 left to do (85% up from 79%). Further finances will have to be secured to get this project completed. 2/9/20 Relying on Medical Engineering staff to do the overtime to get them done and as most are in Brid it will be difficult. It takes 2 - 3 hours to do each bed. Have had volunteers for one weekend and a couple of nights so far. We have 10 in Scarborough, 2 not been used that we are going to do soon and try and find the other 8. In Brid we have 27 to do across all wards. 31/7/20 we have 11 beds in Scarborough and 27 in Bridlington out of a total of 182 left to complete (79% completed). Pause during Covid due to lack of spares and resources. We now have the spares but we are waiting for confirmation from LLP finance manager that we have the money from the trust to claim overtime to complete the process.
7	**Facilities:** Use of Kentucky Mop heads across SGH site	n/a	Move to the use of reusable Microfibre Mop heads across site		J Louth	End April '21	Reusable Microfibre mop heads in use across SGH and BDH.		**09/03/21 - Microfibre mops have been delivered - Staff training commences 20th April followed by roll out**
8	Cleanliness: Commode's regularly identified as being soiled via Audit	n/a	Regular Commode 19 audits (Weekly) performed		A Smith	31/07/2020	Weekly IPC audits completed and Improvement in results over a period of time (End August 2020).		Results from 16/10/20 showed improvement in most areas. Areas of concern: DOK - 67% Chestnut - 75% Lilac - 67% S.Freer requested we include ED in future audits
9	Patients currently transferred from ward to ward on own hospital bed	n/a	Setting up of a group to look at this particular issue and implement process		S Kelly/ S Freer	10/08/2020	Trolley's used to transfer patients, unless absolutely necessary to occur on a bed.		**SGH Transfer team in place**
12	Learning from Post Infection Reviews (PIR's) to sit within the appropriate care group	n/a	Move to a model where the PIR's are run by the individual care groups - In this first instance by CG2 as a pilot for rest of Trust		P Rafferty/ A Whitfield	Nov	Care Group 2 C- Diff PIR's run by CG and monitored by Care Group Quality Group and then plans to		**5/10/20 - Launch of new process November 2020. Reports being made to auto report from Datix system**

13	Lack of awareness on site of current Clostridium Difficile issue on SGH/BDH sites	n/a	Develop a strategy with the communications team to raise awareness		A Whitfield	10/08/2020	Have a communication strategy document.		Materials produced by comms team. Screen Savers gone out twice W/C 24th and 31st August Item in Friday's Staff bulletin Went out 4/9/20
14		n/a	Identify a lead clinician on site to drive message forward		Tim Houghton	03/08/2020	To have an identified consultant to lead/assist in program of work to reduce C.diff across the site.		Tim Houghton/Ed Jones attending C.diff outbreak meetings
15	Improve awareness on site of current Clostridium Difficile issue on SGH/BDH sites	n/a	Introduce weekly IPC matron's huddles		IPC Team	31/08/2020	To have weekly IPC matron huddles.		**13/04/21 - AW to join 1 day a week from w/c 12/04/21** 9/3/21 - AW to join SGH Matron Huddle 1 day a week
16	Different products in use by staff to decontaminate equipment. Including separate Sporicidal wipes that require water to be activated	n/a	Explore potential of moving to a single wipe which contained detergent, disinfectant and sporicidal agents to reduce confusion among staff and to ensure that the sporicidal was being used all the time everywhere.		IPC Team/ Annette Williams	Q4 2020	Identify potential alternative product to be put forward to procurement		**April 2021 - Currently on Trial of Tristel** 5/10/20 - Annette Williams will look at after COVID work decreases
17	When a patient with C.diff is moved out of a bay it is currently adhoc as to if the bay would be decanted to allow for terminal a clean and HPV.	n/a	Look at establishing a process that when a patient with C.diff is moved out of a bay, the bay has to be decanted to allow for terminal clean and HPV.		Alison Wright	End Sept	It becomes the exception not to decant a bay to allow for a terminal clean and a HPV .		**April 2021 has become standard practice - to datix when not able to complete** 1 instance of this in August 2020 and we did empty the bay and HPV. About to do the same on Chest nut ward (as of 8/9/20)
18	Lack of storage in general and equipment stored in inappropriate places	n/a	Introduction of declutter programs		IPC Team/Anne Tateson	Q4 2020	Have a declutter program established.		**May 2021 - Declutter Month to be added to IPC rolling Program of EVENTS** 05/10/2020 - A Tateson will progress this as COVID work allows
19	Improve assurance around cleanliness and quality of Mattresses	n/a	Introduction of mattress audits which results in replacing damaged/soiled mattresses.		IPC Team	Q4 2020	Regular Mattress audits introduced and established.		26/10/20 - Meeting Sam Haigh this week to discuss 05/10/2020 - ACW to meet with Sam Haigh (TVN) to progress work. We are looking at a Trust wide mattress audit program collaboration between IPC and TV
20	Reduce the number of minor works that are outstanding in clinical areas	02/09/2020	A joint IPC, Estates, matron walk round would held to identify minor works needing completing		IPC Team SGH	completed or in diaries by Sept 30th	Assurance that list of works outstanding is correct.		**May 2021 - CLOSED. NEW ITEM REPLACED REGARDING ENVORONMENT MEETING AND ENVIRONMENT AUDITS** Ross Chamberlin and Shaun Fletcher as leads on this from the Estates Department.
21	Delays in stool sampling	02/09/2020	In intentional rounding document stool chart is not for 1 day and contains incorrect information (it only identifies type 6 and 7 as Diarrhoea)		IPC Team/ACW	30th Sept 2020	Stool chart removed from intentional rounding document (as not a wholly owned nursing document) and corrected.		**04/05/21 - Moved to Green as awaiting digital solution. Paper stool charts now back in use** 13/04/21 - Paper stool charts in use on majority of SGH site - Nic Coventry aware. working on a digital solution - ACW 9/3/21 - Group didn't meet during latest COVID wave - ACW to re-pick up with Documentation lead nurse (N Coventry) 26/10/20 - discussing at steering group on 28/10/20 30/9/20 - Took issue to Documentation steering group. Group accept corrections needed. The nurse's from York site feel that the ward staff like and use the Bristol stool chart in the intentional rounding document. ACW to meet with new documentation lead nurse mid October. Audit required on the York site about it's use

Appendix 2. Wall Mounted Visual “Sani-Station”

Appendix 3: York Labour ward IPC recommendations

Findings and recommendations for improvement following Period of Increased Incidence (PII)

<table>
<tr><td colspan="4">Background; Following a period of increased incidence of Caesarean section wound infection cases on…York Hospital labour ward a walk round of the Labour Ward theatres undertaken on the 07/04/2021 following discussion with Gill Locking (Matron) our findings were that the patient environment unit does not meet CQC standards in relation to the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infection and related guidance (updated 2009) criterion 2 with particular reference to;
‘all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition’</td></tr>
<tr><td>Findings - estates</td><td>• Theatre 1 flooring tiles damaged therefore unable to clean theatre floor.
• Environment looking tired with some wall damage and visible plaster.
• Theatre windows have foam strips along the edges.
• Theatre & anaesthetic room 1 - Medical gases boxing on wall damaged with high levels of dust inside and on top.
• Large theatre electrical panel with clock visibly dirty and dusty with surgical tape over switches.
• Scrub sink inside theatre 1 – damaged tap (lime scale),</td><td>Recommendations -</td><td>Flooring to be replaced as not appropriate for a functioning theatre.
.
Wall damage to be repaired as not appropriate for a functioning theatre.

Review windows and remove foam to edges.

Replace medical gas boxing.
Clean and repair theatre panel.
Relocate scrub sink into anaesthetic room
Clean scrub sink tap
Remove and replace any damaged/ broken equipment

Cleaning schedules/ SOP’s to be developed for each area and equipment</td></tr>
</table>

	underneath scrub sink tiles appear to have water damage. • Nail brush holder plastic coating damaged exposing rust. • Anaesthetic room 1 WHB seal perished near wall. • Ventilation grill near floor underneath scrub sink broken		Repair seal Estates to review and repair grill
Findings - storage	Excess of equipment/ consumables in both theatres, clutter on worktops.	**Recommendations -**	Rationalisation of space , declutter and keep only required kit in the theatre. Additional Danicentres for PPE storage
Findings – MDT practice	Drip stands and pumps dusty Soap in sanitizer dispenser High and low level dust in theatre 1	**Recommendations -**	Cleaning schedules/ SOP's to be developed for each area and equipment
Findings – staffing	Staff awareness of environmental issues	**Recommendations -**	Include weekly environmental checks as part of the 'My perfect ward' audits
Findings - general	• The general environment is cramped • High & low level dust within the theatre environment. Anaesthetic equipment dusty, visible blood on theatre 2 main lights. • Leg support attachment for theatre trolley damaged split seams	**Recommendations -**	Declutter and rationalise available space. Deep clean of theatre 1 Damaged / rusty equipment to be disposed of.

	• Rusty bowl trolley wheels • Damaged rusty theatre storage trolley with adhesive tape on top.		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Care Quality Commission (CQC) Update

/ 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

The purpose of this report is to provide the Trust Board of Directors with an updated position on progress with the Care Quality Commission (CQC) action plan.

/ Executive Summary – Key Points

- Statutory notifications were submitted to notify the CQC of the Trusts name change, along with an updated Statement of Purpose to reflect this change. This has been actioned and a new registration certificate has been received.
- An improvement in action delivery is noted within the paper across the Section 31, Section 29A, and Must-Do action plans. One action is behind delivery and this relates to the recruitment of a Scarborough PEM consultant within the Emergency Department. The Care Group are working on a timeline of events to provide assurance that this action is progressing. All other actions are on track for delivery on time.
- On 12th February 2021, 7 notifications were to request the removal of the 3 conditions associated with registration for York Hospital and 4 conditions associated with registration for Scarborough Hospital. Formal notification of the outcome is currently awaited.
- The Head of Compliance is in the process of updating the current “Should-Do” action plan in line with the new SMART action plan format.

/ Recommendation

1. Accept this report as an updated position for the Trust in relation to CQC action plans (Section 29A, Section 31, & Must-Do actions)

Author: Shaun McKenna – Head of Compliance & Effectiveness

Director Sponsor: Caroline Johnson – Deputy Director of Patient Safety & Governance

Date: 10-05-2021

1. Introduction

York & Scarborough Teaching Hospitals NHS Foundation Trust is a CQC registered care provider. Registration with the CQC was granted in 2010, but in order to maintain this registration the Trust must operate in line with the requirements of the Health & Social Care Act 2008 and associated regulations. As a result of the unannounced inspections during June and July 2019, the report published in October 2019 gave the Trust an overall rating of Requires Improvement. Areas for improvement were identified including 26 'must-do' actions in order to comply with legal requirements. In addition a further 50 'should-do' actions were noted to be required to improve the services delivered within the Trust. An unannounced focused inspection took place within York Hospital Emergency Department, Scarborough Hospital Emergency Department and Scarborough Hospital Medical Services in January 2020. These areas were rated as 'inadequate' overall with Medical Care being rated as 'inadequate' for the safe domain. An urgent notice of decision to impose conditions on registration was sent to the Trust on 17th January 2020; 3 conditions were imposed for York Hospital and 4 conditions were imposed for Scarborough Hospital. In addition to the conditions imposed, a Section 29A Warning notice was received on 21st January 2020. The warning notice served to notify the Trust that the CQC had formed the view that the quality of healthcare provided by the Trust requires significant improvement. The purpose of this report is to provide the Trust Board of Directors with an updated position of progress against the Care Quality Commission (CQC) action plan and next-steps for the Trust.

2. Detail of Report and Assurance

2.1 Engagement Meetings

Engagement meetings continue to occur on a monthly basis, as per routine practice. Initial attempts to move towards face-to-face meetings proved to be unsuccessful due to the COVID-19 surge, virtual meetings were utilised throughout. The relationship between the CQC relationship owner and the Trust continues to grow and develop. Benchmarking exercises undertaken within the Trust were shared with the CQC in January and April; on both occasions CQC felt they had sufficient assurances in our approach and responses provided.

Upcoming engagement meetings will feature representation from Senior Nurses to discuss the discharge improvement work-stream and falls improvement work-stream.

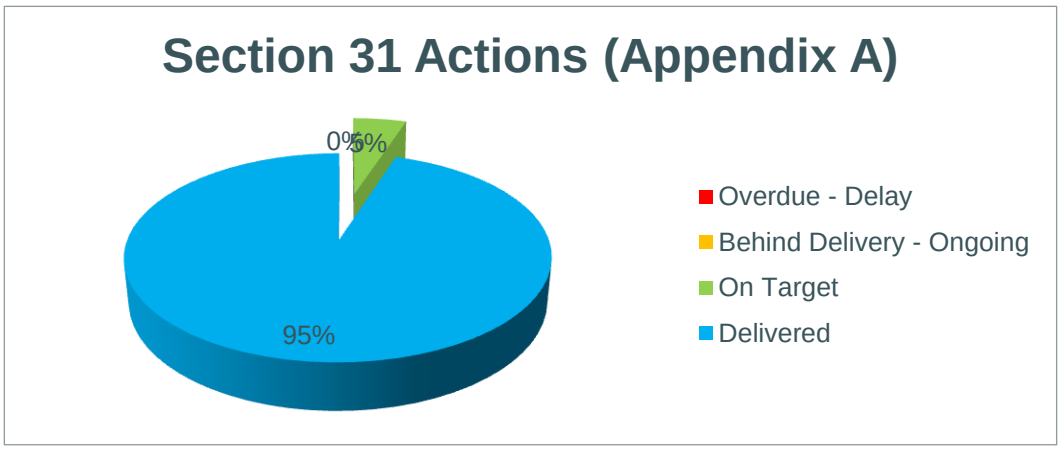
2.2 Notifications

A revised 'Statement of Purpose' was submitted to CQC in early November 2020, along with a request to temporarily register 2 services during the COVID pandemic; Nuffield Hospital and Ramsay Healthcare. In addition, 3 registered locations were removed as they no longer fulfilled the criteria for registration; Whitby Hospital, Malton Hospital, and Archways. On 12th February 2021, 7 notifications were submitted to the CQC on behalf of the organisation. The 7 notifications were to request the removal of the 3 conditions associated with registration for York Hospital and 4 conditions associated with registration for Scarborough Hospital. The CQC responded on 12/04/2021 requesting further information regarding mental health risk assessment audits within the Emergency Departments. Formal notification of the outcome is currently awaited. A statutory notification for the change in Trust name was submitted to CQC on 06-04-2021; this has been completed by CQC and an updated registration certificate has been received. In addition 2 further notifications were submitted to request the removal of 2 temporary locations (Nuffield Hospital and Ramsay Healthcare) as they are no longer required. This has a potential turn-around time of 14 weeks.

2.3 Regulatory Action Plan Update (Appendix A, B & C)

	Overdue - Delay	Behind Delivery - Ongoing	On Target	Delivered
Section 31	0	0	1	19
Section 29A	0	1	1	27
Must-Do	0	0	3	38

Section 31



An urgent notice of decision to impose conditions on registration was sent to the Trust on 17th January 2020; 3 conditions were imposed for York Hospital and 4 conditions were imposed for Scarborough Hospital. A submission to CQC was made on the 12th February 2021 to request the removal of the conditions associated with registration for both York and Scarborough Hospital. A final decision is expected to be made on 27th April 2021, with the Trust being formally notified by the end of the month. Initial discussions have been positive and further information has been provided in line with the CQC request. 95% of actions have been completed, with the one remaining action agreed for completion by the end of June-21. The ongoing action, following agreement to extend the due-date, relates to a benchmarking exercise taking place within Scarborough Hospital Emergency Department; this was initially delayed due to COVID-19. Following completion of this action, the Section 31 action plan will be completed and the Trust can move towards improvement plans. A significant improvement can be seen in action delivery in Chart 1.

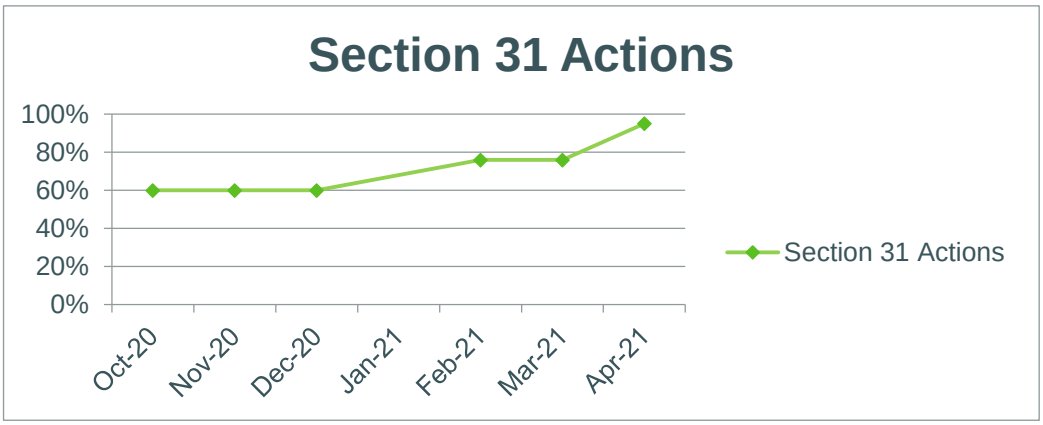
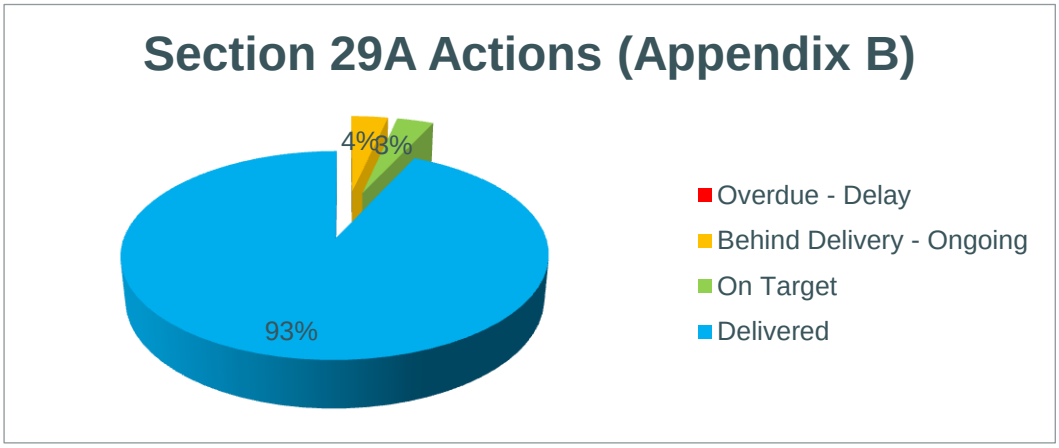


Chart 1: Section 31 Action Plan Delivery

Section 29A



In addition to the conditions imposed, a Section 29A Warning notice was received on 21st January 2020. The warning notice serves to notify the Trust that the CQC have formed the view that the quality of healthcare provided by the Trust requires significant improvement.

A continued improvement in action closure has been noted. The “Behind delivery – Ongoing” action relates to the recruitment of a PEM consultant, a proposal is being drafted by Care Group 2 for Executive Committee to consider as the next steps would require additional funding. A decision is anticipated by May 2021, and anecdotally there is interest in the cross-site post from an internal candidate. The final ‘On-Target’ action is due for completion in June-21 and this would see the Section 29A action plan closed and complete. A significant improvement can be seen in action delivery in Chart 2.

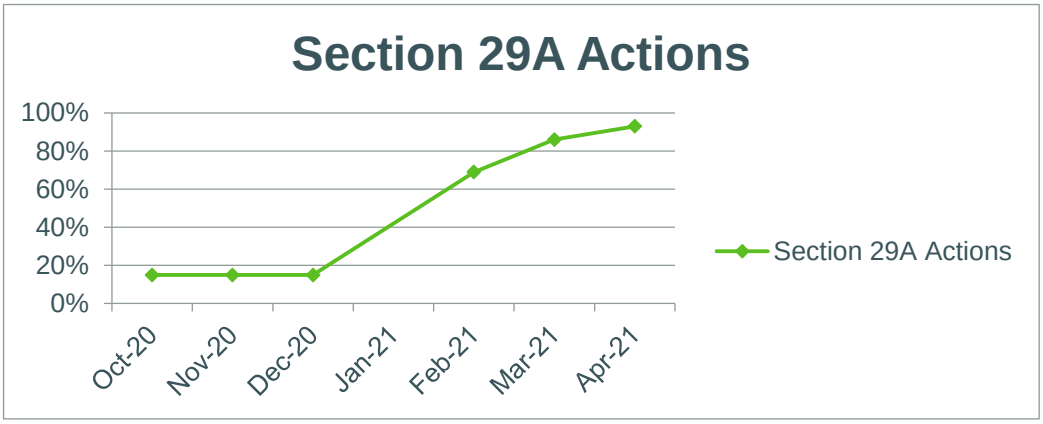
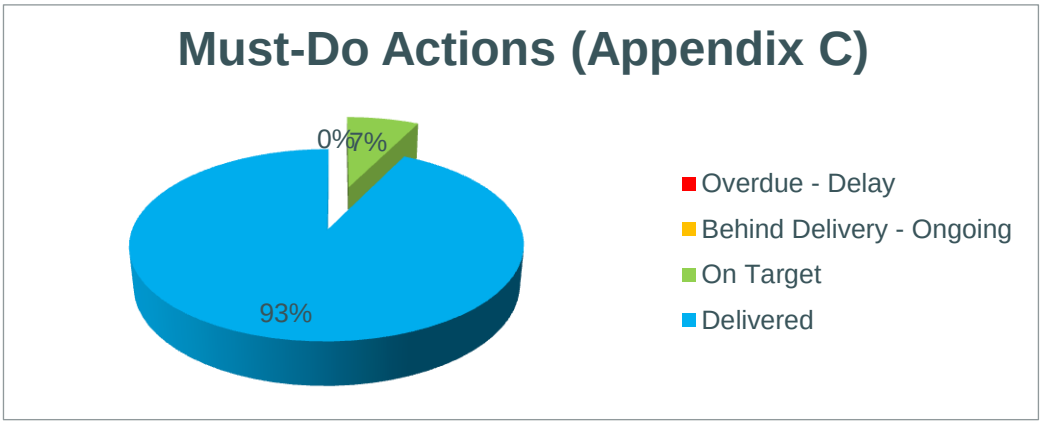


Chart 2: Section 29A Action Plan Delivery

Must-Do Actions



Following the July 2019 Trust inspection, 26 “Must-Do” recommendations were made, in addition following the January 2020 inspections a further 9 “Must-Do” recommendations were made. The Must-Do recommendations have been merged in the table above and an improvement in closed actions has been demonstrated. The 4 remaining actions are on target for delivery; 2 are due for completion in April 2021 and 2 are due in June 2021. Following the completion of the 4 actions, this would see the Must-Do action plan completed with a wider focus enabled on improvement plans and continuous monitoring for key themes. A significant improvement can be seen in action delivery in Chart 3.

Chart 3: Must Do Action Plan Delivery

3. Next Steps

Quality & Regulations Group met in March and April with a revised agenda. The agenda now dedicates one hour to the traditional agenda items, with the second hour being used in a workshop style for continuous improvement in line with the CQC inspection frameworks. The workshop commenced with the "Safe" domain, which covered Mandatory training, department specific training and safeguarding. Actions were taken by the group for consideration at the next meeting. The next workshop will focus on Infection Prevention & Control, in addition to Environment & Equipment. This will assist Care Groups and Departments in creating their focussed improvement plans.

The Section 29A, Section 31, and Must-Do action plans feature on the Quality & Regulations Group agenda each month. The aim is to close the action plans as soon as sufficient evidence is achieved, to allow for care group/department specific improvement plans to be created. The actions plans will continue to be monitored and reported through the Quality & Regulations Group.

The Head of Compliance is in the process of updating the current "Should-Do" action plan in line with the new SMART action plan format; this will assist with the check and challenge process at Quality & Regulations Group in gaining further assurance. A monthly summary report will continue to Quality Committee to ensure oversight of the CQC action plan progress.

4. Detailed Recommendation

Accept this report as an updated position for the Trust in relation to communication with the CQC and the CQC action plans (Section 29A, Section 31, and Must-Do actions)

CQC Regulatory Action - Trust-Wide Action Plan

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/S31-1.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	Senior Operational Manager (A.W)	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & York Emergency Department	Senior Operational Manager (A.W)	Mar-20	Established in April-2020. Action log maintained on a monthly basis.	Apr-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.3	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within York Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered	
Jan20/S31-1.4	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.5	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Senior Operational Manager (A.W)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered	QPAS 10-02-2021
Jan20/S31-2.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Senior Operational Manager (A.W)	Mar-20	Monitored twice monthly through Governance Meetings.	Mar-20	Delivered	QPAS 10-02-2021
Jan20/S31-2.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Jan-21	Delivered	QPAS 10-02-2021
Jan20/S31-1.10	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.11	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Emergency Department Matron (S.F)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.7	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	CG2 Quadrumvirate	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered	QPAS 10-02-2021
Jan20/S31-1.8	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & Scarborough Emergency Department	Emergency Department Matron (S.F)	Apr-21	Informal meetings are held with TEWV on a regular basis. Formalised meeting to be established. New Action	Jan-21	Delivered	On Target

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/S31-1.9	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within Scarborough Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered	
Jan20/S31-2.3	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Emergency Department Matron (S.F)	Jun-21	New target completion date to be established now that COVID presentations are decreasing. Target date agreed with Matron and amedned to Jun-21.		On Target	
Jan20/S31-2.4	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Nov-20	Delivered	QPAS 10-02-2021
Jan20/S31-4.1	Section 31	Chief Nurse	Care Group 2	Medical Wards	Scarborough	The registered provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients within all medical wards at Scarborough hospital.	Safe Responsive Well-Led	Introdcue a daily staffing huddle for CG2, utilising a daily staffing template which feeds into a monitoring database.	CG2 Quadrumvirate	Mar-20	Staffing database monitored monthly.	Mar-20	Delivered	
Jan20/S31-3.1	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Utilisie Nurse Agencies to ensure adequate Registered Childrens Nurses on each clinical shift across both Emergency Departments	Head of Childrens Nursing (S.K)	Jan-20		Jan-20	Delivered	QRG 26/10/2020
Jan20/S31-3.2	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Establish a Paediatric 'In-Reach' Service to enable consistent support for times where RCN cover is less than optimal.	Head of Childrens Nursing (S.K)	Jan-20	Audit undertaken in July 2020 to demonstrate effectiveness of the service being used.	Jan-20	Delivered	QRG 26/10/2020
Jan20/S31-3.3	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Recruit substantive RCN's for York and Scarborough Emergency Department	Head of Childrens Nursing (S.K)	Jun-20	Due to the very low numbers of paediatric attendance in the Scarborough ED and the support which can be offered from the acute Paediatric ward a proposal was made for Scarborough to have one RCN on shift at all times, rather than the guidance of 2.	Oct-20	Delivered	QRG 26/10/2020
Jan20/S31-3.4	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Add the lack of substative Registered Childrens Nurses within the Emergency Deparments to the Risk Register.	Head of Childrens Nursing (S.K)	Jan-20	Risk added to Care Group 5 Risk register with a risk rating of 12. Reviewed in November 2020 and risk rating now 1.	Feb-20	Delivered	QRG 26/10/2020
Jan20/S31-1.6	Section 31	Medical Director	Trust-Wide	Emergency Department	Trust-Wide	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Strategic Oversight Group' which governs the Operational Steering Groups for the Emergency Departments.	Deputy Director of Patient Safety & Governance (C.J)	Jan-21	First meeting took place in January 2021, second meeting scheduled for February 2021. TOR and agenda required.	Jan-21	Delivered	QPAS 10-02-2021
Jan20/S31-2.5	Section 31	Medical Director	Trust-Wide	Emergency Department	Trust-Wide	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Well-Led	Develop a SOP for the use of the PLAN compliant Mental Health Assessment Suite	Mental Health Strategic Oversight Group	Jun-21	New action. This will be incorporated into "Mental Health Care within the ED" SOP.		On Target	

CQC Regulatory Action - Trust-Wide Action Plan

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/R29A-1.1	Section 29A	Medical Director	Care Group 1	Emergency Department	York	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Jan-21	Delivered	QPAS 10-02-2021
Jan20/R29A-1.2	Section 29A	Medical Director	Care Group 1	Emergency Department	York	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	Senior Operational Manager (A.W)	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered	QPAS 10-02-2021
Jan20/R29A-2.1	Section 29A	Chief Operating Officer	Care Group 1	Patient Flow Team	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of patient flow systems and processes, implementing new processes as identified in the review.	Care Group Manager (G.E)	Mar-20	A review has been undertaken and new systems and processes including roles and responsibilities are being implemented. Social distancing is likely to provide a challenge on available beds and flow. Daily attendances continue to increase.	May-20	Delivered	
Jan20/R29A-2.3	Section 29A	Chief Operating Officer	Care Group 1	Emergency Department	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the environment for ambulance handovers and those awaiting triage.	Senior Operational Manager (A.W)	Mar-20	A review has been undertaken and the coridoor previously used for ambulances awaiting triage is no longer in use.	Mar-20	Delivered	
Jan20/R29A-2.5	Section 29A	Chief Operating Officer	Care Group 1	Patient Flow Team	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the systems and processes for discharge, updating and implementing new processes as required.	CG1 Quadrumvirate	Mar-20	New SAFER bundles have been implemented in the Discharge Lounge, flow matron team and bed management team. Home first has recently been implemented in the trust and is becoming embedded.	May-20	Delivered	
Jan20/R29A-2.7	Section 29A	Chief Operating Officer	Care Group 1	Emergency Department	York	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake improvement work with ECIST	CG1 Quadrumvirate	Mar-20	Work commenced, however put on hold due to COVID19. This work stream was reinstated for Streaming in Nov-20	Nov-20	Delivered	
Jan20/R29A-6.4	Section 29A	Medical Director	Care Group 1	Emergency Department	York	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Advertise Consultant vacancies for York Hospital Emergency Deparmtnet	Senior Operational Manager (A.W)	Mar-20	Full establishment of ED consultants.	Nov-20	Delivered	
Jan20/R29A-6.5	Section 29A	Chief Nurse	Care Group 1	Emergency Department	York	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake Emergency Department establishment reviews to ensure staffing establishment refelects the requirements.	Emergency Department Matron (N.G)	Dec-20		Dec-20	Delivered	
Jan20/R29A-1.3	Section 29A	Medical Director	Care Group 2	Emergency Department	Scarborough	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Nov-20	Delivered	QPAS 10-02-2021

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/R29A-1.4	Section 29A	Medical Director	Care Group 2	Emergency Department	Scarborough	Patients who presented at the emergency departments with mental health needs were not being cared for safely in line with national guidance (Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	CG2 Quadrumvirate	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered	QPAS 10-02-2021
Jan20/R29A-2.2	Section 29A	Chief Operating Officer	Care Group 2	Patient Flow Team	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of patient flow systems and processes, implementing new processes as identified in the review.	Care Group Manager (D.T)	Apr-20	A review has been undertaken and new systems and processes including roles and responsibilities are being implemented. Social distancing is likely to provide a challenge on available beds and flow. Daily attendances continue to increase.	May-20	Delivered	
Jan20/R29A-2.4	Section 29A	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Implement a Triage Nurse dedicated to caring for patients who are waiting for initial assessment or awaiting admission		Mar-20	Front door Nurse in situ.	Mar-20	Delivered	
Jan20/R29A-2.6	Section 29A	Chief Operating Officer	Care Group 2	Patient Flow Team	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake a review of the systems and processes for discharge, updating and implementing new processes as required.	CG2 Quadrumvirate	Mar-20	New SAFER bundles have been implemented in the Discharge Lounge, flow matron team and bed management team. Home first has recently been implemented in the trust and is becoming embedded.	May-20	Delivered	
Jan20/R29A-2.8	Section 29A	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital and Scarborough Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.	Safe Responsive Well-Led	Undertake improvement work with ECIST	CG2 Quadrumvirate	Mar-20	Action closed following discussions at March QRG - superseded by Quality & Performance Summit and the subsequent improvement plan created. Evidence to be held in CQC folder.	Mar-21	Delivered	
Jan20/R29A-6.1	Section 29A	Chief Nurse	Care Group 2	Care Group 2	Scarborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Introdcue a daily staffing huddle for CG2, utilising a daily staffing template which feeds into a monitoring database.	CG2 Quadrumvirate	Mar-20	Staffing database monitored monthly.	Mar-20	Delivered	
Jan20/R29A-6.6	Section 29A	Chief Nurse	Care Group 2	Emergency Department	Scarborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake Emergency Department establishment reviews to ensure staffing establishment refelects the requirements.	Emergency Department Matron (S.F)	Mar-21	Establishment reviews completed and will feature at Care Group Board and Executive Committee for an overall decision to be made.	Mar-21	Delivered	
Jan20/R29A-6.7	Section 29A	Chief Nurse	Care Group 2	Emergency Department	Scaborough	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Create a rolling programme of PILS training to enable a consistent departmental compliance rate of above 85%	Emergency Department Matron (S.F)	Feb-21	Clinical Educator holds evidence	Feb-21	Delivered	

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Jan20/R29A-3.1	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Re-establish a Joint Operational Delivery Group between the Emergency Department and Paediatric Department in both of the Trusts Emergency Departments.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered	QRG 26/10/2020
Jan20/R29A-3.2	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Establish a Paediatric Strategic Oversight Group.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered	QRG 26/10/2020
Jan20/R29A-3.3	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Audit against 'Royal College of Paediatrics and Child Health: Facing the Future Standards' and develop an action plan subsequently.	CG5 Quadrumvirate	Jun-20	As a result fast track pathways were reviewed and refreshed.	Jun-20	Delivered	QRG 26/10/2020
Jan20/R29A-3.4	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Add the lack of Paediatric Emergency Medicine (PEM) Consultant at Scarborough Hospital Emergency Department to the risk register and identify mitigations.	CG5 Quadrumvirate	Aug-20	The initial risk rating was 'High' with a score of 16. Mitigations were implemented.	Aug-20	Delivered	QRG 26/10/2020
Jan20/R29A-3.5	Section 29A	Medical Director	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Recruit a Paediatric Emergency Medicine (PEM) Consultant for Scarborough Hospital Emergency Department	Paediatric Strategic Oversight Group	Nov-20	Approval required from Executive Committee for role to feature 4 PA's which will have funding implications.		Behind Delivery - Ongoing	
Jan20/R29A-4.1	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Implement standardised paper documentation across the Trust including care plans and risk assessments.	Deputy Chief Nurse (H.H)	Mar-20		Mar-20	Delivered	
Jan20/R29A-4.2	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Recruit a Documentation Lead Nurse to lead the docmentation standards within the Trust.	Deputy Chief Nurse (H.H)	Nov-20	Lead Nurse for documentation is in place and leading a steering group.	Dec-20	Delivered	
Jan20/R29A-4.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Produce a long term plan for introudcing standarised electronic documentation across the Trust.	Deputy Chief Nurse (H.H)	Dec-20	Paper to Exec Committee with approval for a 2 year digital docuemntation project.	Dec-20	Delivered	
Jan20/R29A-4.4	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Purchase and implement the "perfect ward" app for use across the Trust	Deputy Chief Nurse (H.H)	Sep-20	Perfect-Ward now in use and providing assurance reports including documentation standards.	Oct-20	Delivered	
Jan20/R29A-5.1	Section 29A	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	Staff did not always report incidents and where they did there were often significant delays in reporting	Safe Well-Led	To ensure that staff are appropriately reporting incidents as per trust policy	Deputy Director of Governance (F.J)	Jan-20	CQC response received in January 2020 advising no further information reqired.	Jan-20	Delivered	
Jan20/R29A-6.2	Section 29A	Chief Nurse	Trust-Wide	Trust-Wide	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake ward establishment reviews to ensure staffing establishment refelects the requirements.	Deputy Chief Nurse (H.H)	Nov-20	Proposal has been submitted to Exec Committee and further work is required before a decision can be reached.	Dec-20	Delivered	

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/R29A-6.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Re-launch and utilise Safe-Care as a tool for measuring CHPPD across the organisation	Deputy Chief Nurse (H.H)	Jun-21	New action.		On Target	

CQC Regulatory Action - Trust-Wide Action Plan

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/MD1	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD2	Must Do	Chief Nurse, Medical Director	Care Group 2	Emergency Department	Scarborough	The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD3	Must Do	Chief Nurse	Care Group 5	Emergency Department	Scarborough	The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed	Safe Responsive	Create and implement a Paediatric risk assessment tool to assess the level of risk a patient presents to themselves and others.	CAMHS Nurse	Mar-20	Implemted across the Trust	Apr-20	Delivered	
Jan20/MD4	Must Do	Chief Nurse	Care Group 2	Emergency Department	Scarborough	The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD5	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD6	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure staff are maintaining securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of thecare and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD7	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure systems for recording clinical information, risk assessments and care plans are used in a consistent way across the medical wards. This should include ensuring staff are aware of how to effectively use systems to identify, assess and monitor patients at risk of deterioration.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered	
Jan20/MD8.1	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Uttilise the Staff magazine to educate staff of the value of incident reporting.	Associate Director of Patient Safety & Governance	Nov-20	November 2020 Edition of 'Safety Spotlight'	Nov-20	Delivered	
Jan20/MD8.2	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Update dashboards on Datix to enable senior leaders to monitor and understand their incident reporting data.	Associate Director of Patient Safety & Governance	Oct-20		Oct-20	Delivered	
Jan20/MD8.3	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Develop a monthly Patient Safety assurance report regarding incidents and present this at QPAS.	Patient Safety & Governance Team	Jan-21		Jan-21	Delivered	
Jul19/MD1.1	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and Sis	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered	
Jul19/MD1.2	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Develop a policy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered	
Jul19/MD1.3	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	Review document Revised processes and publications	Mar-20	Delivered	
Jul19/MD10	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Review, revise and deliver a Governance Management structure that meets the needs of the new Care Group	Care Group Quadrumvirate	Apr-21	Draft structure created. Next steps to feature at Quality Committee for approval and sharing with wider team.	May-21	Delivered	

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jul19/MD11	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered	
Jul19/MD12.1	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	Chief Executive to examine recruiting to a director position with a specific focus on digital part of whose remit will be to review how IT can support record keeping.	Chief Executive	Apr-20	Digital Director is in post	Sep-20	Delivered	
Jul19/MD12.2	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	The Medical Director will write to ALL medical colleagues detailing their responsibility to comply with the Record Keeping Standards Medical Staff – Records Management Policy. In addition, the screensaver will be refreshed during September 2019 and a feature in Staff Matters article October 2019.	Medical Director	Oct-19		Oct-19	Delivered	
Jul19/MD13	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered	
Jul19/MD14	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered	
Jul19/MD22	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered	
Jul19/MD15	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Where the Trust has unfilled shifts bank, agency and locums will be utilised.	Care Group Director	Mar-20	Daily monitoring is in place to ensure the safety of the wa	Mar-20	Delivered	
Jul19/MD16	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Dec-20	Delivered	N/A
Jul19/MD17	Must Do	Medical Director / Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Effective Well-Led	Replaced with Section 29A Actions	N/A	N/A	Replaced with Section 29A Actions	Dec-20	Delivered	N/A
Jul19/MD18.1	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	A review of all substances hazardous to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Health, Safety & Security	Mar-20	All Wards have files in place, but need to provide assurance. Evidence of compliance has been provided	Apr-20	Delivered	
Jul19/MD15.1	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Jul-21	Following QRG completion date extended in line with national work-stream. Aiming for implementation from Jul 21.		On Target	
Jul19/MD18.2	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	Up to date list of COSHH Appropriate training or training updates to be delivered to COSHH Leads for all areas to be provided and reported through CG2 Quality Assurance Meeting	Head of Health, Safety & Security	Mar-20	List held by CLAD Evidence requested 50-60 staff have been trained. Staff were trained in 2018 and will require refresher training. Business case has been approved to appoint a Health and Safety Traner which is currently (June 2020) going out to advertisement	Apr-20	Delivered	

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jul19/MD18.3	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	COSHH Leads to provide local training and ensure staff in each department understand their roles and responsibilities associated with the management of hazardous substances	Head of Health, Safety & Security	Mar-20	Evidence has been provided, there is a need to provide refresher training that will be a priority for the H&S Trainer when appointed. Interviews July 2020	Apr-20	Delivered	
Jul19/MD23	Must Do	Director of Workforce & Organisational Development	Care Group 3	Surgery	Bridlington	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered	
Jul19/MD19	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered	
Jul19/MD2.1	Must Do	Director of Workforce & Organisational Development	Trust-Wide	Trust-Wide	Trust-Wide	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Apr-21	Duplicate action - See Action Jul19/MD15.1	N/A	Delivered	
Jul19/MD2.2	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered	
Jul19/MD20	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered	
Jul19/MD21	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Update the RTT Recovery Plan to clearly state the projections for service delivery and backlog reduction	Care Group Manager	Mar-20	Enhanced management of Follow up partial booking currently being rolled out in Diabetes and will follow in cancer and gastroenterology. Two way text reminder service for all OP appointment and follow up. The specific action could be closed as completed. Recommend a new action to meet the national standards for Clinical Validation of the Waiting List and ongoing Risk Stratification.	Dec-20	Delivered	
Jul19/MD25	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered	
Jul19/MD26	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Monitor progress against the Performance Delivery Plan at Trust Board	Chief Operating Officer	Mar-20	Action is complete. The Trust Board receives the performance each month and position against the plan.	Dec-20	Delivered	
Jul19/MD3.1	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department.	Safe	Ensure that there is adequate and accessible paediatric life support training sessions for staff to access and that this is monitored by the care group	D.T (Care Group Manager)	Feb-20	Rolling programme in place, monitored by the Clinical Educator.	Nov-20	Delivered	
Jul19/MD4.1	Must Do	Executive Committee	Care Group 2	Emergency Department	Scarborough	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Mar-20	Delivered	N/A
Jul19/MD5.1	Must Do	Chief Nurse	Care Group 1	Emergency Department	Scarborough	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Update the Trusts Medicines Management policy with 7 key messagesand display in the clean utility / drug storage areas.	Lead Nurse Medicines Management	Oct-19	Policy updated and key message circulated.	Jun-20	Delivered	

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jul19/MD5.2	Must Do	Chief Nurse	Trust-Wide	Pharmacy	Trust-Wide	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief pharmacist	Mar-20	Internal Audit Completed in June 2020 - This showed an increasing risk with a Red/Amber rating. An action plan has been developed and this is monitored through Medicines Management Group on a monthly basis.	Jun-20	Delivered	
Jul19/MD6.1	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered	
Jul19/MD6.2	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Consider privacy screens for monitors in Acute Admission areas such as Emergency Department, SDEC, SAU, AMU to reduce the risk of unintentional viewing of patient identifiable information during situations whereby locking the computer has not been possible.	Care Group Quadrumvirate	Jun-21	New Action		On Target	
Jul19/MD6.3	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Agree with IT a suitable time for implementing an automatic locking function for computers which are inactive for a period of time.	Service Desk	Jun-21	New Action. Awaiting outcome from Service Desk.		On Target	
Jul19/MD7	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough hospital.	Safe Effective Well-Led	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Care Group Director	Jun-20	Clinical Director has provided a response to the RCEM audit findings on the latest audits • QA2018-002 Feverish Children (Care in Emergency Departments) 2018/19 • QA2018-003 Vital Signs in Adults (Care in Emergency Departments) 2018/19	Mar-20	Delivered	
Jul19/MD8	Must Do	Chief Nurse	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital.	Well-Led	Review current compliance rates within the Care Group and dedicate time to achieve required compliance	Head of Nursing (J.B)	Mar-20	Compliance rates monitored within the Care Group and at Trust Board.	Dec-20	Delivered	
Jul19/MD9.1	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. ▪ the median time from arrival to treatment. ▪ the percentage of patients admitted, transferred or discharged within four hours. ▪ the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Develop a recovery plan relating to performance	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Acute Pathway Programme Board overseeing a programme of work with ECIST, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough. Opened Home First Unit SGH. Restoration of Services Plan post COVID submitted to board.	Mar-20	Delivered	
Jul19/MD9.2	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. ▪ the median time from arrival to treatment. ▪ the percentage of patients admitted, transferred or discharged within four hours. ▪ the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Engage with the offer of support from ECIST to further develop approaches to improve the Trusts' performance as identified during the CQC visit.	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Action closed following discussions at March QRG - superseded by Quality & Performance Summit and the subsequent improvement plan created. Evidence to be held in CQC folder.	Mar-21	Delivered	
Jul19/MD24	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered	

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NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes

Resources Assurance Committee
20 April 2021

Attendance: David Watson (DW) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Polly McMeekin (PM), Dylan Roberts (DR), Bobby Anwar (BA), Jill Hall (JH), Wendy Scott, (WS), Lynette Smith (LS), Graham Lamb(GL), Steve Kitching(SK), Jenny Mcaleese (JM) , Steve Holmberg (SH), Joanne Best (minute taker)

Welcome and Introductions

The Committee Chair welcomed everyone to the meeting.

Apologies for Absence:

There were no apologies.

Declaration of Interest

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

Minutes of the meeting held on 23 March 2021

The minutes of the meeting held on 23 March 2021 were approved as a correct record.

Matters arising from the minutes

There were no items to discuss as the action log had been updated prior to the meeting.

It was noted that Steve Holmberg and Jenny McAleese were attending the meeting for the item on 2021/22 Budget and Operational Plan.

2021/22 Budget and Operational Plan

WS introduced the presentation on the recently published planning guidance 2021/22. The requirements on Trust's were noted.

LS explained that the focus was on elective with an expectation to return to pre-pandemic activity (2019/20) levels whilst continuing to abide by both IPC and social distancing rules for the first half of the year. She added that any over achievement in

activity would result in the Trust being able to access the Elective Recovery Fund at 100% of tariff. Planning assumptions were that 5% of beds would be Covid-19.

The presentation set out the changes including bookings by moving away from chronological to priority booking, and staff recovery.

The Committee noted that to enable access to the Elective Recovery Fund all planned performance levels, with the exception of outpatient appointments and the cancer recovery plan, must be achieved along with five gateways. Some additional requests relating to Maternity, Urgent and Emergency Care and Diagnostics' had been made and were reflected in the draft financial plan.

It was noted the overall draft plan related to the Humber Coast and Vale. Discussing pre-pandemic challenges in routine and diagnostics care it was confirmed demand had returned to pre pandemic levels. If Covid-19 restrictions were to continue, as suggested in the plan, this would affect productivity. Funding from NHSE/I was available to outsource activity using private providers. The Trust had used Ramsay Clifton Park Hospital and The Nuffield Hospital to support services throughout the Surge plan. In support of the long wait position, the Trust would continue to use both providers for low risk patients. The implications of operating at a reduced bed base, as set out in the draft plan, would be both challenging with the potential increase in waiting lists.

Differences between the draft plan and the funded plan were discussed, noting that by just doing the funded plan would result in a holding position and would not make inroads into reducing the long waits (those waiting over 52 weeks) the draft plan assumed more activity and therefore would deliver more than was being funded for.

The risks to the plan were highlighted noting that the major risk was around urgent care.

It was noted that the ICS was looking at how to use capacity and staff to address waiting lists in the system and particularly those waiting over 52 weeks. WS added that increased activity in primary care patients accessing emergency departments could suggest difficulties in accessing primary care services.

The time plan was outlined noting that the draft plan was due to be submitted by 6 May. The Trust's plan would contribute to the overall Humber, Coast and Vale plan to be submitted on 6 June 2021.

Financial Plan

AB introduced the financial plan 2021/22 explaining that the first 6 months of 2021/22 (H1), the Trust would be funded by allocations which were based on the second half of 2020/21 and include the Covid allocation which was currently £12m. It was noted that nationally there was an efficiency requirement which equated to just under £800,000 for the organisation. Negotiations between the DoH and Treasury were underway on funding for the second half of the year (H2). The committee noted that funding was via a fixed allocation with no discretionary spend opportunity for activity apart from access to the Elective Recovery fund.

It was noted the Chief Executive and Director of Finance will confirm the fixed allocation of £296m on 6th May 2021. The Funded Plan Plus related to the extra activity, which Care Groups had intimated was possible, funded via the Elective Recovery Fund creating potential additional income of approximately £6m against an assessed cost of £5.3m. Although the plan has not been agreed by the Trust Board, Care Groups had been advised to plan activity on a rolling monthly basis using the Funded Plan Plus to support reduction in the back log of patients.

JD noted concerns with regard to the high number of patients waiting longer than 52 weeks at other Trust's within the ICS, and asked if these patients are seen by the Trust, will the ICS support this additional activity with funding. AB confirmed this additional activity will be funded.

WS highlighted waiting list issues at HUTH, noting other Trust's within the ICS did not have spare capacity to support Hull's situation due to addressing their own waiting list issues. Discussions were underway with regard to the ICS working in a more collaborative way. Resource shortages and concerns with regard to staff response to additional work of other Trusts was acknowledged.

To support staff mental health the ICS has set up a resilience hub led by Psychologists, staff were able to either self-refer or be referred by their organisation.

Concern were raised with regard to the Funded Plus Plan and the impact on both staff and quality of care and patient safety. It was noted that there had been discussions with Care Group managers who gave assurance that staff were keen to return to pre-pandemic working and addressing the waiting lists.

The Committee discussed the restart of the efficiency programme and it was confirmed that CIP targets will remain as they are for the first half of the year, once funding for the second half of the year was agreed targets will be reviewed.

DW noted that whilst the budget has been presented in a manner consistent with prior years, there is no analysis of the c.£600m annual spend of the Trust but merely a roll-forward and adjustment of expenditure from the prior year. To enable the Trust to comply with the timetable for budget approvals, DW indicated that he was agreeable to approving the budget as presented on the grounds that it had been prepared in accordance with NHS guidelines but that this approval was conditional on the creation of a new committee of the Board comprising NEDs with both financial and clinical knowledge to review the expenditure of the Trust in detail. DW stated his expectation that this committee would meet some 2-4 times annually and would review both the expenditure and capex budgets of the Trust with a view to making recommendations to the Board about the appropriateness of the allocation of the Trust's spend between numerous competing and demanding alternatives. This proposal was broadly supported by the NEDs present at the meeting.

RESOLVED

That Resources Assurance Committee AGREED to endorse and recommend the Draft Plan to the Board.

Jenny Mcaleese, Steve Holmberg, Wendy Scott and Lynette Smith left the meeting.

Financial Year end position

AB presented a summary of the Trust's draft Income and Expenditure position as for the full 2020/21 financial year. Noting it was still subject to final technical calculations and adjustments from NHSE/I. AB reported that the year-end position showed a deficit of £1m, however it was subject to technical adjustments which would result in an underlying position of £1m surplus against an agreed deficit of £5.5m. AB updated on the NHSE/I position in relation to Other Income and Annual Leave Accrual adjustments, noting that at the time of the report, the Trust had been notified of £3.5m for Other Income and £4.3m (as at month 11) for Annual Leave Accrual. It was noted this was subject to change.

The Committee discussed the employment law case and subsequent framework agreed with NHS Staff Council working in partnership with relevant unions, noting that NHSE/I in recognising the impact on organisations had confirmed an agreed amount for each Trust, for the Trust this was £1.012m. PM confirmed that local negotiations had been implemented in relation to regular hours worked by staff in substantive jobs; back payments would be aligned to the national agreement and will be made relating to the previous 2 years.

RESOLVED
That the Resources Assurance Committee discussed the 2020/21 year-ed financial position.

Integrated Business Report (Workforce and OD Indicators)

PM presented the workforce and OD section of the IBR, highlighting the following;

- The internal Leadership Development programme which commenced in January 2021 was receiving a favourable response;
- The Trust's research activity had increased over the previous 12 months achieving 4760 accruals, higher than the target set by the Clinical Research Network.
- Partnered with Tees Esk & Wear Valley NHS Foundation Trust and York University, the Trust is undertaking new Covid vaccine trial.

PM reported on staff turnover noting that there had been some small changes in turnover and compared well with the model hospital data which pre-dates the pandemic. She added that staff retention has improved during the pandemic.

LM raised concerns that the Research and Innovation was discussed infrequently and could it be brought on a more regular basis to the Committee and Board for discussion It was noted that the Research Strategy was being reviewed and

following discussion it was agreed that a presentation on research activities should be presented to the Board

Action: JH/PM to add to Board workplan

Gender Pay Gap

PM gave a brief overview of the Gender Pay Gap report noting data was always one year behind and was a snapshot based on 7530 full pay employees. PM highlighted concerns with regard to the year on year deterioration, noting that medical and dental staff remained the focal point. To support understanding as to why there was a lower than expected percentage of female consultants within the Trust a survey had been sent to all female consultants. LM sought assurance regarding the outcome of the survey for females in leadership positions and secondly the encouragement for females to apply for the Clinical excellence awards.

Discussing the outcome of the survey, PM noted job planning principles were now under review with the LMC and looking at a number of ideas including if some work could be undertaken off site. She added that the Trust recognised challenges for all staff members when balancing work and home life responsibilities with the aim to support this through the new Agile & Flexible Working Policy and establishment of a Carer's Network as well as implementing the new Values and Behaviours framework. The Gender Pay Gap paper will be submitted to the Executive Committee in May who will oversee he action plan.

Discussing the Clinical Excellence Awards, it was noted there was a higher number of male's applicants when we have run rounds with an application process although as we are in a transitional period whilst the new criteria is being determined nationally; this has neutralised the gender pay gap. Going forward female consultants will be encouraged to undertake the application process.

Board Assurance Framework

Changes to the BAF were discussed, noting track changes remain in the document to allow updates to been seen. The Trust Secretary referred to the report which detailed the proposal to de-escalate some risks to the CRR and that risk 9 and 12 would be merged. All proposed updates will be discussed at the Board time out session next week.

Risk 8 – PM confirmed the stability of the Board supported the reduction of this risk.

Risk 5 – Following discussion it was agreed DR will update this with a realistic target noting the Board had released the first £2m in support of the IT system.

Corporate Risk Register

BA discussed the 12 risks on the CRR which included a new risk relating to the Trusts ability to deliver change, noting an action column had been included; risk target scores will be included in the future

Documents for consideration

- Any IBR issues not already covered
- BAF
- Digital and Information Report Update

This paper will be covered at the next meeting.

Reflection on the Meeting and Any other business

AOB

Data Report Surplus Land

Action: Deferred to June meeting.

Reflection on the meeting

The Committee reflected on today's meeting with the following points being highlighted:

- Papers very encouraging
- Committee would like to understand how the budget is allocated
- Budgets should be discussed at the RC exploring funding waste with an Executive summary submitted to the Board
- Relevant people should attend the RC meeting when budgets are discussed
- LM asked for a clearer executive summary on the Surplus Land report when it is submitted in June, such as a table highlighting for example current use of property, options, recommendations and risks
- Clinical links to Trust strategy is a positive move
- Summarising each section is an improvement

Time and Date of next meeting

The next meeting will be held on 18 May 2021

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

Committee/Group: Resources Committee	Date:18 May, 2021	Chair:DW

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
Finance	Andy reported a £1m surplus (ahead of budget) for April 2021. Some £0.5m of the surplus was due to under-spend on COVID-related items. A positive start to the financial year	BOARD	INFORMATION
Finance	The finance team prepared a detailed and thorough analysis of COVID-related spend which identified three de minimis items of COVID-related expenditure which may, with the benefit of hindsight, been deemed sub-optimal. The Committee applauded the paper and indeed the quality of financial controls that have operated through the COVID crisis	BOARD	INFORMATION
Workforce	Polly presented the People Plan (which comprises over 100 individual action points) and the staff survey (plus further action points). Concerns were noted in relation to the number of "below average" staff survey scores as previously escalated from this Committee. It was noted that the survey presented did not include the LLP results (which were disappointing). It was suggested that we seek a more succinct format to summarise the status of the action plans and to facilitate easier comprehension. Finally, it was noted that efforts would be made to encourage learning across Care Groups	BOARD	INFORMATION
Digital	Concern was expressed, as has been previously escalated from this Committee, in relation to the paucity of capex available to support the essential fixes to our core IT and cyber infrastructure. Dylan reported that there are a number of potential avenues for the Trust to secure additional capex for the IT-fix programme but none is easy to access and each comes with different conditions. For	BOARD	INFORMATION

	example, access to the “digital aspirant programme” is now tied to the upgrade across the ICS of the electronic patient record system, a huge and complex project in its own right. Dylan proposed that the team continue to explore these external funding options for a limited further time period following which the team should focus on getting the optimum enhancement to the IT infrastructure of the capex that has already been made available from internal resources.		
Digital/Risk	Bobby advised that Cyber is now identified as the single greatest threat to the Trust in the new CRR. Mitigations and risk appetite to be discussed when the CRR is presented to Board	BOARD	ACTION

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021 (April data)
Integrated Business Report Executive Summaries

/ 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

Executive Summaries from Integrated Performance Report

/ Executive Summary – Key Points

As contained in individual summaries

/ Recommendation

The Board is asked to receive the summaries and note the impact on KPIs and actions been taken to address performance challenges

Author: Shown on individual Executive Summaries

Director Sponsor: Shown on individual Executive Summaries

Date: May 2021

EXECUTIVE SUMMARIES

Quality & Safety

• Compliance with 14 hour post take remains at 80% for the Trust.
• NEWS2 compliance for York has slipped slightly below 90%, Scarborough is at 94.5%.
• Cardiac arrest calls at Scarborough has risen significantly and this is being looked into further.
• Medication incidents remain within normal variation; however April has seen an increase in Discharge medication incidents. Discharge medications are one of 4 facets of the discharge improvement project.
• Inpatient deaths continue to reduce, with the SHMI within normal variation and below 1.
• There were 10 SJCR's requested in April.

Author	Caroline Johnson, Deputy Head of Patient Safety & Governance
Director Sponsors	James Taylor, Medical Director Heather McNair, Chief Nurse

Workforce

Following engagement work undertaken initially in 2019, the newly co-created values of Kindness, Openness and Excellence and associated behaviours are now being launched across the Trust. Senior managers across the Trust will be the sponsors for this programme of cultural change, being responsible for embedding the new values and behaviours in their services.

Staff health and wellbeing continues to be a priority with the Trust offering an expanded programme of interventions to support the workforce with their mental health and wellbeing. Additional funding has already been agreed to increase capacity of the Staff Psychological Wellbeing Team. Additional wellbeing support has also been put in place for those staff who have been shielding.

Author	Sian Longhorne, Deputy Head of Resourcing
Director Sponsor	Polly McMeekin, Director of Workforce & Organisation Development

Finance

The report for April 2021 marks the first of the new financial year 2021/22.

<u>Emergency Financial Regime</u>

For 2021/22, NHSE&I have decided to continue to employ a similar emergency financial regime used during 2020/21, in supporting the NHS address the Covid-19 pandemic.

With regard to the first half year of 2021/22 only (April 2021 to September 2021), the Trust will be subject to the same allocation based approach used in the second half year of

2020/21. NHSE&I have as yet made no announcement regarding the financial framework that will be in place for the second half year of 2021/22.

Under the announced framework, the Trust has received a base allocation to cover normal activities linked to its actual performance in Q3, 2020/21 doubled to give a half year allocation, and then adjusted for inflation and other issues. A secondary allocation to cover additional costs resulting from the Covid-19 pandemic will also be received at a similar level to that seen in the second half year, 2020/21. In addition, the Trust has also planned to receive other 'non-patient' activity income at similar levels seen in Q3, 2020/21.

A notable change to the 2020/21 regime is the reintroduction for 2021/22 of national and local efficiency targets, which had been suspended throughout the previous financial year.

The final financial plan for the first half year of 2021/22 (with an indicative full year plan for information only), was submitted to and agreed by the Board at its 28 April 2021 meeting. The agreed plan produces a balanced I&E position.

Month 1 Position

For April, the Trust is reporting an I&E position of £1.0m surplus against a balanced I&E position, placing it £1.0m ahead of the system plan submitted to NHSE&I.

The Trusts overall CIP target for the first half of 2021/22 is £2.8m. In April the Trust has delivered £233k of the £462k month's target.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 86% of suppliers being paid within 30 days, whereas those paid in response to the national ask to accelerate payments down to 7 days where possible is averaging around 14%.

Author	Graham Lamb, Deputy Finance Director
Director Sponsor	Andrew Bertram, Finance Director

Operational Performance

Nationally, the COVID-19 Pandemic NHS Emergency Preparedness, Resilience and Response incident level moved back to a level 3 national response on the 25th of March. A level 3 national response is defined as "an incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level".

The Trust has continued to operate within its COVID-19 Command and Control structure throughout April and as at the 6th of May there was one COVID-19 positive inpatient in our acute and community hospitals. The number of COVID-19 positive inpatients peaked on the 26th of January at 216.

The Trust has had 2,775 COVID-19 positive inpatients since 17th March 2020, with 2,161 patients discharged, sadly 612 patients have died.

As the number of COVID-19 positive inpatients has reduced the number of COVID-19 wards has been decreased. As at the 6th of May, York Hospital had one COVID-19 positive ward with a process in place for any new cases on the Scarborough site to be transferred to York.

The Trusts' Theatre prioritisation panel has continued to run throughout the third COVID-19 wave. There were no patients cancelled by the Trust for COVID-19 reasons during April 2021.

Trust Planning

National planning guidance was released on the 25th of March covering the period April to September 2021.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in 2021-22 to support the start of the recovery of elective activity, and the recovery of cancer services.

Systems were asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021.

The Trust has engaged with partners in the ICS and the finalised draft operational plan for the first half of 2021-22 was submitted on the 6th of May.

Our ambition for 2021/22 is to over-achieve the national ask on our hospital sites, focussing on delivering clinically urgent work within reasonable timescales (cancer and Priority 2 surgical patients) and to stabilise the long wait position. Over-achieving on the national activity ask, will enable us to access the ERF and support further improvement in patient care and timely treatments.

The Trust over-achieved the national activity ask against all elective points of delivery in April 2021.

Point of Delivery	April 2019 Outturn	April 2021 Actual	Variance	Proportion of April 2019 delivered in April 2021
First Outpatient Appts	14,528	16,434	1,906	113%
Follow up Outpatient Appts	37,207	42,169	4,962	113%
Ordinary Electives	616	444	-172	72%
Day Cases	5,940	5,781	-159	97%

Please note: colour key denotes performance against national activity ask. For April 2021 any elective Point of Delivery above 70% achieved the national activity ask.

April Performance Headlines:

• 80.7% of ED patients were admitted, transferred or discharged within four hours during April 2021.
• March saw challenging cancer performance with the Trust achieving 2 of the core national standards, and narrowly missing national compliance on three others by less than 1%.
• 2,023 fifty-two week wait pathways have been declared for the end of April 2021.

• The Trust saw improvement against the overall Referral to Treatment backlog, with the percentage of patients waiting under 18 weeks at month end, increasing from 64.7% in March to 65.8% at the end of April 2021.

Author(s)	Andrew Hurren, Deputy Head of Operational Planning and Performance Lynette Smith, Head of Operational Planning and Performance Steve Reed, Head of Community Services
Director Sponsor	Wendy Scott, Chief Operating Officer

Digital and Information Service

The Digital and Information Service is making exciting progress across many fronts which in of itself is a challenge with due consideration for the capacity of the service to do all of these things in parallel.

These include:

- The initial £2M out of £11.3M investment has been allocated by the trust to deliver the Essential IT Services Programme, which is to address the backlog maintenance for critical IT infrastructure necessary in order to mitigate the risks of major IT failure and cyber security attack. Detailed planning and prioritisation work is being completed, with the support of a third party that includes the majority of the teams, to deliver by mid to late June with a view of delivering the projects themselves from that date.
- In order to secure external funds from NHSX the Trust are progressing with the development of a Strategic Outline Case for the future Electronic Patient Record (EPR) Strategy for both the Trust and the ICS which brings into question the future of CPD our current system.
- Our review of our business intelligence and reporting capabilities is close to completion with recommendations and an outline case for how we improve this area and in particular integrate work across the ICS.
- A future structure and proposal has been developed for the future of the Digital and Information Service which will involve extensive staff consultation and change

This is alongside 49 current “in flight” priority programmes of work which are on a critical path for delivery that include, not exclusively, technology to manage Rapid Expert Input, the rationalisation and digitisation of Clinical Nursing Documentation, the migration to Microsoft Office 365, the implementation of a new Radiology Information System, a regional Laboratory Information Management System as examples.

The trust have gone through a prioritisation process to bring the number of projects down to 49

As such it is important that no more new initiatives are added to that which is already on without stopping something first.

Author(s)	Dylan Roberts, Chief Digital Information Officer Simon Hayes, IT Service and Infrastructure Transformation Lead
Director Sponsor	Dylan Roberts, Chief Digital Information Officer

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Operational Plan June-September 2021/22: Activity and Performance

/ 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 on the adjustments made to the operational plan for activity and performance in the final activity plan submission to the Humber Coast and Vale Integrated Care System (ICS).

/ Executive Summary – Key Points

Following the draft submission to the ICS; the system and each organisation has received feedback on the draft plan and a series of oversight and assurance meetings have taken place during May to consider any adjustments prior to submitting the final plan.

The Trust is proposing adjustments to Ordinary Electives to reflect the April actuals and non-elective demand pressures. In addition the Trust is proposing changes to the Outpatient position to reflect updated guidance from NHSE and data quality adjustment. The impact of these, reduces the anticipated activity compared to 19-20 outturn, however continues to meet the national planning ask for Ordinary Electives and exceeds the national ask for Outpatients.

/ Recommendation

It is recommended to the Board of Directors:

1. That the adjustments to the final operational plan are noted and approved inclusion for submission to the ICS in the final plan;
2. That the amendments to the trajectory for the Trust's Total Waiting List is noted and approved;
3. That the risks to delivery are noted. Ongoing monitoring of those risks will be reported through the Quality Committee.

Author: Lynette Smith, Head of Peformance and Planning

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 19th May 2021

1. Introduction and Background

The Humber, Coast and Vale Integrated Care System (ICS) is required to submit an operational plan to cover the first half of 2021-22 which responds to the national requirements. York and Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) is a key contributor to the ICS operational plan as one of four acute trusts within the system. The draft plan was shared with the Trust Board in April 2021 and approved for draft submission.

Following the draft submission the ICS, the system and each organisation has received feedback on the draft plan and a series of oversight and assurance meetings on the operational plan have taken place during May to consider any adjustments prior to submission of the final plan. Due to the timing of the operational plan submissions, the Trust has also delivered the April activity allowing assessment against actuals.

This paper sets out the proposed changes from the Trust's draft plan submission to the Trust's final plan submission.

2. Activity adjustments

As part of the operational plan process the draft submission is subject to final checks, updated national guidance and confirm and challenge. This process has resulted in the following adjustments to the plan.

Data quality adjustment

Revised outpatient follow up activity numbers following a data quality review.

April Activity:

The Trust over-achieved the national activity ask against all elective points of delivery in April 2021. The Draft Plan was met for all PODs, with the exception of Ordinary Electives which was at 72% of 19/20 outturn although this did achieve the national planning 'ask'.

A re-assessment of the ordinary elective capacity has been undertaken in May taking account of:

- Increased non-elective pressures.
- Anticipated impact of the 3 major capital builds on flow across the York site.
- Updated workforce assessment to the theatre team capacity.

This has been reflected as a reduction in ordinary elective activity compared to the draft plan. The final plan aligns to the national 'asks' of 70% April, 75% May, 80% June and 85% July onwards and is expected to continue to meet the thresholds to access the Elective Recovery Fund.

Required adjustments

The Trust received confirmation from NHSE/I (following on from the Trust Board meeting) of two additional national guidance activity changes for the final operational plan submission:

- Removal of 'See and Swab' activity (Outpatients).
- Removal of Radiology activity (Outpatients).

Acute TFCs - Excluding See & Swab, Contacts and Radiology							
POD	Apr*	May	Jun	Jul	Aug	Sep	Total H1
Ord Elec	446	539	603	604	574	563	3,329
Day Case	5,664	6,531	6,625	6,085	6,302	6,180	37,387
OPFA	13,558	13,855	15,214	14,512	13,660	14,489	85,288
OPFU	35,347	37,673	35,485	38,560	33,682	34,923	215,670
Outpatients combined	48,905	51,528	50,699	53,072	47,342	49,412	300,958

Proportion of 19/20

POD	Apr*	May	Jun	Jul	Aug	Sep	Total H1
Ord Elec	72%	78%	82%	90%	93%	86%	83%
Day Case	95%	105%	110%	95%	105%	99%	101%
OPFA	93%	91%	101%	89%	98%	99%	95%
OPFU	95%	95%	95%	94%	95%	95%	95%
Outpatients combined	95%	94%	97%	93%	96%	96%	95%

*April activity is shown as 'plan' not actuals.

The activity and performance submission is attached at Appendix A.

3. Trajectory adjustments

The principles within the final plan remain unchanged to prioritise urgent activity within the available capacity. The activity adjustments therefore do not impact on trajectories relating to urgent surgical work (P2 activity) or the Cancer Trajectories. These remain unchanged from the draft plan.

The long waiter position is predominately day case activity and as such will remain unchanged from the draft plan.

The Total Waiting List position has been reassessed to take account of current demand and the reduction in planned ordinary elective activity. The revised trajectory shows an increase from the draft plan, rising to 33,554. Three of the four Acute Trusts within the ICS are predicting increased total waiting lists.

4. Elective Recovery Fund Gateways

The ICS is required to meet 5 'Gateways' to access the national Elective Recovery Fund (ERF). The Trust is contributing to these gateways through the Collaborative of Acute Providers. The draft feedback from the ICS narrative was positive overall and this is being reviewed and amended by the ICS team.

Gateway criteria for access to the Elective Recovery Fund (ERF):

1. Addressing health inequalities.
2. Outpatient transformation.
3. System led recovery.
4. Clinical Validation.
5. Staff wellbeing.

The Executive Team will ensure the Trust's ongoing support and contribution to the Gateways as the ICS action plans emerge during June 2021.

The Board are aware that the original assessment of potential ERF income was estimated at £6m. Following the revisions to activity this has been re-assessed and is now forecast to be around £9.7m. We have indicated as part of the submission that a sensible provision for additional costs associated with stepping up activity would be at 80% of income tariff levels. This suggests a provision of circa £7.8m. The System's final plan submission reflects these values.

5. Risks to delivery

The Trust Plan is based on the following assumptions:

- 19/20 demand for referrals.
- 1% increase in elective activity.
- 1% increase in unplanned care activity.
- No significant COVID surge (bed occupancy with COVID-19 positive patients below 5%).
- Workforce availability for surgical additional activity (Waiting List Initiatives).

Any changes to the underlying assumptions above and may affect the delivery of the plan. The Trust is operating in an unpredictable public health environment and there is no available prediction, as yet, on the levels of demand for planned and unplanned care post-pandemic. Increases in demand and, or, COVID-19 surge(s) will affect the delivery of the activity plan.

The operational plan could also be affected by a change in the type of demand, for example significant increases in urgent demand (cancer, trauma and other priority 2 conditions) as patient demand returns. These theatre procedures can take longer or are more complex, and therefore can reduce the level of overall elective activity.

The Trust will continue to work with health and social care partners to support patients to access healthcare to address cancellation and 'Do Not Attend' rates in the light of the pandemic.

6. Recommendation

It is recommended to the Board of Directors:

1. That the adjustments are noted and approved for submission in the final operational plan.
2. That the amendments to the trajectory for the Total Waiting List is noted and approved.
3. That the risks to delivery are noted and ongoing monitoring of those risks will be reported through the Executive Committee and the Quality Committee and reported to Trust Board.

ActivityCategory

Total OP

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.32	Count/Total	Total outpatient attendances (all TFC; consultant and non consultant led)	946590	475065	476733	76816	79394	81754	83673	75535	79561
		E.M.32a	Count	Total outpatient attendances (all TFC; consultant and non consultant led) - Face to face	895207	449731	369519	65217	64230	61234	62671	56576	59591
		E.M.32b	Count	Total outpatient attendances (all TFC; consultant and non consultant led) - Telephone/virtual	51383	25334	107214	11599	15164	20520	21002	18959	19970

ActivityCategory

OP Transformation

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.33	Count	Total Advice and Guidance requests processed/answered			13676	2171	2062	2388	2496	2171	2388
		E.M.34	Count	Number of patients moved or discharged to a PIFU pathway for the first time			232	8	8	24	64	64	64

ActivityCategory

1st OP

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.8	Count	Consultant-led first outpatient attendances (Spec acute)	287981	143250	85288	13558	13855	15214	14512	13660	14489
		E.M.8b	Count	Consultant-led first outpatient attendances with procedures (Spec acute)	23199	12137	11176	1810	1861	1997	1911	1743	1854

ActivityCategory

FU OP

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.9	Count	Consultant-led follow-up outpatient attendances (Spec acute)	461884	227843	215670	35347	37673	35485	38560	33682	34923
		E.M.9b	Count	Consultant-led follow-up outpatient attendances with procedures (Spec acute)	65856	32863	36164	5939	6480	6017	6413	5553	5762

ActivityCategory

Electives

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.10	Count/Total	Total number of Specific Acute elective spells in the period	82520	40812	40716	6110	7070	7228	6689	6876	6743
		E.M.10a	Count	Total number of Specific Acute elective day case spells in the period	74674	36819	37387	5664	6531	6625	6085	6302	6180
		E.M.10b	Count	Total number of Specific Acute elective ordinary spells in the period	7825	3993	3329	446	539	603	604	574	563
		E.M.10c	Count	Total number of Specific Acute elective day case spells in the period of which children under 18 years of age	1943	992	1122	170	196	199	183	189	185
		E.M.10d	Count	Total number of Specific Acute elective ordinary spells in the period of which children under 18 years of age.	246	120	99	13	16	18	18	17	17

ActivityCategory

A&E 1-4

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.12	Count/Total	Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1&2 + Types 3&4)	136030	69613	70730	11280	12318	11940	12140	11625	11427
		E.M.12a	Count	Total number of attendances at all Type 1 and Type 2 A&E departments, excluding planned follow-up attendances	136016	69613	70730	11280	12318	11940	12140	11625	11427
		E.M.12b	Count	Total number of attendances at all Type 3 and Type 4 A&E departments, excluding planned follow-up attendances	0	0	0	0	0	0	0	0	0

ActivityCategory

Non-Electives

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.11	Count/Total	Number of Specific Acute non-elective spells in the period	70447	33881	36207	5831	6141	6140	6100	6067	5928
		E.M.11a	Count	Number of Specific Acute non-elective spells in the period with a length of stay of zero days	24631	10978	13640	2197	2314	2313	2298	2285	2233
		E.M.11b	Count/Total	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days	45829	22903	22567	3634	3827	3827	3802	3782	3695
		E.M.11c	Count	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID)	162	0	1106	178	188	188	186	185	181
		E.M.11d	Count	Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (Non-COVID)	45667	22903	21461	3456	3639	3639	3616	3597	3514

ActivityCategory

Ordinary - Specialties

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.36a	Count	Neurosurgery - Ordinary (TFC 150)			0	0	0	0	0	0	0
		E.M.36b	Count	Cardiology - Ordinary (TFC 320)	157	80	70	11	12	12	12	12	11
		E.M.36c	Count	Cardiac Surgery - Ordinary (TFC 172)			0	0	0	0	0	0	0
		E.M.36d	Count	Vascular Surgery - Ordinary (TFC 107)	240	137	121	17	20	23	23	19	19
		E.M.36e	Count	Neurology - Ordinary (TFC 400)	6	3	0	0	0	0	0	0	0
		E.M.36f	Count	Solid organ Transplant - Ordinary (TFC 102 or 174)			0	0	0	0	0	0	0

ActivityCategory

Day Case - Specialties

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.M.35a	Count	Neurosurgery - Day Case (TFC 150)			0	0	0	0	0	0	0
		E.M.35b	Count	Cardiology - Day Case (TFC 320)	1818	863	924	140	161	164	150	156	153
		E.M.35c	Count	Cardiac Surgery - Day Case (TFC 172)			0	0	0	0	0	0	0
		E.M.35d	Count	Vascular Surgery - Day Case (TFC 107)	1494	794	770	118	133	137	126	130	126

		E.M.35e	Count	Neurology - Day Case (TFC 400)	1043	559	529	79	94	94	85	89	88
		E.M.35f	Count	Solid organ Transplant - Day Case (TFC 102 or 174)			0	0	0	0	0	0	0

ActivityCategory

Diagnostics

Provider Level					Apr 2019-Mar 2020	Apr 2019-Sep 2019	Apr 2021-Sep 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	E.B.26a	Count	Diagnostic Tests - Magnetic Resonance Imaging	26542	13650	10884	1721	1775	1822	2066	1811	1689
		E.B.26b	Count	Diagnostic Tests - Computed Tomography	49600	24400	19528	2818	3107	3093	3669	3403	3438
		E.B.26c	Count	Diagnostic Tests - Non-Obstetric Ultrasound	58936	29390	23541	3261	3752	3882	4604	4047	3995
		E.B.26d	Count	Diagnostic Tests - Colonoscopy	6015	2669	2139	304	323	351	389	359	413
		E.B.26e	Count	Diagnostic Tests - Flexi Sigmoidoscopy	2396	1202	961	139	152	177	176	157	160
		E.B.26f	Count	Diagnostic Tests - Gastroscopy	7374	3747	2978	462	526	614	473	400	503
		E.B.26g	Count	Diagnostic Tests - Cardiology - Echocardiography	13677	6756	5405	757	917	857	997	992	885

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Code of Governance

/ 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 receive the updated Code of Governance for discussion and approval.

/ Executive Summary – Key Points

The NHS Foundation Trust Code of Governance (the Code) was first published in 2006 and has undergone several updates.

The purpose of the code is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code sets out a common overarching framework for the corporate governance of NHS foundation trusts and complements the statutory and regulatory obligations on them.

The document has been reviewed by the Interim Trust Secretary and any changes have been highlighted in red type. Many of the changes include additional evidence to support the comply statement.

/ Recommendation

The Board is asked to approve the changes to the Code of Governance.

Author: J Hall, Interim Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: May 2021

YORK & SCARBOROUGH HOSPITALS NHS FOUNDATION TRUST

CODE OF GOVERNANCE REVISED VERSION 2020

Based on NHSI (Monitor) publication dated 2014

Version 0.01
Updated March 2021
Author: Foundation Trust Secretary

Introduction

This Code published by NHSI (Monitor) is best practice advice and is released on a 'comply or explain' basis. The provisions of the Code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of NHS Foundation Trust Condition 4 of the NHS provider licence (also known as the Governance condition). However, the relevant statutory requirements included should be noted and it should be ensured that the trust is able to demonstrate compliance with those elements.

Good governance is an important tool for ensuring the quality of care. All NHS foundation trusts are encouraged to take account of the best practice provisions described in this Code. Reasons for non-compliance with the Code should be explained. This "comply or explain" approach has been in successful operation for at least the last 15 years in the private sector and is not new to the NHS foundation trust sector. In providing an explanation for non-compliance, the NHS foundation trust should aim to illustrate how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the NHS foundation trust expects to conform to the provision.

Satisfactory engagement between the board of directors, the council of governors, members and patients is crucial to the effectiveness of NHS foundation trusts' corporate governance approach. Directors and governors both have a responsibility for ensuring that "comply or explain" remains an effective alternative to a rules-based system and a key aspect of this is ensuring improved interaction between directors, governors, members and – crucially – patients, communities and the public.

The document is split into 5 sections:
Leadership
Effectiveness
Accountability
Director remuneration
Relationship with stakeholders

The attached spreadsheets are divided into the specific sections and collectively they form the whole of the Code of Governance. The last spread sheet is from a short analysis against the Walker Review. This review looked at corporate governance in the banking industry specifically, but it can be related to other industries, such as health.

The Code of Governance is reviewed annually as part of the year end processes. It is considered by the Audit Committee as evidence of internal control and assurance of good governance being adopted in the organisation. When systems are changed during the year, the Code of Governance is taken into account to ensure best practice continues to be followed by the organisation.

Section A: Leadership
A1 The role of the Board of Directors
Main principles

Provision	Comment		Notes
A.1.a. Every NHS foundation trust should be headed by an effective Board of Directors. The board is collectively responsible for the performance of the NHS foundation trust.	The Trust is headed by a Board of Directors that meets 12 times a year as a formal Board and the Board has met with the Council of Governors twice during the year to debate elements of the strategy or operational performance. The Board has agreed a 5 Year Strategy which includes vision, mission, goals and values together with high level strategic themes. A number of corporate objectives have been finalised and these have been linked to a revised BAF. The appraisals of the Non-executive Directors and Executive Directors are linked to the ambitions and the public Board agenda is also formulated around the goals and themes. Work of the Board is evidenced through the papers and the quarterly returns to and from NHSI (Monitor), along with the reports from CQC and other external agencies. A Well-Led Review by CQC in July 2019 and a review carried out by Deloitte in June/July 2019 has informed and supported work to enhance and further build on governance and effectiveness.		
A.1.b. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.	The members of the Board collectively and individually promote the success of the organisation and engage with members of the Trust and the general public through the Council of Governors. The Trust endeavours to ensure the benefits for members and the public are maximised. This is evidenced through the operational plan and as part of the governance arrangements employed in the Trust. The Trust also encourages Governors to be involved with their local communities to support them in understanding what the public is seeking in terms of service from the Trust. Governors are encouraged to provide feedback to the Trust on service development issues and have been kept informed of any developments with the operational plan and the move towards being part of an Integrated Care System (Humber Coast & Vale)		Looks ok and needs to reference COVID

Supporting principles

Provision	Comment		
A.1.c The role of the Board of Directors is to provide entrepreneurial leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assess and managed.	The membership of the Board includes individuals with commercial, public sector and third sector backgrounds. The Board continues to work within a prudent and effective control framework. The Trust continually reviews the risk management and governance systems in the organisation and continues to make improvements to the systems and in providing better understanding to the Board on the risks in the Trust through a number of routes including the Board Assurance Framework and Corporate Risk Register. Work continues in respect of providing clarity to reporting lines, especially in relation to the Care Group structure and LLP. Work is ongoing on the overall governance structure to ensure the appropriate escalation of risk and appropriate ward to Board reporting. The Board commissioned a Well Led review from Deloitte which has fed into the Board Development Programme. An NHSI Licence Review and CQC Well-Led Review have also been used to enhance reporting and engagement.		What's happened in 2020/21
A.1.d The Board of Directors is responsible for ensuring compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by NHSI (Monitor), relevant statutory requirements and contractual obligations.	The Board considers all aspects of performance at each Board meeting and has in place a Quality Committee and Resources Committee as committees of the Board. These committees consider in more detail, the issues that are arising in the Trust from a quality and safety, finance and performance, workforce and environment perspective. All the committees are chaired by Non-executive Directors and are supported by Executive Directors and senior officers of the Trust. The Trust also has an Audit Committee which seeks to provide assurance to the Board around the systems and processes employed in the organisation.		Fine

A.1.e The Board of Directors should develop and articulate a clear “vision” for the trust. This should be a formally agreed statement of the organisation’s purpose and intended outcomes which can be used as a basis for the organisation’s overall strategy, planning and other decisions.	The Board has developed a clear vision for the Trust. The Trust has a stated vision that is underpinned by the Trust values and Personal Responsibility Framework. The Trust has reviewed the values and incorporated them into a document that includes the personal responsibilities of employees. The 5 Year Strategy and Our Strategy at a glance documents link the vision, values and goals and themes to provide a shared commitment.		
A.1.f The Board of Directors should set the NHS foundation trust’s strategic aims at least annually taking into consideration the views of the council of governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.	The Board of Directors does set the trust's strategic aims as part of the operational plan process and includes taking into account the views of the Council of Governors. This is achieved by either holding a meeting with the Governors specifically about the operational plan and strategic direction of the Trust or incorporating it into the Council of Governors meeting. The Board approves the operational plan which describes the strategic aims of the Trust. The Trust has in place a number of committees of the Board including a Quality Committee and a Resources Committee. Each of these committees are required to provide assurance to the Board on the subject matters they cover or escalate items of concern.		**What's happened in 2020/21 in light of COVID**
A.1.g The Board of Directors as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS board of directors.	The Board of Directors has three committees in place that support the Board in testing and gathering assurance for the Board on the delivery of healthcare, education, training and research from a quality and safety perspective. The key committees are the Quality Committee, the Resources Committee and the Audit Committee. Each of the Committees provide feedback to the Board following any meeting of the committees. This information is supplemented at the Board by the receipt of annual reports from key areas such as safeguarding, heath & safety, infection control, maternity and research and development.		
A.1.h The Board of Directors should also ensure that the NHS foundation trust functions are effective, efficient and economical.	The Board of Directors does test that it is functioning effectively, efficiently and economically through its year end processes. The Board reviews the Annual Governance Statement prior to being signed by the Chief Executive. The statement is also reviewed by the Audit Committee prior to approval by the Board of Directors. The Board also prepares an Annual Corporate Governance Statement which supports the underpinning expectation that the Trust is functioning effectively, efficiently and economically. Where lapses have been identified the Trust has sought to address the lapse as a matter of urgency and when appropriate included the issue on the Corporate Risk Register.		

Section A Leadership
A.2 Division of responsibility
Main principles

Principle	Comment
A.2.a There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the Boards of Directors and the Council of Governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.	The Chair and the Chief Executive have a clear division of responsibility. The Chair chairs the Board of Directors and presides over the Council of Governors meetings. The Chair is responsible for the Non-executive Directors and the Chief Executive is responsible for the Executive Directors.
A.2.1. The division of responsibilities between the Chairperson and Chief Executive should be clearly established, set out in writing and agreed by the Board of Directors.	The Chair and the Chief Executive have a clear division of responsibility. This division between the Chair and the Chief Executive has been agreed by the Board of Directors.

Relevant statutory requirement

Principle	Comment
A.2.2.The roles of Chairperson and Chief Executive must not be undertaken by the same individual.	The Trust has a separate Chair and Chief Executive

Section A Leadership
A.3 Chairman
Main Principles

Principle	Comment
A.3.a.The Chairperson is responsible for leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.	The Chair takes responsibility for the leadership of the Board of Directors and Council of Governors and her performance is reviewed on an annual basis as part of her appraisal. The Chair takes the lead in all aspects of leading the Board of Directors and the Council of Governors.

Supporting principles

Principle	Comment
A.3.b. The Chairperson is responsible for leading on setting the agenda for the Board of Directors and the Council of Governors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The Chair sets the agenda for each Board meeting and for each Council of Governors meeting. The Chair does this in consultation with the Foundation Trust Secretary, Chief Executive and the Council of Governor's Lead Governor. The Board work programme is reviewed as part of the preparation of the monthly Board agenda. The work programme for the Council of Governors meeting is reviewed as part of the preparation work for the agenda for the Council of Governors and the Governors are consulted as part of their Forum meetings. The Board calendar ensures extra time is allocated for strategic discussion.
A.3.c. The Chairperson is responsible for ensuring that the Board and Council work together effectively.	The Chief Executive attends the Council of Governors on a regular basis. The Chair and the Chief Executive work together to ensure there is clarity of the role of the Board and the Council of Governors. The Chair ensures that the Board of Directors and the Council of Governors receives information that ensures they can work together effectively. Board to Council of Governors meetings are held twice a year to enhance effective working.
A.3.d. The Chairperson is also responsible for ensuring that Directors and Governors receive accurate, timely and clear information which enables them to perform their duties effectively. The Chairperson should take steps to ensure that Governors have the skills and knowledge they require to undertake their role.	The Chair reviews the information provided to Board in advance of the meeting with the Foundation Trust Secretary. The Chair also reviews the information provided to the Council of Governors in advance of the meeting with the Foundation Trust Secretary. The Chair with the Foundation Trust Secretary, reviews the training requirements of the Governors to ensure they have the skills and knowledge they require. The Board to Council of Governors is used to enhance the Governors understanding of issues and provides the opportunity to question members of the Board. Governwell provided a joint Governor Training Day in 2018 for the Trust in partnership with Harrogate Foundation Trust. Governors are also given some opportunities to attend meetings regionally/nationally.
A.3.e. The Chairperson should promote effective and open communication with patients, service users, members, staff, the public and other stakeholders.	The Chair does promote effective and open communication with patients, service users, members, staff, the public and other stakeholders. The Chair also prepares a regular report for the Council of Governors. The Chair ensures that she attends external meetings to understand other stakeholder agendas. The Council of Governors have introduced an informal session to meet members of the public at every Council meeting (this has been postponed due to Covid-19 and Government guidance to restrict large gatherings
A.3.f. The Chairperson should also promote a culture of openness and debate by facilitating the effective contribution of Non-executive Directors in particular, and ensuring constructive relations between Executive and Non-executive Directors.	The Chair does promote a culture of openness and encourages the Non-executive Directors to have constructive relationships with the Executive Directors. The Chair works with the Chief Executive to support the constructive working relationship. The Governance Structure encourages the Non-executive Directors to work closely with the Executive Directors through the key Board Committees structure.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
A3.1			
The Chairperson should, on appointment by the Council of Governors, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the chairperson of the same NHS foundation trust.	The Trust has a process for the appointment of the Chair approved by the Council of Governors. As part of the process for the appointment of the Chair, each candidate is required to complete a Fit and Proper Person Test in advance of their appointment. This includes confirming their independence. The Chief Executive does not act as Chair of the Trust.	Comply	Process in place, Annual Report, Register of interests, Constitution, Nominations Committee minutes, Council of Governors minutes, Fit and Proper Persons Requirements

Section A Leadership
A.4 Non-executive Directors
Main Principle

Principle	Comment
A.4.a As part of their role as members of a unitary Board, Non-executive Directors should constructively challenge and help develop proposals on strategy. Non-executive Directors should also promote the functioning of the Board as a unitary Board.	The Board operates as a unitary Board and the Non-executive Directors along with the Executive Directors challenge each other in the Board meetings. The Board also spends time developing proposals on strategy through discussions in the Board meetings and sessions outside the formal Board. The Executive Directors also undertake the preparation work on strategy through discussions with the Executive Committee

Supporting Principles

Principle	Comment
A.4.b Non-executive Directors should scrutinise the performance of management in meeting agreed goals and objectives, and monitor the reporting of performance. They should satisfy themselves on the integrity of financial information and that financial controls and systems of risk management are robust and defensible. They are responsible for determining appropriate levels of remuneration of Executive Directors and have a prime role in appointing, and where necessary, removing Executive directors, and in succession planning.	The Non-executive Directors scrutinise the performance through the Board Committees. The NEDs also use the Audit Committee to ensue themselves that systems are in place. All the committees meet on a regular basis, anything between monthly meetings and quarterly basis. The Non-executive Directors hold a regular Remuneration Committee meeting to determine the remuneration of the Executive Directors and undertake succession planning.

Code provisions

Code of Governance reference	Action	Comply/Explain or Action	Evidence
A4.1			
In consultation with the Council of Governors, the Board should appoint one of the independent Non-executive Directors to be the Senior Independent Director to provide a sounding board for the Chairperson and to serve as an intermediary for the other Directors when necessary. The Senior Independent Director should be available to Governors if they have concerns that contact through the normal channels of Chairperson, Chief Executive, Finance Director or Trust Secretary has failed to resolve, or for which such contact is inappropriate. The Senior Independent Director could be the Deputy Chairperson.	The Board appointed a Non-executive Director in consultation with the Council of Governors and the role has been explained to the Council of Governors. The Senior Independent Director is available for Governors to contact if they have concerns that cannot be discussed through the normal channels. The Senior Independent Director does not hold the Vice Chairman position.	Comply	Council of Governors minutes, Board minutes and paper written by the Chair
A4.2			
The Chairperson should hold meetings with the Non-executive Directors without the Executives present. Led by the Senior Independent Director, the Non-executive Directors should meet without the Chairperson present, at least annually, to appraise the Chairperson's performance, and on other such occasions as are deemed appropriate.	The Chair meets the Non-executive Directors on a monthly basis without the Executive Directors present. The Senior Independent Director does meet with the Non-executive Directors annually as part of the process for the appraisal of the Chair.	Comply	Assurance from the Senior Independent Director
Code of Governance reference	Action	Comply/Explain or Action	Evidence
A4.3			
Where Directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes. On resignation, a Director should provide a written statement to the Chairperson for circulation to the Board, if they have any such concerns.	Any concerns raised are recorded in the appropriate set of minutes either Board or Remuneration Committee.	Comply	Board minutes - Remunderation Committee minutes

Section A Leadership
A.5 Governors
Main Principles

Principle	Comment
A.5.a The Council of Governors has a duty to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.	The Council of Governors seeks assurance from the Non-executive Directors through a number of methods. Governors attend the Board of Directors meetings and see the Non-executive Directors working. Governors seek opportunities for the Non-executive Directors to join them on various groups where the Non-executive Director's expertise can be used. Non-executive Directors attend the Council of Governors meeting. Two Board to Council of Governors meetings have been held this year which allows Governors to debate and understand areas of strategy with both Non-executive Directors and Executive Directors. Governors were also invited to attend some of the Board Committees in order to see and evaluate Non-executive Director performance.
A.5.b The Council of Governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.	Members of the Council of Governors are asked annually to sign the code of conduct and are reminded of the values of the Trust. Governors do seek the views of the membership and the general public through a number of forums and do bring that information back to the Council of Governors. The Governors have developed a specific group which seeks the views of the public and members on the services the Trust provides, specifically around Out of Hospital Care, but this does, in practice extend to the Acute Services. Governors have been invited to observe the Board Committees as part of their work to review the performance of the Non-executive
A.5.c Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty.	The Council of Governors meeting is held in public and Governors encourage members of the public to attend the meetings. Governors also provide information that is published by the Trust on the activities of the Governors. The Trust supplements this information by adding details of the activities of the Trust. Governors also attend the Annual Members Meeting/Annual General Meeting, open daysheld the Trust in order to meet existing members and encourage new members. The Trust also produces a monthly membership matters email. A membership survey was carried out in 2018 which was fed back to Governors and continues to be acted on. The Council of Governors have included an informal session with members of the public before every public Council meeting (this has been paused due to Covid-19 and the Trust following Government guidance on large gatherings)

Supporting Principles

Principles	Comment
A.5.d Governors should discuss and agree with the Board of Directors how they will undertake these and any other additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the local community and emerging best practice.	The Council of Governors has agreed with the Board of Directors through the Chair how they will undertake their additional roles. The Council of Governors have considered some draft procedures around how they will request the attendance of Directors and their use of NHSI's (Monitor) former independent panel (however, this panel has now been disbanded). The Chair works with the Council of Governors to ensure the Board to Council meetings are led by Governors requirements.
A.5.e Governors should work closely with the Board of Directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the trust's business plan.	The Council of Governors receives a copy of the Annual Report and Accounts and a presentation on the Operational Plan. The Chief Executive has kept the Governors informed of work with partners on the STP and East Coast Review at the Council of Governors meetings, public Board meetings or advanced receipt of media releases. The Governors are kept informed of any developments and significant changes to the Trust's plans.

A.5.f Governors should use their voting rights (including those described in A.5.14 and A.5.15) to hold the Non-executive Directors individually and collectively to account and act in the best interest of patients, members and the public. If the Council of Governors does withhold consent for a major decision, it must justify its reasons to the Chair and the other Non-executive Directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust. The Council of Governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.	The Governors have debated how they hold the Non-executive Directors to account. The Non-executive Directors are regular attendees at the Council of Governors meeting. The Council of Governors have considered a process to hold Non-executive Directors to account which takes into account the Nolan principles. The NEDs have been invited to attend the Private Council of Governor meetings to allow them to engage more approporiately.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
A5.1			
The Council of Governors should meet sufficiently regularly to discharge its duties. Typically the Council of Governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the Council of Governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	The Council of Governors meet in public four times a year. The members of the Council of Governors also meet with the Chair, Chief Executive and other key board members during the year. The Trust arranges specific sessions with the Governors to ensure they are kept up to date with the strategic changes being proposed by the Board and to promote understanding of key issues. Governors make every effort to attend the Council of Governors meetings and the public Board of Directors meetings. Governor attendance is regularly reviewed and discussed.	Comply	The minutes from the Council of Governors/NomRems Committee and other group meetings. Council of Governors attendance log.
A5.2			
The Council of Governors should not be so large as to be unwieldy. The Council of Governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the Council of Governors should be reviewed regularly as described in provision B.6.5.	The Council of Governors has 27 members, the membership is weighted towards public members.	Comply	The minutes from the Council of Governors meeting Constitution
A5.3			
The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated Lead Governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.B.1.	The Annual Report identifies the Governors, and their constituencies, their period of appointment and has a record of attendance included. The Annual Report identifies the Lead Governor and highlights the number of Council of Governor meetings that have taken place during the year. An attendance log is updated after every Council meeting.	Comply	The Annual Report. CoG Attendance Log, CoG minutes
A5.4			
The roles and responsibilities of the Council of Governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the Council of Governors towards members and other stakeholders and how Governors will seek their views and keep them informed.	The constitution details the roles and responsibilities of the Council of Governors as set out in the legislation.	Comply	Constitution
A5.5			
The Chairperson is responsible for leadership of both the Board of Directors and the Council of Governors (see A.3) but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance of other Executives and Non-executive Directors, as appropriate. In these meetings other members of the Council of Governors may raise questions of the Chairperson or her deputy, or any other relevant Director present at the meeting about the affairs of the NHS foundation trust.	The Chair does lead the Board of Directors and the Council of Governors. The Chief Executive is invited to each Council of Governors meeting and either attends or sends an Executive Director to update the Governors on the activities of the Trust. Other Directors regularly attend the Council of Governors as appropriate and when invited to attend by the Council of Governors do attend the meetings. The Council of Governors have formatted a process for requesting Directors to attend the Council of Governors. Other senior managers of the Trust are also invited as and when different topics are raised.	Comply	Council of Governor meeting packs.

A5.6			
The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the new provider licence or 23 other matters related to the overall wellbeing of the NHS foundation trust. The Council of Governors should input into the Board's appointment of a Senior Independent Director (see A.4.1).	The Senior Independent Director attends the Council of Governors meetings on a regular basis and ensures they are available to the Governors should they have any issues they would like to raise. The Trust has a written process for dealing with concerns raised by the Governors. The Council of Governors has formulated a process for requesting Executive and Non-executive Directors to attend the Council of Governors and explain the performance of the Trust. The appointment of the Senior Independent Director was discussed at the Nomination & Remuneration Committee.	Comply	The minutes from the Council of Governors/NomRems Committee meetings.
A5.7			
The Council of Governors should ensure its interaction and relationship with the Board of Directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Members of the Council of Governors attend the public Board of Directors meetings. The Chair updates the Council of Governors meeting on specific items discussed in the Board of Directors. The members of the Council of Governors have input into agenda through a Governor forum meeting that is held in advance of the Council of Governors meeting or by requesting items at the Council of Governors. The Council of Governors and the Board of Directors collectively agree when appropriate the communication of relevant information to the general public. The Council agendas are preparely in agreement with the Chair and Lead Governor. Board members attend meetings of the Council of Governors	Comply	Council of governor meeting packs details of other sessions held for governors

Section B: Effectiveness
B1 The composition of the Board
Main principles

Principle	Comment
B.1.a The Board of Directors and its Committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.	The Board of Directors and its Committees does have an appropriate balance of skill. Each member of the committee has been chosen to sit on that committee because of their skills. The committees review their membership as part of the review of their Terms of Reference. Most Board committees have a connection through their membership with another committee.

Supporting Principles

Principle	Comment
B.1.b The Board of Directors should be of sufficient size that the requirements of the organisation can be met and that changes to the Board's composition and that of its committees can be managed without undue disruption, and should not be so large as to be unwieldy.	The Board of Directors is sufficient in size to ensure that the requirements of the organisation are met. The Board committees are managed so that there is no disruption to business decisions or planned arrangements. The Board of Directors keeps its size under review.
B.1.c The Board of Directors should include an appropriate combination of Executive and Non-executive Directors (and in particular, independent Non-executive Directors) such that no individual or small group of individuals can dominate the Board's decision taking.	Each Board committee has an appropriate mix of Executive and Non-executive Directors so that no individual committee or group of Directors dominates the Board's decision taking. Please see the makeup of the Board which is described above.
B.1.d All Directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.	Each voting Board member has one vote with the Chair having a second vote, this is included in the Trust's Standing Orders.
B.1.e The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairpersonship and the membership of committees. The value of appointing a Non-executive Director with a clinical background to the Board of Directors should be taken into account by the Council of Governors.	The Council of Governors has appointed a Non-executive Director with a clinical background. The Council of Governors in discussion with the Chair consider the skills needed for the Board and agree the skills required prior to each search.
B.1.f Only the committee chairperson and committee members are entitled to be present at meetings of the Nominations, Audit or Remuneration committees, but others may attend by invitation of the particular committee.	The Trust follows this requirement. The membership of the committees is restricted to the Non-executive Directors or Governors (varies in each committee). Other officers of the Trust are in attendance at the meeting.

Code provisions

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B1.1			
The Board of Directors should identify in the Annual Report each Non-executive Director it considers to be independent. The Board should determine whether the Director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. The Board of Directors should state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the Director:	The Non-executive Directors are identified in the Annual Report. The Board consider all the Non-executive Directors to be independent in character and judgements. The NEDs complete a declaration of interest document prior to each Board meeting which declares any interest they hold that might impact on the Trust. The interests declared by the NED are available for inspection and are reported in the Annual Report	Comply	Annual Report, Register of Interests, Fit & Proper Persons Declarations, report to BoD on Non-Execuitve Director Independence
• has been an employee of the NHS foundation trust within the last five years;	None of the Non-executive Directors have been employed by the Trust in the last five years	Comply	Declaration of interest

• has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a Board of Directors that has such a relationship with the NHS foundation trust;	None of the Non-executive Directors currently have a material business relationship. One of the Non-executive Director's spouse is a member of senior medical team.	Comply	Declaration of interest
• has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;	No Director has received additional remuneration from the trust. The Medical Director receives a salary for his role as a clinician and separately as the Medical Director which the Board Remuneration Committee consider and approve. The Medical Director has also been awarded Clinical Excellence Award.	Comply	Declaration of interest, Annual Report
• has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;	No Non-executive Director's have any family ties with any of the NHS Foundation Trust's advisors, directors or senior managers	Comply	Declaration of interest
• holds cross-directorships or has significant links with other directors through involvement in other companies or board of directors;	No Director has cross directorship or significant links with other directors through involvement in other companies or Board of Directors.	Comply	Declaration of interest and fit and proper person test
• has served on the Board of the NHS foundation trust for more than six years from the date of their first appointment; or	The Chair has been reappointed for a third term by the Council of Governors which is appraised on a year on year basis. The Governors specifically confirmed that the Chair had received positive and successful appraisals during the year. One Non-executive Director completed her final term of office in 2020.	Explain	Annual Report, report and minutes fo the Council of Governors
• is an appointed representative of the NHS foundation trust's university medical or dental school.	The Council of Governors appointed a Non-Executive Director to the Board from the university medical school. The Council of Governors does have an appointment process and considers the skills that are being sought for each appointment.	Comply	Nom/Rem minutes CoG minutes March 2020
B1.2			
At least half the Board of Directors, excluding the Chairperson, should comprise Non-executive Directors determined by the Board to be independent.	7 members of the Board are independent Non-executive Directors including the Chair. 7 members of the Board are currently voting Executives and 1 member of the Board is currently a non-voting director.	Comply	Board minutes, Board structure, Standing Orders, Constitution
B1.3			
No individual should hold, at the same time, positions of Director and Governor of any NHS foundation trust.	No member of the Board holds the position of Director and Governor of any NHS foundation trust	Comply	Board minutes, board structure, Register of Interests, Fit and Proper Persons Declarations
B1.4			
The Board of Directors should include in its Annual Report a description of each Director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	The Annual Report includes a description of each Director's skills, expertise and experience and includes a statement of the balance, completeness and appropriateness of the Board. The Annual Report is published on the Trust's website.		Annual report

Section B: Effectiveness
B.2 Appointments to the Board
Main Principle

Principle	Comment
B.2.a There should be a formal, rigorous and transparent procedure for the appointment of new Directors to the Board. Directors of NHS foundation trusts must be “fit and proper” to meet the requirements of the general conditions of the provider licence	There is an agreed process for the appointment of Directors to the Board of Directors. Each Director is required to confirm on an annual basis that they satisfy the fit and proper person test. The members of the Board are required to complete the fit and proper person test prescribed by the CQC. Each year the Board members are asked to complete a declaration and once every three years an independent search will be undertaken by the External Auditors. Full checks of the Board have been carried out in 2018.

Supporting Principles

Principle	Comment
B.2.b The search for candidates for the Board of Directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and the requirements of the Trust.	The agreed process for Non-executive Directors requires a group of Governors to agree the skills and the approach to the search of the candidates. The Governors are involved in creating the short list of candidates and the interview process. All Directors are appointed on merit against agreed criteria which have due regard of diversity and the requirements of the Trust. The process for Executive Directors is carried out by the Chief Executive and the Executive Directors using HR expertise.
B.2.c The Board of Directors and the Council of Governors should also satisfy themselves that plans are in place for orderly succession for appointments to the Board, so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the Board.	The Nominations Remuneration Committee for the Council of Governors does concern itself with the succession planning of Non-executive Directors and reviews the time line of each of the Non-executive Directors periods of office at each meeting. The Board Remuneration Committee spends time reviewing the succession planning of the Executive Directors

Code provisions

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B2.1			
The Nominations Committee or Committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-executive Directors. The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the Board of Directors to meet them.	The Nomination and Remuneration Committee with membership from the Governors supports the Chair in undertaking a review of the Board structure, size and composition. The Remuneration Committee considers the succession of Executive Directors.	Comply	Statement to be included in the Annual Report revised on an annual basis Committee Minutes, CoG minutes, Board of Directors Minutes
B2.2			
Directors on the Board of Directors and Governors on the Council of Governors should meet the “fit and proper” persons test described in the provider licence. For the purpose of the licence and application criteria, “fit and proper” persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at NHSI's (Monitor) discretion an exemption to this may be granted. Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	The Directors on the Board of Directors and the Governors on the Council of Governors are required to complete the fit and proper person test on an annual basis. If a Director or Governor is not able to satisfy the test during the year the Director or Governor will be removed from office. The Board of Directors is also required to completed the additional fit and proper person test published by the CQC. The Board members will complete the test on annual basis and once every three years there will be an independent assessment made by the External Auditors. Full checks of the Board have been carried out in 2018.	Comply	Fit and proper person test Declaration of Interest, Personal Files Board of Directors minutes

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B2.3			
There may be one or two Nominations Committees. If there are two committees, one will be responsible for considering nominations for Executive Directors and the other for Non-executive directors (including the chairperson). The Nominations Committee(s) should regularly review the structure, size and composition of the Board of Directors and make recommendations for changes where appropriate. In particular, the Nominations Committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the Board of Directors and, in light of this evaluation, prepare a description of the role and capabilities required for appointment of both Executive and Non-executive Directors, including the Chairperson.	The appointment of Non-executive Directors is managed by the Nominations Remuneration Committee with membership from the Council of Governors. The appointment of Executive Directors is managed by the Remuneration Committee with a membership of Non-executive Directors. The Nominations Remuneration Committee considers the skills needed in the Boardroom before each appointment of a Non-executive member of the Board of Directors. The required skills are agreed with the Nominations Remuneration Committee and the Council of Governors. The Remuneration Committee considers the skill mix required in relation to Executive Directors in conjunction with the Chief Executive.	Comply	Minutes and Terms of Reference of the Governor's Nominations Committee/Remuneration Committee
B2.4			
B.2.4. The Chairperson or an independent Non-executive Director should chair the Nominations Committee(s). In the case of appointments of Non-executive Directors or the Chairperson, a Governor should chair the Committee.	The Nominations Committee and Remuneration Committee are chaired by the Trust Chair, except for discussions relating to their own position in which case the committee will be chaired by the Lead Governor. The Remuneration Committee is chaired by the Chair	Comply	Terms of Reference of the two committees. Committee minutes.
B2.5			
The Governors should agree with the Nomination and Remuneration Committee a clear process for the nomination of a new Chairperson and Non-executive Directors. Once suitable candidates have been identified the Nominations and Remuneration Committee should make recommendations to the Council of Governors.	The Nominations Remuneration Committee has a clear process for the appointment of a new Chair and Non-executive Directors. The Committee reviews the process on a regular basis in advance of any search. Governors also receive appropriate training in advance of process	Comply	Process. Committee minutes, Constitution,.
B2.6			
Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The Governor's Nominations and Remuneration Committee membership consists mainly of Governors. Two officers of the Trust are members of the Committee- those being the Chair of the Trust who chairs the meeting and the Foundation Trust Secretary. The appointments panel consists mainly of Governors.	Comply	Terms of reference of the Nominations Committee. Minutes of the meetings.
B2.7			
When considering the appointment of Non-executive Directors, the Council of Governors should take into account the views of the Board of Directors and the Nominations Committee on the qualifications, skills and experience required for each position	The Council of Governors takes into account the views of the Board of Directors and Nomination and Remuneration Committee on the qualifications, skills and experience.	Comply	The process adopted by the Council of Governors. Minutes of the Nom/Rems Committee
B2.8			
B.2.8. The Annual Report should describe the process followed by the Council of Governors in relation to appointments of the Chairperson and Non-executive Directors.	The Annual Report describse the process followed by the CoG for the appointment of the Chair and Non-executive Director. The Annual Report also describes the process the Governors adopted to confirm the reappointment of the Non-executive Director when the Director has serviced six years.	Comply	Annual Report
B2.9			
B.2.9. An independent external adviser should not be a member of or have a vote on the nominations committee(s).	An independent external adviser is not a member/does not have a vote on the nominations committee.	Comply	Process
B2.10			
A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments. The main role and responsibilities of the Nominations Committee should be set out and have publicly available written terms of reference.	The Annual Report describes the work of the Nomination and Remuneration Committee and the Remuneration Committee. The terms of reference are publically available	Comply	Annual Report, Committee, Nomination and Remuneration Committee Terms of Reference, Remuneration Committee Terms of Reference.

Relevant statutory requirements

Principles	Comment
B.2.11. It is a requirement of the 2006 Act that the Chairperson, the other Non-executive Directors and – except in the case of the appointment of a Chief Executive –the Chief Executive are responsible for deciding the appointment of Executive Directors. The Nominations Committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The Chair leads the appointment of Executive Directors along with the Chief Executive - the NEDs are involved.
B.2.12. It is for the Non-executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.	The Chair lead the process for the recruitment of a new Chief Executive with involvement from th NEDs and ratification by the Council of Governors.
B.2.13 The Governors are responsible at a general meeting for the appointment, reappointment and removal of the Chairperson and the other Non-executive Directors.	The Council of Governors receive a recommendation from the Nominations Committee regarding the appointment and reappointment of the Chair and Non-Executive Directors.

Section B:Effectiveness
B.3 Commitment
Main Principle

Principle	Comment
B.3.a All Directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.	All Directors do allocate sufficient time to the Trust to discharge their responsibilities effectively.

Code Provisions

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B3.1			
For the appointment of a Chairperson, the Nominations Committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report. No individual, simultaneously whilst being a Chairperson of an NHS foundation trust, should be the substantive Chairperson of another NHS foundation trust.	The appointment of the Chair is reviewed in detail by the Council of Governors. The current Chair does not hold any significant other commitments, Governors would be informed if that position was to change.	Comply	Chair's interests and attendance at the Trust, Chair's Terms and Conditions of Appointment, Appointment Letter
B3.2			
The terms and conditions of appointment of Non-executive Directors should be made available to the Council of Governors. The letter of appointment should set out the expected time commitment. Non-executive Directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	The terms and conditions of appointment of the Non-executive Directors are made available to the Council of Governors. All Non-executive Directors are given an indication of time commitment and other significant commitments are disclosed to the Board and the Council of Governors through the Directors interests which is updated on a monthly basis.	Comply	Non-Executive Director Terms and Conditions of Appointment, Appointment Letter, Declarations of interests and attendance at meetings
B3.3			
B.3.3. The Board of Directors should not agree to a full-time Executive Director taking on more than one Non-executive Directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the Chairpersonship of such an organisation.	No Executive Directors hold Non-executive Directorships of an other NHS foundation trust or other organisation of comparable size and complexity to the Trust	Comply	Declaration of interests, Fit and Proper Persons Declarations, Annual Report

Section B: Effectiveness
B.4 Development
Main principle

Principle	Comment
B.4.a All Directors and Governors should receive appropriate induction on joining the Board of Directors or the Council of Governors and should regularly update and refresh their skills and knowledge. Both Directors and Governors should make every effort to participate in training that is offered.	All Directors and Governors are given induction on joining the Trust . They are also invited to engage in additional training as and when appropriate. The Trust has a mandatory training programme that Directors are required to attend. The Governors are provided with an induction programme and a programme of on-going internal and external training as required.

Supporting Principles

Principle	Comment
B.4.b The Chairperson should ensure that Directors and Governors continually update their skills, knowledge and familiarity with the NHS foundation trust and its obligations to fulfil their role both on the Board, the Council of Governors and its committees. The NHS foundation trust should provide the necessary resources for developing and updating its Directors' and Governors' skills, knowledge and capabilities.	The Governors and Directors are provided with additional training as appropriate. The Governors have received induction and the Board to Council of Governors seeks to enhance their understanding of critical issues. External Governor training was provided in 2018. A Board development programme was put in place in December 2019.
B.4.c To function effectively, all Directors need appropriate knowledge of the NHS foundation trust and access to its operations and staff.	The Directors have knowledge of the Trust and access to its operations and staff.

Code provisions

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B4.1			
The Chairperson should ensure that new Directors and Governors receive a full and tailored induction on joining the Board or the Council of Governors. As part of this, Directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	The Governors and Directors are provided with induction and additional training as appropriate. The Governors have received induction and the Board to Council of Governors seeks to enhance their understanding of critical issues. External training was provided for Governors in 2018. A Board development programme was put in place in December 2019.	Comply	Training records, Training and Induction programmes, appraisal process.
B4.2			
The Chairperson should regularly review and agree with each Director their training and development needs as they relate to their role on the Board.	As part of the annual appraisal the Non-executive Directors discuss the training requirements needed to achieve their set objectives. The Chair works with the Chief Executive to reflect the performance of the Executive Directors in the Boardroom and identifies any specific training needs that are felt appropraite.	Comply	Appraisal reports, Nominations Committee minutes, CoG minutes

Relevant Statutory requirements

Principle	Comment

B.4.3 The Board has a duty to take steps to ensure that Governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	The Governors have received induction and the Board to Council of Governors seeks to enhance their understanding of critical issues.

Section B: Effectiveness
B.5 Information and support
Main Principle

Principle	Comment
B.5.a The Board of Directors and the Council of Governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the Board of Directors to the Council of Governors are provided in Your statutory duties: A reference guide for NHS foundation trust governors.	The Board of Directors and Council of Governors are supplied with information in a timely manner with relevant information in a form that is appropriate to enable them to discharge their respective duties.

Supporting Principles

Principle	Comment
B.5.b The Chairperson is responsible for ensuring that Directors and Governors receive accurate, timely and clear information. Management has an obligation to provide such information but Directors and Governors should seek clarification or detail where necessary.	The management are provided with detailed timelines for providing information so that appropriate information packs can be put together and provided to appropriate Directors and Governors
B.5.c The responsibilities of the Chairperson include ensuring good information flows across the Board, the Council of Governors and their Committees, between Directors and Governors, and between Senior Management and Non-executive Directors, as well as facilitating appropriate induction and assisting with professional development as required.	The Chair oversees the information flows and ensures that there is flow of information between the Board and Council of Governors and the Committees. She also ensures there is a flow of information that exists between the Senior Management and the Non-executive Directors. The Chair also supports the induction process and assists where ever appropriate with the professional development of Directors. The information provided to the Board Committees ensures the Non-executive Directors have up to date information to discuss prior to the Board meeting and at the Board meeting.

Code provision

Code of Governance reference	Action	Comply/ Explain or Action	Evidence
B5.1			
The Board of Directors and the Council of Governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The Board of Directors and the Council of Governors should agree their respective information needs with the Executive Directors through the Chairperson. The information for the Boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The Board of Directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to Senior Management and other employees.	The Board of Directors and the Council of Governors is supplied with high quality information prior to any meetings. The information provided to the Board of Directors and the Council of Governors is concise, objective, accurate, and timely. All complex issues are explained in a clear and concise method. The Board of Directors and the Council of Governors has access to any information about the Trust it deems necessary to discharge its duties, including access to Senior Management and other employees. The Trust has spent considerable time recently developing the information booklet that is presented to Board members. The Board members have been involved in the development. This booklet is continually being reviewed.	Comply	Board of Directors and Council of Governors agendas and meeting packs, Trust Website
Code of Governance reference	Action	Comply/ Explain or Action	Evidence
B5.2			

The Board of Directors and in particular Non-executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the Board of Directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, Non-executive Directors may reasonably decide that external assurance is appropriate.	The Board of Directors seeks assurance directly and through its committees by requiring the CEO and EDs to provide assurance reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors have the opportunity to challenge at Board and Committee meetings. Challenges are recorded in the minutes. Non-Executive Directors have the opportunity to request external assurance as appropriate. All Board Sub-Committees have NED representation and are chaired by a NED. Remuneration Committee can request attendance as appropriate by the Director of Workforce to provide support and advice	Comply	Board of Directors and Council of Governors agendas, BoD agendas and Minutes, BoD reports, External Assurance Reports, eg, CQC, Internal Audit, Committee Chairs Assurance Reports
B5.3			
The Board should ensure that Directors, especially Non-executive Directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as Directors. Decisions to appoint an external adviser should be the collective decision of the majority of Non-executive Directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Independent advice may be sought by the Board of Directors as appropriate. Independent external sources of advice can include the Trust's External Auditors and Internal Auditors and legal services Directors undergo annual appraisal and have access to training courses and/or materials consistent with identified personal development needs.	Comply	Board of Directors minutes, External and Internal Audit Reports, Nominations Committee Minutes, Remuneration Committee Minutes, BoD Minutes
B5.4			
Committees should be provided with sufficient resources to undertake their duties. The Board of Directors should also ensure that the Council of Governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance	All Committee Terms of Reference ensure that the Committee is provided with sufficient resources to undertake their duties. The Board of Directors ensures the Council of Governors is appropriately resourced so that it can undertake its duties.	Comply	Committee terms of reference
B5.5			
Non-executive Directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board, in particular making full use of their skills and experience gained both as a Director of the Trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a Non-executive Director of an NHS foundation trust as they would in other similar roles.	Executive Directors work collectively to ensure information is provided to NEDs in a timely manner. NEDs have the opportunity at Board meetings and sub- committee meetings to challenge and/or to request 1:1 meetings with Executive Directors to seek further clarification/assurance All Board sub-committees have NED representation and are Chaired by a NED Any such challenges are recorded in the minutes NED skills balance considered in succession planning	Comply	Discussion with NEDs, Board minutes, External Assurance Reports, e.g.CQC / Internal Audit
B5.6			
Governors should canvass the opinion of the Trust's members and the public, and for appointed Governors the Board of directors they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	The Council of Governors considers a presentation on the Operational Plan before it is submitted to the Board for final approval. Governors are able to ask questions and seek clarification or changes before the finalisation of the plan and invited to provide information from members.	Comply	Discussion with Governors, minutes from Council of Governors meetings
B5.7			
Where appropriate, the Board of Directors should take account of the views of the Council of Governors on the forward plan in a timely manner and communicate to the Council of Governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	The Board of Directors does ensure that it seeks the views of the Council of Governors on the development of the Operational Plan. The Trust does communicate to the Governors where their views have been incorporated in to plan and does explain where other ideas have not been incorporated.	Comply	Operational Plan process and document

Relevant Statutory Requirements

Principle	Comment		
B.5.8 The Board of Directors must have regard for the views of the Council of Governors on the NHS foundation trust's forward plan.	The Board of Directors does ensure the Council of Governors are encouraged to have views about the development of the Operational Plan. The Board does have regard for the views of the Council of Governors.	Comply	Minutes of the Council of Governors and Board of Directors minutes

Section B: Effectiveness
B6 Evaluation
Main Principles

Principle	Comment
B.6.a The Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual Directors.	Individual Directors: Individual Directors and Non-executive Directors are annually appraised and succession planning together with discussions about skills and experience are led by both the Remuneration Committee and the Nominations and Remuneration Committee. Board Committees: The Audit Committee has recently undertaken an effectiveness review and some of the Board Committees have produced annual reports which identify their work and progress. Effectiveness reviews and annual reports need formalising in the Board Committee work programmes. The CQC Well Led Review and NHSI Licence Investigation have been used to develop action plans which are monitored. Deloitte undertook a well-led review/CQC preparation in 2019.
B.6.b The outcomes of the evaluation of the Executive Directors should be reported to the Board of Directors. The Chair should take the lead on the evaluation of the Executive Directors.	Historically the Chief Executive has been responsible for the evaluation of the Executive Directors. The Chief Executive continues to lead the evaluation with the exception of the elements related to the performance of the Executives in the Board. The Chair takes the lead on this element of the evaluation.
B.6.c The Council of Governors, which is responsible for the appointment and reappointment of Non-executive Directors, should take the lead on agreeing a process for the evaluation of the Chairperson and the Non-executive Directors. The outcomes of the evaluation of the Non-executive Directors should be agreed with them by the Chairperson. The outcomes of the evaluation of the Chairperson should be agreed by him or her with the Senior Independent Director. The outcomes of the evaluation of the Non-executive Directors and the Chairperson should be reported to the Governors. The Governors should bear in mind that it may be desirable to use the Senior Independent Director to lead the evaluation of the Chairperson.	The Council of Governors has a robust system in place for the evaluation of the Chair and the Non-executive Directors. The process is reviewed regularly by the Nomination and Remuneration Committee on behalf of the Council of Governors. The Committee sends recommendations to the Council of Governors for them to approve. The appraisal of the Chair is led by the Senior Independent Director and the Lead Governor.
B.6.d The Council of Governors should assess its own collective performance and its impact on the NHS foundation trust.	The Council of Governors has added this to its work programme.

Supporting Principles

Principles	Comment
B.6.e Evaluation of the Board of Directors should consider the balance of skills, experience, independence and knowledge of the NHS foundation trust on the Board, its diversity, including gender, how the Board works together as a unit, and other factors relevant to its effectiveness. This should be reported to the Council of Governors with a specific focus on what changes are needed for improvement.	The CQC Well Led Review and NHSI Licence Investigation have been used to develop action plans which have been monitored. Deloitte undertook a well-led review/CQC preparation in 2019.

B.6.f Individual evaluation of Directors should aim to show whether each Director continues to contribute effectively and to demonstrate commitment and has the relevant skills for the role (including commitment of time for Board and Committee meetings and any other duties) going forwards.	Individual evaluation of Non-executive and Executive Directors is undertaken as part of the appraisal process.
B.6.g The Chairperson should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the Board, identifying individual and collective development needs, and, where appropriate, proposing new members be appointed to the Board or seeking the resignation of Directors.	The Chair acts on the results of the performance evaluation.
B.6.h The focus of the Chairperson's appraisal will be his/her performance as leader of the Board of Directors and the Council of Governors. The appraisal should carefully consider that performance against pre-defined objectives that support the design and delivery of the NHS foundation trust's priorities and strategy described in its forward plan.	The appraisals do take into account the Chair's leadership at the Board of Directors and the Council of Governors and does consider performance against pre defined objectives.

Section B: Effectiveness
B.7 Re-appointment of directors and re-election of governors
Main Principle

Principle	Comment
B.7.a All Non-executive Directors and elected Governors should be submitted for reappointment or re-election at regular intervals. The performance of Executive Directors of the Board should be subject to regular appraisal and review. The Council of Governors should ensure planned and progressive refreshing of the Non-executive Directors.	All Non-executive Directors are considered for reappointment at the end of their appointed period of office. Governors are required to stand (if they wish) for a further period of office as a Governor. The performance of Executive Directors is subject to appraisal and review on an annual basis. The Council of Governors does ensure there is planned and progressive refreshing of the Non-executive Directors. The Council of Governors consider the skills that are needed for the Board to function effectively.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
B7.1			
In the case of re-appointment of Non-executive Directors, the Chairperson should confirm to the Governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a Non-executive Director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board. Non-executive Directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.	The Chair and Non-executive Directors receive an annual appraisal on their performance. The consideration of re-appointment of a Non-executive Director will take into account the annual appraisals and will be considered by the Nomination/Remuneration Committee in consultation with the Board of Directors. The Governors considered the reappointment of a Non-executive Director for a third term and agreed that the appraisals had been successful in the past six years and therefore sought the reappointment of the Non-executive Director. Non-executive Directors who are appointed for a third term are appointed on a year on year basis following review.	Comply	Annual appraisal system. Minutes
B7.2			
Elected Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of Governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	The Constitution provides for regular elections for public and staff governors. Election information events are held for members prior to each election. Attendance records of Governors are reported within the Annual Report.	Comply	Election material. Constitution Review Group Minutes - CoG minutes, Election Process, Constitution, Annual Report, Annual Members Meeting Minutes

Relevant Statutory Requirements

Principle	Comment

B.7.3. Approval by the Council of Governors of the appointment of a Chief Executive should be a subject of the first general meeting after the appointment by a committee of the Chairperson and Non-executive Directors. All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairperson and Non-executive Directors.	The approval of the appointment of the Chief Executive took place in January 2019 at an extraordinary Council meeting.The appointment would be subject to the ratification of the appointment by the Council of Governors. All other Executive Directors are appointed by a panel of the Chief Executive, Chair and Non-executive Directors.
B.7.4 Non-executive Directors, including the Chairperson should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	The Constitution states the terms of office and reappointment arrangements of non-executive directors, by the Council of Governors. This is in line with the provisions of the code. Covered under: B.2.5 B.2.6 B.2.7 B.3.1 The Chair and Non-executive Directors receive an annual appraisal on their performance. The consideration of re-appointment of a Non-executive Director will take into account the annual appraisals and will be considered by the Nomination/Remuneration Committee in consultation with the Board of Directors. A recommendation is formulated and considered by the Council of Governors
B.7.5 Elected Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	See 7.2 above

B.8 Registration of directors

Main Principles

Principle	Comment
B.8.a The Board of Directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by NHSI (Monitor), relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its Board of Directors and works with the Council of Governors to ensure there is appropriate succession planning.	The Board of Directors does ensure that it maintains compliance with the requirements of the licence, constitution and mandatory guidance. The Trust regularly engages in succession planning discussions at the Remuneration Committee and Nomination & Remuneration Committee to ensure the it retains the necessary skills with its Board of Directors.

Code provisions

Code of Governance reference	Action	Comply/ Explain or Action	Evidence
B8.1			
B.8.1 The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.	The Remuneration Committee ensures Executive members of the Board leave in accordance with the terms of their contract of employment. If the Committee has any concerns, it will ensure they are kept under regular review.	Comply	Remuneration Committee Minutes Annual Report

Section C: Accountability
C.1 Financial, Quality and operational reporting
Main Principle

Principle	Comment
C.1.a The Board of Directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.	The Board of Directors through monthly meetings and the continuous assessment of information is able to present a fair, balanced and understandable assessment of the Trust. This is also supported through the Board Committees. The Board receives information that is considered at the Board meeting that provides assurance to the Board of the Trust's position and prospects.

Supporting Principle

Principle	Comment
C.1.b The responsibility of the Board of Directors to present a fair, balanced and understandable assessment extends to all public statements and reports to regulators and inspectors, as well as information required to be presented by statutory requirements.	The Board of Directors does present a fair, balanced and understandable assessment of the Trust. The statements made by the Board are underpinned by information discussed at the Board meetings or Board Committees. The Trust regularly meets and submits reports to the regulators.
C.1.c The Board of Directors should establish arrangements that will enable it to ensure that the information presented is fair, balanced and understandable.	The Board of Directors has established arrangements to ensure that the information is presented appropriately. The Trust has developed an extensive information booklet. This continues to be developed and improved.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
C1.1			
The Directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	The Board does provide the required statements as part of the Annual Report. The external auditors provide a statement on their reporting responsibilities and the directors do explain their approach to quality governance in the annual governance statement	Comply	Annual governance statement and annual report
C1.2			
The Directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Board of Directors does report that the trust is a going concern as part of the year end process	Comply	Going concern statement
C1.3			
At least annually and in a timely manner, the Board of Directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the NHS Foundation Trust Annual Reporting Manual.	The Board of Directors fulfils these requirement with the development of the Annual Report, the Five Year Strategy and the Operational Plan	Comply	Annual report and annual plan

Relevant Statutory Requirement

Principle	Comment

C4.1a) The Board of Directors must notify NHSI (Monitor) and the Council of Governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.	The Trust complies with this requirement. The Trust reported the proposed transaction for the acquisition of Scarborough to the Council of Governors as it was discussed by the Board of Directors. The Board of Directors and Council of Governors reviewed significant transactions and the Trust kept the public informed of the progress of the transaction through media reports and interviews and public meetings. The Trust has in place an agreement with the Council of Governors around Significant Transactions which is regularly reviewed. The Council of Governors is kept informed of any strategy developments that the Trust puts in place and the Trust does notify the public as and when appropriate.
b) The Board of Directors must notify NHSI (Monitor) and the Council of Governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	The Trust believes in being open and transparent. The Trust would advise the Governors if an issue arose in the Trust. The Trust would also advise NHSI (Monitor) and the general public as appropriate. At each Board meeting held in public the Board debates the financial position of the Trust along with its performance. The Chief Executive regularly attends the Council of Governors and keeps them informed of issues or developments.

Section C: Accountability
C.2 Risk management and internal control
Main Principle

Principle	Comment
C.2.a The Board of Directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.	The Board approve the risk management framework used in the Trust. The Board Assurance Framework and Corporate Risk Register is reviewed by the Audit Committee and Board Committees regularly The Board receives the BAF and CRR quarterly. The BAF goes to every Board meeting.
C.2.b The Board of Directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The Board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.	The Board of Directors does report on internal systems of control in the Annual Governance Statement.

Supporting Principles

Principle	Comment
C.2.c An internal audit function can assist a Trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and continually improving the effectiveness of its risk management and internal control processes.	The Trust employs a full internal control function which acts independently. Internal Audit are managed by the Director of Finance and report to the Audit Committee. They submit audit reports and recommendations to the Audit Committee which detail the risk level and priority for the organisation
C.2.d If a Trust has an internal audit function, the head of that function should have a direct reporting line to the Board or to the Audit Committee to bring the requisite degree of independence and objectivity to the role.	The Chief Auditor/Head of Internal Audit has a direct reporting line to the Audit Committee and reports directly to the Board of Directors annually. She has access to the Chief Executive and the Finance Director and the Chair of the Audit Committee

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
C2.1			
The Board of Directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and Governors that they have done so. A regular review should cover all material controls, including financial, operational and compliance controls.	The Board of Directors reviews the internal systems on a regular basis through the reports and assurances received by the Board at each board meeting. The Board also receives information from the Board Committees which review the information provided in more detail. The Trust has Committee structure which considers the risk registers and assurance framework. Internal Auditors include an annual review of risk management within their Internal Audit plans.	Comply	Board pack - Committee papers BAF/CRR, Audit Committee minutes, Annual Governance Statement, Internal Audit Plan
C2.2			

A trust should disclose in the Annual Report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	The Annual Report confirms that the Trust has a robust internal audit function that reports via the Trust's Audit Committee against the agreed IA plan.	Comply	Annual report,Audit Committee minutes, Internal Audit Plan, Internal Audit Reports

Section C: Accountability
C.3 Audit committee and auditors
Main Principle

Principle	Comment
C.3.a The Board of Directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors. NHSI's (Monitor) publications, Audit Code for NHS Foundation Trusts and Your statutory duties: A reference guide for NHS foundation trust governors, provide further guidance.	Corporate reporting and risk management and internal control principles are in place as part of the Board and Committee structure and is being further embedded following the dis-establishment of the Corporate Risk Committee. The BAF and CRR are reviewed at the Board, Audit Committee and Board Committees quarterly, but are also reflected upon at intervening meetings. The Trust has in place mechanisms for an appropriate relationship with the Trust's auditors including meetings with the Finance Director and a private meeting with the NEDs.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
C3.1			
The Board of Directors should establish an Audit Committee composed of at least three members who are all independent Non-executive Directors. The Board should satisfy itself that the membership of the Audit Committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the Audit Committee has recent and relevant financial experience. The Chairperson of the Trust should not chair or be a member of the Audit Committee. He can, however, attend meetings by invitation as appropriate.	The Board of Directors has established an Audit Committee which is composed of a core membership of three independent Non-executive Directors. The Non-Executive Director who chairs the Audit Committee has recent and relevant financial experience. The Chair is not a member of the Audit Committee nor has he been invited The Audit Committee also fulfills the requirement of the Audit Code.	Comply	Audit committee terms of reference, minutes of meetings. Audit Committee Annual Report Annual Report
C3.2			
C.3.2. The main role and responsibilities of the Audit Committee should be set out in publicly available, written terms of reference. The Council of Governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will: · Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them; · Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; · Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; · Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; · Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and · Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.	The Audit Committee's terms of reference are reviewed on an annual basis and are based on the Audit Code. They detail the main responsibilities and role of the Audit Committee. The terms of reference details how the committee monitors the integrity of the financial statements. The Audit Committee reviews the internal financial controls. It is assisted by internal and external audit. The Audit Committee reviews the performance of internal audit on an annual basis with the support of the external auditors. The Audit Committee reviews the performance of the external auditor's independence and objectivity and the effectiveness of the audit process. The Trust tendered the contract for External Audit services which was awarded to Mazars in August 2020. The Chair of the Audit Committee presents the Audit Committee annual report to the Council of Governors.	Comply	Audit committee terms of reference Audit Committee Agenda, Minutes and work plan, CoG minutes, Annual Report, Audit Committee Annual Report, Internal Audit Plan, External Audit selection process

Section D: Remuneration
D.1 The level and component of remuneration
Main Principle

Principle	Comment
D.1.a Levels of remuneration should be sufficient to attract, retain and motivate Directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.	The Trust provides the Remuneration Committee with appropriate information to consider the level of remunerations that should be paid to the Executive Directors. The Executive Directors remuneration is based on survey information provided to the Committee on an annual basis.

Supporting principles

Principle	Comment
D.1.b Any performance-related elements of Executive Directors' remuneration should be stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any competencies required and specified within the job description for the post.	The Trust does not use performance related pay
D.1.c The Remuneration Committee should decide if a proportion of Executive Director's remuneration should be structured so as to link reward to corporate and individual performance. The Remuneration Committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration levels with no corresponding improvement in performance.	The Trust does not link a proportion of the Executive Director's remuneration to performance. The Trust does benchmark its pay against other trusts and similar sectors using nationally recognised intelligence
D.1.d The Remuneration Committee should also be sensitive to pay and employment conditions elsewhere in the NHS foundation trust, especially when determining annual salary increases.	The Trust does benchmark its pay against other Trusts and similar sectors using nationally recognised intelligence

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
D1.1			
Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the Remuneration Committee should consider the following provisions:	The Executive Directors work in a collaborative and collective fashion to achieve the appropriate standards and targets. Any move to any individual PRP is felt to be a threat to that arrangement.	Does not apply	Remuneration committee minutes

i) The Remuneration Committee should consider whether the Directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.	The Remuneration Committee does consider if the Directors should be eligible for annual bonuses and has always confirmed that annual bonuses are not paid	Comply	Remuneration committee minutes
ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator 42 trusts in some key indicators, and the taking of independent and expert advice where appropriate.	The Trust does not use incentive schemes	Does not apply	Remuneration committee minutes
iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed.	The Trust does not pay annual bonuses	Does not apply	Remuneration committee minutes
iv) The Remuneration Committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	The Remuneration Committee does consider the pension consequences and associated costs of the basics salary increases of the directors	Comply	Remuneration committee minutes
D1.2			
D.1.2. Levels of remuneration for the Chairperson and other Non-executive Directors should reflect the time commitment and responsibilities of their roles.	The Council of Governors approve the levels of remuneration paid to the Chair and other Non-executive Directors. The Governors in the Nominations Remuneration Committee discuss the Non-executive Director remuneration on an annual basis and formulate a recommendation that is agreed by the Council of Governors. This can be demonstrated in the discussions which took place in Nov/Dec 2019 following receipt of NHSI guidance.	Comply	Nominations Remuneration Committee minutes
D1.3			
Where an NHS foundation trust releases an Executive Director, for example to serve as a Non-executive Director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the Director will retain such earnings.	Currently no executive directors serve as non-executive directors elsewhere	Comply	Directors register of interests Annual report
D1.4			
The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing Director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a Director returning to the NHS within the period of any putative notice.	This has not arisen. The Remuneration Committee is responsible for agreeing Executive Directors' termination arrangements.	Comply	not arisen Remuneration Committee minutes Supporting paperwork

Section D:Remueration
D.2 Procedure
Main Principle

Principle	Comment
D.2.a There should be a formal and transparent procedure for developing policy on executive remuneration, and for fixing the remuneration packages of individual Directors. No Director should be involved in deciding his or her own remuneration.	The Remuneration Committee, chaired by the Chair with membership from the Non-Executive Directors, formulates the remuneration package policy and ensures that it is transparent. The Remuneration Committee does ensure that the remuneration of the Executive Directors is transparent and reported in the Annual Report. None of the Executive Directors are involved in deciding their own remuneration.

Supporting principle

Principle	Comment
D.2.b The Remuneration Committee should consult the Chairperson and/or Chief Executive about its proposals relating to the remuneration of other Executive Directors.	The Remuneration Committee does consult with the Chair and the Chief Executive on the remuneration of Executive Directors. The Chief Executive provides a report on an annual basis that benchmarks the Executive Director salaries.
D.2.c The Remuneration Committee should also be responsible for appointing any independent consultants in respect of Executive Director remuneration.	The Trust has not appointed any independent consultants. If it was considered appropriate to appoint such an individual this would be undertaken by the Remuneration Committee.
D.2.d Where Executive Directors or senior management are involved in advising or supporting the Remuneration Committee, care should be taken to recognise and avoid any conflicts of interest.	The Remuneration Committee is careful to ensure there are no conflicts of interest created by the advice given to the Committee. The Committee's terms of reference ensure that the Committee has the right to ask for any Director or senior manager to advise the Committee as the Committee feels appropriate.

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
D2.1			
The Board of Directors should establish a Remuneration Committee composed of Non-Executive Directors, which should include at least three independent Non-Executive Directors. The Remuneration Committee should make available its terms of reference, explaining its role and the authority delegated to it by the Board of Directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS Foundation Trust.	The Remuneration Committee has membership from all independent Non-Executive Directors and is chaired by the Chair. The terms of reference are availablefor inspection. The Remuneration Committee has not appointed external consultants.	Comply	Remuneration Committee minutes and terms of reference
D2.2			

The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the Board, but should normally include the first layer of management below Board level.	The Remuneration Committee has delegated responsibility for settting the remuneration of all Executive Director including pension rights and compensation payments. The Trust uses Agenda for Change, and as such the Remuneration Committee does not specifically involve itself with any senior managers remuneration under Agenda for Change. The Remueration Committee requests external benchmarking data to use in determining the Executive Directors' salaries.	Comply	Remuneration Committee minutes and terms of reference
D2.3			
The Council of Governors should consult external professional advisers to market-test the remuneration levels of the Chairperson and other Non-Executive Directors at least once every three years, and when they intend to make a material change to the remuneration of a Non-Executive Director.	The Council of Governors has a Nomination Remuneration Committee that is provided with external benchmarking data, which allows the Committee to test the remuneration level of the Chair and the other Non-Executive Directors. This data is provided through the HR department. The Council of Governors can ask to use an external professional advisory to market-test if they are not satisfied with the information being provided to the committee.	Comply	Minutes of the Nomination Remuneration Committee

Section E: Relations and Stakeholders
E.1 Dialogue with members, patients and local community
Main Principle

Principle	Comment
E.1.a The Board of Directors should appropriately consult and involve members, patients and the local community.	The Board of Directors seeks engagement with members, patients and local communities. The Chief Executive and Deputy Chief Executive attend the Overview and Scrutiny Committee. The Chief Executive is a member of the Health and Wellbeing Board. Other Directors ensure they are engaged with the local community through meetings with stakeholders and the local community. Directors also ensure they consult with members and patients through other methods, such as open forums and patient user groups. Members of the Board regularly attend the Council of Governors.
E.1.b The Council of Governors must represent the interests of Trust members and the public.	The Council of Governors does represent the Trust members and the public. The Council of Governors hold meetings in public and encourages members of the Trust and the general public to attend the meetings and talk to Governors before or after the meeting. The Council of Governors has introduced a dedicated slot in their quarterly meeting programme to informally meet with members and the public. During the current pandemic this has not taken place as all meeting has held virtually via Webex to ensure the organisation complies with the Government guidance on social distancing and large gatherings
E.1.c Notwithstanding the complementary role of the Governors in consultation, the Board of Directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.	The Board of Directors seeks engagement with Trust members, patients and local communities. The Chief Executive attends the Overview and Scrutiny Committee on a regular basis. The Chief Executive is a member of the Health and Wellbeing Board. Other Directors ensure they are engaged with local community through meetings with stakeholders and the local community. Directors also ensure they consult with members and patients through other methods, such as open forums and patient user groups.

Supporting principle

Principle	Comment
E.1.d The Board of Directors should keep in touch with the opinions of members, patients and the local community in whatever ways are most practical and efficient. There should be a members meeting at least annually.	The Board does keep in touch with opinions through engagement with members, patients and local communities. The Board holds meetings that are open to the public on a monthly basis. The Board also ensures that the Governors are provided with a presentation on the Operational Plan before it is approved by the Board. Governors are required to be aware of what the members of the public would like the Trust to provide in terms of services. The Board asks for a number of press releases to be made during the year to ensure the local community is kept up to date with the changes being made in the Trust. The Trust has also started to produce a monthly newsletter which is circulated to all members. The Trust holds an Annual Members Meeting incorporating the Annual General Meeting.
E.1.e The Chairperson (and the Senior Independent Director and other Directors as appropriate) should maintain regular contact with Governors to understand their issues and concerns.	The Non-Executive Directors (including the Senior Independent Director) and Chair do maintain contact with the Governors. The Chair regularly sends emails to the Governors to update them on changes in the Trust. The other Non-Executive Directors meet the Governors on a regular basis at meetings where the Governors are involved.
E.1.f NHS Foundation Trusts should use an open Annual Meeting and open Board meetings, both of which Trusts are required to hold, to encourage stakeholder engagement.	The Trust does use the AMM/AGM and the open Board meetings and Council meetings to encourage stakeholders to engage with the Trust. The Board has held meetings with the Commissioners during the year.

E.1.g Governors should seek the views of both members and the public on material issues or changes being discussed by the Trust. Governors should provide information and feedback to members and the public regarding the Trust, its vision, performance and material strategic proposals made by the Board of Directors.	The Governors are provided with information on issues in the Trust which with the support of the Trust is fedback to members and the public. At the Council of Governors meetings the Board ensures there is up to date information for the Governors to consider. The Chief Executive attends the meeting and updates the Governors on any areas they request additional information on. Governors are encouraged to seek the views of members and a new meeting slot has been provided on Council days to assist with this.
E.1.f It is also incumbent on the Board of Directors to ensure Governors have the mechanisms in place to secure and report on feedback that will enable them to fulfil their duty to represent the interests of members and the public	The Board of Directors do ensure there are processes in place to support the Governors feeding back to the members of the Trust and the public more generally. The Trust encourages Governors to be involved in local community through various forums and to ensure they are aware of the developments being made in the Trust. Governor activity reports are placed on the website, a monthly membership newsletter is now being produced and a number of members seminars have been held. A slot has been introduced on council days for informal chat to members and the public. During the current pandemic this has not taken place as all meeting has held virtually via Webex to ensure the organisation complies with the Government guidance on social distancing and large gatherings

Code provision

Code of Governance reference	Action	Comply/Explain or Action	Evidence
E1.1			
The Board of Directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	The Board of Directors has a Membership Strategy that has been developed with involvement from the Council of Governors. The Board also has clarity about the occasions when it will consult, but does not have a specific document that describes such consultations. The Trust has dedicated sections on the website on how to Get in Touch and Becoming a Member.	Comply	Membership Strategy Trust website
E1.2			
The Board of Directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between Governors and any local consultative forums (e.g. Local Health Watch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	The Annual Governance Statement and Annual Report set out how the public interests of patients and the local community will be represented. The Operational Plan also explains how the interests of patients and the local community is represented. The Annual Report also includes a section that describes the work the Trust undertakes around the interest of patients. The Quality Report also describes how the Trust ensures the interests of the patients are being taken into account.	Comply	Operational Plan, Annual Report and Quality Report
E1.3			
E.1.3. The Chairperson should ensure that the views of Governors and members are communicated to the Board as a whole. The Chairperson should discuss the affairs of the NHS Foundation Trust with Governors. Non-Executive Directors should be offered the opportunity to attend meetings with Governors, and should expect to attend them if requested by the Governors. The Senior Independent Director should attend sufficient meetings with Governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of Governors.	The Chair provides detailed feedback to the Board of Directors on the views of the Council of Governors. The Chair discusses the affairs of the Foundation Trust with the Governors at each meeting and through email and newsletter. The Non-Executive Directors are invited by the Governors to attend both the public and private Council of Governors meetings.	Comply	Minutes from the Board of Directors meeting.
E1.4			
E.1.4. The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between Governors and members from its constituencies. Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website and in the Annual Report.	The Trust publishes a Trust wide email address in the Annual Report and on the website that members can use to contact Governors or members of the Board. A monthly membership newsletter has been developed. Public Council and Board papers are placed on the website and a number of members seminars have been held.	Comply	Annual Report, Newsletter, Membership Development Group agendas and notes
E1.5			

The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members regarding the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of member opinions and consultations.	The Non-Executive Directors regularly attend the Council of Governors and discuss issues with the Governors. The Non-Executive Directors are involved in committees and groups where the Governors are members or attend the meetings. A Board to Council of Governors is held twice a year. The Annual Report includes statements on how the Board of Directors have engaged with the Council of Governors to develop their understanding of the views of Governors. The Annual Report includes information about the role of NEDs, Governors and the Senior Independent Director.	Comply	Diary timetable Annual Report Board of Director Agendas CoG Agendas
E1.6			
The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report. This information should be used to review the Trust's membership strategy, taking into account any emerging best practice from the sector.	The Chief Executive and Non-executive Directors attend the Council of Governors regularly. The Council of Governors has a Membership Development Group which reports to the Council of Governors meeting.	Comply	Council of Governors agendas, minutes and membership reports.

Relevant Statutory Requirement

Principle	Comment
E.1.7. The Board of Directors must make Board meetings and the Annual Meeting open to the public. The Trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	The Board of Directors meetings are open to the public as is the AGM meeting. The Council of Governor meetings are also held in public.
E.1.8 The Trust must hold annual members meetings. At least one of the Directors must present the Trust's Annual Report and Accounts, and any report of the auditor on the accounts, to members at this meeting.	The Trust holds an AMM which incorporates the AGM annually. At least one Director presents the Annual Report and Accounts and any report of the auditor on the accounts to members at the meeting.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
26 May 2021
Fit and Proper Persons Review

/ 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

The Board of Directors is asked to receive and note the assurance provided in relation to the CQC Fit & Proper Person Regulation.

The Board of Directors is also asked to note that all Directors Annual Declarations of Interest have been completed and returned.

/ Executive Summary – Key Points

CQC Regulation 5 Fit & Proper Persons requires the Trust to ensure that there is up to date evidence of checks and records of photographic identification, qualifications and DBS certificates. The matrix and declarations continue to be updated when new members of the Board start in post.

Please see appendix 1 – Matrix of Evidence – All Board members are fully compliant with the regulation.

Directors have also been asked to sign and return their Directors Annual Declaration of Interest which has now been completed and the register updated and published on the Trusts public website.

/ Recommendation

To receive and note the assurance provided in relation to the Fit and Proper Person Annual Review and the Annual Declarations by the Board.

Author: J Hall, Interim Trust Secretary
Director Sponsor: Susan Symington, Chair
Date: 28 May 2021

Appendix 1

CQC 2020 – Fit & Proper Person Matrix of Evidence

Individual	Photographic ID	Evidence can work in the UK	Qualifications	Disclosure and Barring Service	Insolvency Bankruptcy Check	Disqualified Directors Register Check
Simon Morritt – Chief Executive	Halifax Credit Card Statement Copy Passport Copy Driving Licence	✓	Diploma in Coach-Mentoring Master of Business Administration BA Politics	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Andy Bertram – Dep. Chief Executive & Finance Director	Copy Passport Copy Driving Licence	✓	Certificate – the Chartered Institute of Public Finance and Accountancy	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Heather McNair – Chief Nurse	Copy Passport Copy Driving Licence Copy Tax self-assessment	✓	MSc Health & Social Services Management BSc – Midwifery Ser GDip in Midwifery Studies	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Jim Taylor – Medical Director	Copy Passport Copy Driving Licence	✓	GMC Registration confirmed	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Wendy Scott – Chief Operating	Copy Passport Copy Driving Licence Council Tax	✓	Degree Certificate Various others certificates BSc Advanced	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20

Officer			Professional Studies ENB various certificates GCE Certificates Nye Bevan Certificate			
Polly McMeekin – Director of Workforce & OD	Copy Passport Copy Driving Licence Santander Card Summary page	✓	CIPD Member – Chartered Fellow MA in Personnel & Development Health & Human Science Degree	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Lucy Brown – Director of Comms	Copy Passport Copy Driving Licence	✓	PG Cert in Health Communications Shadow Board Certificate CIPR Diploma Psychology Degree	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Dylan Roberts – Chief Digital Information Officer	Copy Passport Copy Driving Licence First Direct & Council Tax letters	✓	Computer Studies Certificates MBA Certificate	Copy of certificate on file	Clean – 23.4.20	Clean – 23.4.20
Sue Symington - NED	Copy Passport Miele Credit Note Gas/Elect Statement	✓	Qualifications seen at Apt. Inst. Of Directors - Chartered Director CIPD – Chartered Fellow	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Jenny McAleese - NED	Copy Passport Copy Driving Licence Council Tax	✓	The Institute of Chartered Accountants in England & Wales	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20

			Certificate			
Lorraine Boyd - NED	Copy Passport Copy Driving Licence Copy Council Tax Demand Notice	✓	Registered with the GMC – No: 2847757	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Lynne Mellor - NED	Copy Passport Copy Driving Licence Copy annual mortgage statement	✓	Master of Business Administration	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Stephen Holmberg - NED	Barclaycard Statement Copy Driving Licence Copy Passport	✓	Medical Degree Membership Royal College of Physicians	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Jim Dillon - NED	Copy Passport Copy Driving Licence N Power monthly statement Yorkshire Water bill	✓	BA – Business Economics with Manpower Studies CIPD	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Matt Morgan – HYMS NED	Copy Passport Barclays Bank Letter	✓	Batchelor of Medicine & Surgery PG Renal Medicine Philosophy Doctorate GMC Registration confirmed	Copy of certificate on file	Clean – 14.05.20	Clean – 26.05.20
David Watson - NED	Copy Passport Copy Driving Licence NPower Bill	✓	Chartered Accountant	Copy of certificate on file	Clean – 21.10.20	Clean – 21.10.20