York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

28 July 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:

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**
12.15	**Lunch**		
13.00	**Board of Directors – Private (including Digital Strategy)**		**Board of Directors**
13.45	**Digital Strategy Workshop**		**Board of Directors**
16.15	**Close**		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
Public Agenda

Date: 28 July 2021
Venue: LNER lounge, York Community Stadium Leisure Complex, Kathryn Avenue, Monks Cross Dr, Huntington, York YO32 9AF
Time: 09.00 - 12.30

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).

ITEM	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 26 May 2021** To be agreed as an accurate record.	Chair	A	9	
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

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
6.	**Patient Story**	Chair	Verbal	-	09.10
7.	**HYMS Update**	Professor Vijay Jayagopal	Presentation	-	09.25
8. 8.1	**Chief Executives Update** To receive an update from the Chief Executive • Board Assurance of Compliance with Asymptomatic staff testing regime	Chief Executive	B	19	09.45
9.	**Board Assurance Framework** To note the report.	Chief Executive	C	25	10.00
Strategic Goal: To deliver safe and high quality patient care					
10. 10.1 10.2	**Quality Committee Escalation Report** Items for escalation to the Board: • To receive and note the minutes of the meetings held on 18 May 2021 and 22 June 2021 • To receive and discuss the committee escalation logs from 22 June 2021 and 20 July 2021	Committee Chair	D1 & D2 E1 & E2	35 & 45 55 & 57	10.05
11.	**Safer Staffing Report**	Chief Nurse	Verbal		10.10
12.	**Medical Staffing Update**	Medical Director	Verbal		10.20

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
13.	**Perinatal Clinical Quality Surveillance Update** (Ockenden)				10.30
13.1	• Perinatal Clinical Quality Surveillance Report	Chief Nurse	F	59	
13.2	• Continuity of Carer Report (Appendix 1-5)	Chief Nurse	G	67	
14.	**Infection Prevention & Control Annual Report (DIPC)**	Chief Nurse	H	75	10.45
14.1	Appendix 1-4				
15.	**Care Quality Commission Report**	Chief Nurse	I	107	10.50
15.1	Appendix A-B				
	BREAK				**11.00**
Strategic Goal: To ensure financial sustainability					
16.	**Resources Assurance Committee Escalation Report** Items for escalation to the Board:	Committee Chair			11.10
16.1	• To receive and note the minutes of the meetings held on 18 May 2021 and 22 June 2021		J1 & J2	115 & 121	
16.2	• To receive and discuss the committee escalation logs from 22 June 2021 and 20 July 2021		K1 & K2	129 & 133	

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
17.	**Integrated Performance Report** To note and discuss the performance of the Trust	Chief Operating Officer Chief Nurse Diector of Workforce & OD Director of Finance	*Separate report*		11.15
Strategic Goal: To support an engaged, healthy and resilient workforce					
18.	**Guardian of Safe Working Hours Q4 report** To receive the report.	Ruwani Rupesinghe	L	137	11.25
Governance					
19.	**Siro Annual Report** To receive the report.	Chief Digital and Information Officer	M	143	11.40
20.	**Fire Safety Policy** To receive assurance and note the changes to the policy.	Chief Nurse	N	165	11.45
21.	**Risk Management Strategy** To approve the strategy.	Chief Executive	O	167	11.50
22.	**Reflections of the meeting**	All	Verbal	-	12.00
23.	**Any other business**	Chair	Verbal	-	12.05

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
24. 26.1 26.2	**Items for information :** • Star Award Nomination Booklet – August • Star Award Nomination Booklet – September				
25.	**Time and Date of next meeting** The next meeting will be held on 29 September 2021.				
26.	**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.**				12.15

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes
Board of Directors Meeting (Public)
26 May 2021

Minutes of the Board of Directors meeting held on Wednesday 28 May 2021 at the Community Stadium, York, commencing at 12.30 and concluding at 14.00.

Members present:

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

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 Communications

In Attendance:
Miss J Hall, Interim Trust Secretary

The Chair welcomed everyone to the meeting.

21/36 Apologies for absence

Apologies were received from Jenny McAleese, Non-Executive Director and David Watson, Non-Executive Director

21/37 Declaration of Interests

The following changes were advised:

Polly McMeekin – remove entry to Nightingale Hospital
Dr Lorraine Boyd – include Trustee of St Monica's
Simon Morritt – remove entry to Reconfiguration Panel
Professor Matthew Morgan – notified of changes to his Declarations of Interest register entry and Fit and Proper Persons Declarations. These would be recorded outside the meeting and the registers updated accordingly.

21/38 Minutes of the meeting held on 31 March 2021

The Board approved the minutes of the meeting held on the 31 March 2021 as an accurate record of the meeting.

RESOLVED
That the Board approved the minutes of the meeting held on the 31 March 2021

21/39 Matters arising from the minutes

No matters arising were discussed.

21/40 Patient Story

Due to technical reasons the patient story was postponed to a future meeting.

21/41 Chief Executives Update

The Chief Executive introduced his regular report, in particular highlighting:

- Numbers of patients in hospital with Covid was down, however he referred to the new variant first detected in India and the importance of continuing to be vigilant. It was noted that there had been no outbreaks of the variant in the Trust to date;
- The Board had agreed at the Timeout session, that as a thank you to staff, an additional days' annual leave would be provided for all staff to take on their birthday The cost will be offset against last year's provision;
- The launch of the new Values and Behaviours was being organised across the hospital sites;
- Work on the Trusts Strategies was ongoing with a Board Strategy session scheduled for 23 June. The work on the strategy would be brought to the Board at its meeting in September for sign off.
- The development of Quality Improvement (QI), reminding the Board that the Trust had partnered with Central London Community NHS Trust who have developed a QI coaching package. The Medical Director added that he was speaking to candidates across the sites to join the project noting it was essential to recruit individuals with the right leadership skills. He added he was exploring bringing in an acute emergency care physician with a QI portfolio.
- The collaborative system work at Bridlington was continuing with the launch of a conversation between the health and social care system and residents of Bridlington, which was running for 6 weeks from the 27 May, on developing plans for a healthier community and how to meet the needs of people. In response to a question on healthcare and education in the area it was noted there were several pieces of work including engaging with schools and East Riding Council on what could be done collectively in terms of careers locally. MM added that this could include linking with the University. The Board further discussed the options this brought and in particular if it was a blue print that could be used in other areas of Place. In response it was highlighted that the key was the ability to engage, SM outlined the areas in particular including Health Care Alliance; East Coast, led by North Yorkshire CCG, and smaller areas likely to be GP led. The Chair welcomed the changes at Bridlington and the ongoing collective work. SM added that other organisations also provided services at the hospital and that the CCG had core responsibility on delivery. JD added the importance of ensuring peoples understanding and some thought needed to go on how the site was referred to. SH added the importance of being clear about which services the trust can actually offer on the Bridlington site, and being equally clear about services which cannot be offered, against the context of the trusts core services being provided at the York and Scarborough acute hospital sites. Effectively being proactive in managing the expectations of the community.

The Board were reminded that working collaboratively was a key strategic objective for the ICS.

RESOLVED
That the Board received and discussed the Chief Executives update report.

20/42 Board Assurance Framework

The Board received the report of the Chief Executive which provided an update on progress to develop the 2021/22 Board Assurance Framework (BAF). The Board were reminded that at the April Board Time Out session it had agreed the new template and noted the changes being made to the Risk Management Framework and Corporate Risk Register (CRR). The report outlined the conversations had at the first Risk Committee on 26 May on the Principal Risks to the Strategic Objectives, as set out in the report, and signed off by the Committee.

An amended Risk Management Framework (RMF) had been discussed by the Committee and following the Board's approval would be published on the Trust Intranet site. Once the work on risk appetite was complete this would be included in the RMF as part of a full review.

The Chief Nurse reported that the RMF had been shared with the CQC at a recent meeting and they were complimentary saying it reflected a step change.

The Board discussed the principal risks identified in the BAF noting that the Lead Executive could be more than one and that a trend analysis would be included in the summary report. The Risk Committee would report through to the Assurance Committees to Board on any changes to the CRR.

LM welcomed the new format, in response to a question on finance risks on the BAF it was noted that finance was on both the BAF and CRR, the Finance Director explained that currently the way in which Trusts were funded meant it was not a high risk.

The Board agreed changes to Principal Risk 1 – *Inability to meet clinical standards (NICE guidance, learning from Incidents)* to include Constitutional targets; and that the lead Executive for PR3 *Inability to fill vacancies and develop existing staff due to unavailability of workforce supply and skills being unable to meet demand*, should be the Director of Workforce & OD, Chief Nurse and Medical Director. Education, and research and development were also discussed

Following a discussion on preparation for a CQC visit the Board agreed that the Chief Nurse would update the briefing documents produced for the last CQC inspection.

Action: Chief Nurse

The Chair of the Quality Assurance Committee added that the Committee had requested the documents be updated and should include a 'look forward'. In response it was noted the work was underway, and included use of resources, and would be brought to the Board in due course. The Board noted that the CQC had requested to recommence attending future meetings. The Chief Operating Officer expressed the importance of staff being able to articulate improvements in care as well as all the good things that are happening to the CQC and other stakeholders. The Chair of the Quality Assurance Committee added that the Committee had discussed this at length recognising the amount of work needed to be put in place to move forward.

RESOLVED
That the Board:

a. **Agreed the Principal risks subject to amendments to PR1 to include *Constitutional Targets,* and PR3 – that the lead executive be the *Director of Workforce & OD, the Chief Nurse and Medical Director*; and,**
b. **Approved the changes to the Risk Management Framework.**

21/43 Quality Assurance Committee Escalation Report

The Chair of the Committee introduced his report which set out a number of matters the committee had discussed at its meeting in May 2021 to escalate to the Board, this included an ongoing short-fall in medical resource in key areas; an ongoing concern about the rate of C Difficile infections especially in Scarborough, the fabric of the building in clinical areas contributing to the risk; concerns around long waiting for diagnostics, particularly endoscopy and non-obstetric ultrasound; an update was given on the Ockenden Report, in particular obstetric ultrasound.

During discussion LB gave more detail on the Ockenden report and reminded the Board of its responsibility around the maternity agenda. She reminded the board that the maternity agenda was overseen by the Chief Nurse and supported by herself as NED Maternity Safety Champion. She added that three risks were beginning to materialise:

1. Conditions with the CNST rebate - compliance obstetric scanning and non-compliance with Saving Babies Lives v2 (safety action 6);
2. An aging estate risk and closure of labour wards pending repairs;
3. Lack of midwives and clinical staff

RESOLVED
That the Board received and noted the Quality Assurance Committee Escalation Report.

21/44 Nurse Staffing Report

The Board received and noted the regular report from the Chief Nurse which provided assurance to the Board on the nursing and midwifery (safe) staffing levels for March 2021. The report had previously been discussed by the Quality Assurance Committee who had requested a trajectory on recruitment. It was noted that international recruitment was continuing, however there had been a temporary suspension on nurses from India. In response to a comment on training, the Chief Nurse explained that local training had been approved and would likely be Place based. She also refrred to the intake of student nurses from Coventry University at Scarborough which was increasing from 20 students in 2021, rising to 60 in 2023.

The report set out the initiatives and actions being taken to increase nurse numbers.

The Board discussed the report in particular staff retention in acute medical areas, noting that initiatives to move staff to work in other areas for short periods had not improved retention rates.

RESOLVED
That the Board received and noted the report.

21/45 Perinatal Clinical Quality Surveillance Report

The Chief Nurse introduced the report reminding that this was a regular report in response to Ockenden review and recommendations. The new quality surveillance model was introduced to provide consistent oversight so as to identify and address any arising issues.

The Chief Nurse highlighted the non-compliant areas as: CNST Saving Babies v2 (safety action 6) due to being unable to meet the current guidelines on scanning; safety action 4, clinical workforce. The Board noted the detailed action plan developed to improve compliance.

The Board noted a bid for funding had been submitted and a response was due shortly. The national pot of money equated to £700k per organisation and to bridge the likely shortfall in funding a business case would be submitted to the Executive Committee. The importance of filling vacancies was emphasised however noting that there was a national shortage of midwives. It was further noted that non-compliance with Ockenden affected the CNST premium with a knock-on effect to the Care Group who usually benefitted from the premium reduction.

The Finance Director referred to the partial compliance with safety action 6 and the withdrawal of an external company who provided a service to review scans, adding that the £150k funding was still available, however following a subsequent quote of £450k to provide the service the Care Group had decided not to engage. The Chief Nurse explained that the Executive Committee had agreed to the uplift of salaries for stenographers from a Band 7 to 8a to bring pay in line with other local trusts. She described other initiatives including the training of Midwives. The Board noted that a plan had been signed off to support the Trust being compliant, as required, by the end of 2021.

In response to a comment on the reluctance of staff to change their ways of working and so preventing progress it was noted that Trusts had to comply with the national guidelines as set down. The Chief Nurse added that other areas of non-compliance were where there was no clear line of sight. A piece of work was being done to address this.

LM commented on the actions log and requested these were put into a standardised format so as actions and issues were clear.

RESOLVED
That the Board received and discussed the report and noted the progress in relation to the Ockenden required minimum dataset around perinatal clinical quality.

21/46 Clinical Workforce Review – Maternity Incentive Scheme

The Chief Nurse introduced the report which provided an update on the clinical workforce review including action plans and provided information on compliance in relation to Maternity Incentive Scheme standard 4. In particular it was noted that most organisations were struggling to deliver the Ockenden recommendations, she added that the timescales to deliver the continuity of carer recommendations would slip.

RESOLVED
That the Board agreed the proposed action plans.

21/47 Infection Prevention and Control Monthly Report

The Board received and noted the report of the Chief Nurse which summarised information on healthcare-associated infections (HCAIs) for April 2021. The report also provided assurance on actions being taken to reduce HCAIs. It was noted that the IPC team were now working proactively. Plans had been developed to carry out remedial work on some wards including obstetric theatres to address surgical site infections.

The Board noted the report for information.

21/48 Care Quality Commission (CQC) Update

The Board received the report which provided an update on progress with the CQC action plan for 'should do' and 'must do' actions. The Board noted that the Quality Assurance Committee had discussed the action plan in depth. It was further noted that following the request to remove 7 notifications, 3 associated with York Hospital and 4 associated with Scarborough Hospital, formal notification of the outcome was awaited. The Chief Executive added that there was confidence that 5 of the 7 notifications would be lifted. Further information had been requested for mental health risk assessment audits within the emergency departments.

RESOLVED
That the Board received and noted the updated position for the Trust in relation to CQC action plans (Section29A, Section 31, and Must-Do actions).

21/49 Resources Committee Chairs Report

LM introduced the report which set out a number of matters the Committee had discussed at its meeting on 18 May 2021 and sought to escalate to the Board, this included an update on month 1 finance which showed a £1m surplus, £0.5m due to an under-spend on COVID related items; an analysis of COVID-related spend, the Committee applauded the quality of financial controls that have operated throughout COVID; discussed the People Plan and the below average scores on the staff survey; concerns raised in relation to Capex available to support essential fixes to core IT and cyber infrastructure. The Chief Digital and IT Officer (CDIO) added that Cyber was the biggest risk on the Corporate Risk Register.

The Board discussed the financial position and if, going forward, the ICS could claw back any underspend, in response it was noted that in future monies could be moved around. A discussion was also had on investment and non-recurrent funding which would impact on future years. The CDIO added that a lot of items bought through COVID had a recurrent cost which would create significant pressures.

RESOLVED
That the Board received and noted the Resources Committee Chair escalation report.

21/50 Integrated Business Report

The Chief Operating Officer provided an update on operational issues as set out in the IBR. In particular highlighting 6 week diagnostics test achieving 66.2% performance against a target of 99% in March, she outlined the challenge and the national ask to risk stratify those waiting longer than 6 weeks. A first submission was due on 1 July 2021. Demand across all services, elective and non-elective, had increased with ED back to

2019 levels. The increase in out-patients was above those seen in April 2019 which was adding to pressures, as well as managing the backlog. She added this was being experienced nationally and the Humber Vale and Coast ICS was seeing an unprecedented rise. There had been good progress against Cancer targets.

In response to a comment on socially distancing beds and the impact on capacity and productivity it was noted that there was a need to be flexible, the pressure nationally, would be the pace of recovery and risk assessments.

In response to comments on winter pressures it was noted that planning had commenced and would need to include the eventuality of COVID and flu co-existing which would be challenging. The NHS was planning for a third COVID surge. It was noted that 5% of bed base was identified for COVID patients and the plan needed to take into account this could rise. The plan would be brought back to the Board.

Action: COO to bring Winter Plan report back

LM asked if there had been an increase in the number of young people and children with mental health issues and particularly an increase of eating disorders, in response it was noted that there had not been a significant rise to date. The Chief Nurse reported on the increase in safeguarding. SH reported on a recent paediatric ward walk-about in which staff were concerned with the lack of support from mental health services, it was noted that some Trusts were employing mental health nurses.

The Chief Nurse highlighted an increase in the number of falls and pressure ulcers, a number of these patients were deconditioned on arrival.

RESOLVED
That the Board noted and discussed the Integrated Board Report.

21/51 Operational Plan – Final Report

The Chief Operating Officer introduced the report reminding the Board that it had approved the plan for submission at its meeting in April. The report provided an update on feedback on the draft plan including the oversight and assurance meetings that had taken place during May which had considered adjustments prior to the final submission. The Board discussed the report at length in particular the adjustments made to the elective and non-elective plans, and financial opportunities as set out in the report. In response to bidding for ERF it was noted that the estimation had increased from £6m to around £9.3m following the publication of the new guidance on allocation. The Finance Director explained ERF funding and that the Trust could be due around £3-4m above activity, he highlighted this would be revenue not capital. The Board discussed and noted that unless activity grew the non-elective activity in the plan was achievable.

The Board discussed the financial elements of the plan particularly any surplus, noting that the ICS Finance Directors Group had a document which defined the principles and made clear there was some financial incentive to work above plan to build reserves to supplement capital. The Chief Operating Officer added that mutual aid was a key element.

In response to a question from LM about mitigation to risks, the Chief Operating Officer reported that there was some mitigation which was reliant on capacity and would be impacted if there was an increase in demand and COVID.

RESOLVED
That the Board:

a. **Approved and noted the adjustments to the final operating plan for inclusion in the submission to the ICS in the final plan;**
b. **Approved and noted the amendments to the trajectory for the Trust's Total Waiting List; and,**
c. **Noted the risks to delivery and that the ongoing monitoring of those risks to be reported through the Quality Assurance Committee.**

21/52 Research Presentation

The Board welcomed Lydia Harris, Head of Research and David Yates, Clinical Lead for Research who provided a presentation on research plans. The presentation highlighted the benefits of research in terms of income, recruitment and retention, better outcomes for patients and CQC results which were better in a research active hospital. The Board noted that as research activity was low, the Trust was only receiving £20k per year, it was noted that Hull and Leeds received significantly more.

The presentation outlined the Research Strategy 2021/24 and opportunities for nurses, midwives and other groups to engage in research. Untapped income was also highlighted.

The Board discussed the presentation and were supportive, noting that improving and developing the trust profile as a research organisation would require a cultural change. It was suggested that job descriptions/plans should include time for research and in some cases be part of HYMS with a clinical academic in post. The Finance Director added that following discussion with LH there was an opportunity to support the development of a project manager whose role would be to exploit grant opportunities.

The Board thanked LH and DY for the presentation.

21/53 Code of Governance

The Trust Secretary introduced the report which sought to provide assurance to the Board on compliance with the Code. The Board noted the compliance status and that there had been some updates since the last report in 2020.

RESOLVED
That the Board approved the changes to the Code of Governance.

21/54 Fit and Proper Persons Requirements

The Board received and noted the report which provided assurance in relation to the CQC Fit and Proper Person Regulation.

RESOLVED
That the Board received and noted the assurance provided in relation to the Fit and Proper Person Annual Review and the Annual Declarations by the Board.

21/55 Reflections of the Meeting

The Board reflected on the meeting:

- Good to be back face to face
- Enjoyed the meeting and the Research presentation

21/56 Any Other Business

No further business was discussed.

21/57 Time and Date of next meeting

The next meeting will be held on 28 July 2021, at the Community Stadium, York

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 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
  - COVID-19 update
  - COVID-19 staff testing (LAMP)
  - COVID-19 mouthwash trial
- The Humber, Coast and Vale Health and Care Partnership objectives
- White Paper
- Good Business Charter
- York Hospital Emergency Department
- Scarborough Multimorbidity Research Hub

/ Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: 28 July 2021

1. COVID-19

1.1 COVID-19 update

The Trust has seen a slow but steady rise in the number of COVID positive patients in recent days and at the time of writing we now have a COVID ward at both Scarborough and York hospitals.

The Trust has robust surge plans in place which detail when and how to release additional beds and staff to convert wards into 'COVID wards' and create additional critical care capacity in a phased way. Many of the things we will need to do to manage another wave, such as isolating and testing patients, and creating separate areas for infected and non-infected patients, are already firmly established and have been well tested, which puts us in the best position possible.

Added to this, operational pressures are being felt across all system partners and our hospitals are no exception. There is no doubt our emergency departments are busier than usual, which includes an increase of children being presented. In June 2021 our emergency departments saw a 12% rise in attendance when compared to the same time in 2019 (pre-pandemic), which is an additional 1,260 patients attending our hospitals.

Concurrently we are working hard to catch up on elective procedures which were affected by the pandemic. Despite the operational pressures we are facing, we have been able to make significant progress against our agreed recovery plan, particularly for urgent and long wait care. Since February, at the height of the last COVID-19 wave, there has been a 42% reduction in the number of patients who have had to wait for more than a year for treatment in our hospitals.

Increased staff absence is a combination of staff sickness and the impact of Track and Trace, but we working hard to ensure we are maintain safe staffing levels through the use of bank and agency staffing.

1.2 COVID staff testing

Despite the success of the national vaccination campaign, given the recent trend of rising numbers of COVID-19 cases in the community, it is more important than ever that staff participate in a testing programme that identifies asymptomatic cases, in order to limit the spread of the virus and protect themselves and patients.

Nationally, the latest data at the time of writing, from swab tests in the community suggests one in every 160 people now has the virus. This is up from one in every 250 in the previous week. For England, it is the highest level since mid-February and numbers of COVID inpatients are also increasing across trusts in all geographical areas, including our own.

While the vast majority of Trust staff (85%) are now fully vaccinated, it is still entirely possible to catch and spread COVID-19 while not displaying symptoms of the virus.

Despite the successful organisation and deployment of the logistical arrangements to support the LAMP self-testing programme and an extensive communications plan, the general take up rate within the Trust remains low.

The anticipated forecast take up from initial start at 5% to 40% after 10 weeks based on actual experience from one Hospital Trust is well below expected take up. The actual

take-up after 8 weeks was 9.59% against a forecast 22.3%. As at mid-July, this stands at approximately 12% of the total staff group within the Trust.

Reasons for low take up include perception of immunity following double vaccination, staff being used to/continuing with lateral flow, issues around the information portal registration and feedback on sample rejection.

Given the importance of staff asymptomatic testing and the expectation from NHSE/I that NHS organisations ensure staff comply with a locally agreed testing regime, senior managers and care groups will be tasked to actively endorse and promote the LAMP programme through the line management structure, with the clear expectation of a commitment to self-testing in their teams.

Going forward, the Trust Board will be sighted monthly on organisational compliance as part of our Board Assurance Framework.

1.3 COVID mouthwash trial

The Research Department is undertaking a clinical trial to see whether using mouthwash can inactivate the COVID-19 virus.

A previous study between the Trust and Public Health England (PHE) has proven that multiple commercially available mouthwashes reduce the level of SARS-CoV-2, the virus that causes COVID-19, in a laboratory setting. This trial is to investigate how well the mouthwashes perform in the real world and how long the effects last for.

The trial, which is taking place at York Hospital, invites volunteers to rinse their mouth using a mouthwash and then provide saliva samples at different times during a one hour period. These samples are then analysed to see if the COVID-19 virus is present and at what levels.

2. White Paper

The government's Health and Care Bill, which sets out plans to reform the NHS in a bid to deliver more joined up care, has gone through the first reading of parliament. If it is accepted the timetable for implementation is anticipated to be 1 April 2022.

3. The Humber, Coast and Vale Health and Care Partnership objectives

The Humber, Coast and Vale Health and Care Partnership has issued its strategic objectives for 2021/22.

These objectives set out the direction of travel of the Partnership over the next 12 months, which culminates in the HCV Partnership, as the region's integrated care system, being embedded into legislation from April 2022 subject to legislation approval.

The objectives have been developed in collaboration with health and care leaders in Humber, Coast and Vale, including senior leaders from NHS organisations and local authorities.

In summary:

- Continue to use the strength of the Partnership to support organisations to work together for the good of our communities, patients and staff.

- Continue to strengthen partnership working at all levels to continue to combat the consequences of the pandemic and build back resilient health and care services that fulfil the needs of our communities, patients and our staff.

- Address the wider societal and economic impact of COVID-19, as well as other health inequalities which have been exacerbated by the pandemic.

- Support the health and wellbeing of staff and invest in recruitment and retention of our workforce and establish governance to ensure our people receive the high-quality care they deserve.

- Recover and transform mental health and learning disabilities services, expand capacity in primary care to improve access and transform community and urgent and emergency services.

- Manage the transition to new arrangements for integrated cares systems in accordance with the Government's White Paper to improve health and social care services. This includes successfully redeploying people in accordance with the employment commitment in the policy guidance for integrated care systems and the regional guidelines agreed by NHS England and NHS Improvement and the integrated care systems in North East and Yorkshire.

Find out more: www.bit.ly/HCVobjectives

4. Good Business Charter

The Trust has been accredited under the Good Business Charter, making us the first NHS trust nationally.

The Good Business Charter has been developed in partnership with the Confederation of British Industry, the Trades Union Congress and Federation of Small Businesses and promotes responsible behaviour through ten key components, including employee wellbeing, diversity and inclusion, environmental responsibility and ethical sourcing.

York has become the first city in the UK to sign up to the Good Business Charter. Key organisations in the city of York who have signed up to the charter include the City of York Council, the University of York, Aviva, the Joseph Rowntree Foundation and the Trust.

I am delighted that we are the first NHS trust nationally to be recognised and accredited by the Good Business Charter, which demonstrates the values that we believe in and our commitment to responsible and good business practices.

5. York Hospital Emergency Department

Work is due to begin in earnest on the £15 million project to expand and reconfigure the department's urgent and emergency care facilities. This will deliver a vital new eight bedded resuscitation area along with improvements to both the waiting room and the consultation and treatment areas.

As well as twelve new assessment and treatment cubicles, where patients will be met by the senior team as soon as they arrive, there will be a dedicated safe room for mental health patients.

There is a new resuscitation zone which will increase capacity significantly, with a dedicated area for children. There will also be a new infectious diseases cubicle that

includes a point of care testing laboratory and glazed cubicles for privacy and infection control.

The new remodelled waiting area will include a separate children's area and supporting facilities such as a nappy changing area.

I appreciate we have lots of building activity on the go at the moment, particularly on the York site, which is less than ideal and we know it is causing some disruption. However this investment will provide the much needed extra space and facilities we need, and improve initial assessment and faster decision making for patients, as well as creating a much better working environment for staff.

6. Scarborough Multimorbidity Research Hub

The Trust and Hull York Medical School has agreed to jointly fund the creation of a Scarborough Multimorbidity Research Hub.

Research plays a vital role in improving patient outcomes by increasing our understanding of health and disease, by developing and refining evidence-based interventions and by enhancing service delivery.

The Hub will enable patients who have previously not had the opportunity to benefit from research to take part in studies. By working across primary and secondary care boundaries, it will allow patients, whose care is normally delivered in the community setting (e.g. GP surgery based diabetes clinics) to access more research projects.

It is anticipated that the Hub will be operation from November 2021.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021
Board Assurance Framework

/ 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 note the progress to date on the development of the BAF and next steps.

/ Executive Summary – Key Points

The first iteration of the BAF, in its new format, was presented to the June meeting.

At the Boards meeting in August there will be workshop session on Risk Appetite Following this session the Head of Risk and the Trust Secretary will meet with Executive Directors to review the BAF including updating the controls and assurances, identification of any actions and rescoring the newly stated risks. The target risk score will not be set until we have the Board agreement of risk appetite.

/ Recommendation

The Board is asked to note the on-going progress on developing the Board Assurance Framework and the ongoing work with Executive Directors.

Author: Jill Hall, Interim Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: 28 July 2021

Board Assurance Framework
Summary Report

Board Assurance Framework

Strategic Objective: To deliver safe and high quality patient care as part of an integrated system

Principal Risk Ref	Risk Title	Risks description:	Lead Director
PR1	Clinical Standards	Inability to meet clinical standards (NICE guidance, learning from SIs etc)	HN/JT/ WS
PR2	Minumum service standards	Failure to deliver the minimum service standard for IT and keep data safe	DR
PR3	Covid-19 recovery	Risk of non-delivery of national, system and local efficiency and productivity requirements necessary as part of the economic recovery from covid-19	WR
Strategic objective: To support an engaged, healthy and resilient workforce			
PR4	Capacity and capability of workforce	Inability to fill vacancies and develop existing staff due to unavailability of workforce supply and skills being unable to meet demand	PM/JT
PR5	Succession planning	Failure to manage the leadership and wider workforce talent pipeline	PM
PR6	Agile working	The infrastructure and culture of the Trust does not support an agile workforce	PM
Strategic objective: To ensure financial sustainability			
PR7	Inadequate funding	Risk of inadequate funding to deliver the Trust and System Strategies; comprising inadequate revenue funding to meet the ongoing running costs of service strategies, inadequate capital funding to meet infrastructure investment needs and inadequate cashflow to support operations.	AB

Strategic Objective: To deliver safe and high quality patient care as part of an integrated system						
Risk description:	Inability to meet clinical standards (NICE guidance, learning from Incidents, Constitutional targets etc)				**Risk appetite:**	
Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Quality**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Heather McNair/Jim Taylor/Wendy Scott**
Overall risk rating					**Links to CRR:**	**CN1, DIS2, MD1, COO1**

Controls	Gaps in Control	Sources of Assurances (including Line of defence)	Assurance rating	Gaps in Assurance
Conduct Incident Reporting, SIs/Never Event Reports	None identified	- Audit of action plan following investigation - Datix incident reports		None identified
Recording of escalations e.g. NEWS	None identified	Escalations captured on CPD		None identified
Conduct National Surveys, NICE, NSF & Clinical Audit	- Volume of data makes it difficult to focus on key issues - Data does not always flow through correct governance	- HED reporting - National survey results - clinical effectiveness audit portfolio		None identified
Implementation of Clinical and Professional standards for Doctors	None identified	Registration Appraisal and Revalidation system & process Revalidation Report to Board		None identified
Use Performance Management Framework	None identified	- Monthly meetings with Care Groups - QPaS minutes		None identified
Conduct Trust operational planning	None identified	- OPAM minutes - Exec Co minutes - IBR		None identified
Monitoring by Corporate Performance team	IBR doesn't contain external benchmarking	IBR		None identified

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date

Strategic Objective: To deliver safe and high quality patient care as part of an integrated system						
Risk description:	Failure to deliver the minimum service standard for IT and keep data safe				**Risk appetite:**	

Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Resources**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Dylan Roberts**
Overall risk rating					**Links to CRR:**	**DIS1, DIS3, DIS4**

Controls	**Gaps in Control**	**Sources of Assurances (including Line of defence)**	**Assurance rating**	**Gaps in Assurance**
Implementation of Data Security and Protection Toolkit standards and principles	None identified	- Audit of IG compliance		None identified
IG and Security Governance arrangements in place e.g. IG Executive	None identified	- Resources Committee minutes - IG Executive Group minutes		None identified
Password protocols aligned to NCSC guidance	None identified	- System enforced control		None identified
Trust Portable devices encrypted - mobiles and laptops	None identified	- System enforced control e.g. bit locker encryption on Trust laptops		None identified
Implementation of IG policies and procedures	None identified	- Published on intranet - Stat/mand training		None identified
The identification, investigation, recording and reporting of IG incidents	None identified	- Reported to IG Executive - Incidents logged on Datix		None identified
Review and sign-off of IG documentation	None identified	- IG team sign-off		Further evidence required of IG documentation being signed-off

Action Plan: *flight path to green (target)*

Action description	**Progress to date / Status**	**Lead action owner**	**Due Date**

Strategic Objective: To deliver safe and high quality patient care as part of an integrated system						
Risk description:	Risk of non-delivery of national, system and local efficiency and productivity requirements necessary as part of the economic recovery from covid-19				**Risk appetite:**	
Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Quality**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Wendy Scott**
Overall risk rating					**Links to CRR:**	**COO1**

Controls	Gaps in Control	Sources of Assurances (including Line of defence)	Assurance rating	Gaps in Assurance
Oversight of performance via the Operational Performance	None identified	- Reporting of performance metrics through governance structure - Integrated Board Report - CG dashboards to inform to CG board discussions - Dashboard reporting across KPIs and clinical services		None identified
Implementation of the Performance Management Framework	None identified	- Operational meetings to monitor and respond to operational requirements, risks and issues		None identified
Implementation of surge plans	None identified	- Scenario testing of surge plans		None identified
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements		None identified
Implementation of winter plans and resilience plans				
Development of the clinical strategy				- Clinical strategy is still in draft so control not yet
Implementation of building better care programme	None identified	- Programme structure, resource requirements and assurance documentation agreed.		Programme to be initiated in July therefore control has not yet been operationalised.
Clinical Risk stratification, validation and monitoring of waiting lists	None identified	- Risk stratified elective waiting lists.		- Diagnostic waiting lists to be risk stratified in July; outpatient list to follow.
Deployment of health inequality assessment to inform waiting list management	None identified	- Health inequality lead at board		- Reporting against health inequalities

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date

Strategic Objective: To support an engaged, healthy and resilient workforce						
Risk description:	Inability to fill vacancies and develop existing staff due to unavailability of workforce supply and skills being unable to meet demand				**Risk appetite:**	
Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Resources**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin / Jim Taylor**
Overall risk rating					**Links to CRR:**	**WFOD1, WFOD2**

Controls	Gaps in Control	Sources of Assurances (including Line of defence)	Assurance rating	Gaps in Assurance
Implement Workforce models and planning	National contract limitations			None identified
Target overseas qualified staff	None identified	- QIA for new nurse roles - CHPPD		None identified
Incentivise recruitment	None identified	Reduced vacancy rates in IBR		None identified
Monitor staffing levels (temp/perm)	None identified	- IBR - Executive Committee Agency Usage Report		None identified
Oversight of rotas - e-Rostering	None identified	- Internal Audit reports on E-Rostering - CHPPD		None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas			None identified
Monitor performance against the People Plan	None identified	Resource Committee updates against the People Plan		None identified
Implement Workforce & OD Strategy	None identified	- Board/Committee papers - Equality, diversity and inclusion data reporting		None identified
Oversight of training needs				
Monitor Bank Training Compliance				

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date
Implement Workforce Plan			**Oct-21**
E-Job planning			**Mar-22**
HCV Workforce Action Plan			**Oct-21**
Deliver medical recruitment project			**Dec-21**
International Nurse Recruitment			**Mar-22**
Implement Medical E-Rostering system			**Dec-21**

Strategic Objective: To support an engaged, healthy and resilient workforce						
Risk description:	Failure to manage the leadership and wider workforce talent pipeline				**Risk appetite:**	
Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Resources**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin**
Overall risk rating					**Links to CRR:**	**WFOD2**

Controls	Gaps in Control	Sources of Assurances (including Line of defence)	Assurance rating	Gaps in Assurance
Implement Workforce & OD Strategy	Poor diversity in leadership positions (gender pay, race equality)	- Board/Committee papers - Equality, diversity and inclusion data reporting		None identified
Delliver Board development sessions	None identified	Board/Committee papers		None identified
Conduct Talent Management Framework	None identified	- Learning Hub - PREP		None identified
Design and Deliver Internal Leadership Programmes	None identified	- List of programmes on Learning Hub		None identified
Develop Succession plans	None identified	- Workforce plan - REMCOM papers		None identified
Conduct NED development programme	None identified	- Updates from Gatenby Sanderson		None identified
Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Equality, diversity and inclusion data reporting		None identified

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date

Strategic Objective: To support an engaged, healthy and resilient workforce						
Risk description:	The infrastructure and culture of the Trust does not support an agile workforce				**Risk appetite:**	
Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Resources**	
Impact				**Last reviewed:**		
Likelihood				**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin**
Overall risk rating					**Links to CRR:**	

Controls	Gaps in Control	Sources of Assurances (including Line of defence)	Assurance rating	Gaps in Assurance
Communicate guidance for Managers for remote working	Space restrictions	- Workforce data		None identified
Implement Values and behaviours	Workforce pipeline	- Staff survey - Employee Relations data		None identified
Implementation of DIS strategy	Limited funding to invest (in DIS)	- DIS reporting		None identified
Implementation of People plan	None identified	- Staff survey - Board / Committee papers		None identified

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date

Strategic Objective: To ensure financial sustainability						
Risk description:	Risk of inadequate funding to deliver the Trust and System Strategies; comprising inadequate revenue funding to meet the ongoing running costs of service strategies, inadequate capital funding to meet infrastructure investment needs and inadequate cashflow to support operations.			**Risk appetite:**		

Risk Rating	**Initial**	**Current**	**Target**	**Initial date of assessment:**	**Lead Committee: Resources**	
Impact	5	4	3	**Last reviewed: June 2021**		
Likelihood	5	3	2	**Target date: Month / Year**	**Risk Owner:**	**Andrew Bertram**
Overall risk rating	25	12	6		**Links to CRR:**	**FIN1**

Controls	**Gaps in Control**	**Sources of Assurances (including Line of defence)**	**Assurance rating**	**Gaps in Assurance**
Annual Business Planning process including Trust Strategy	Lack of clarity over funding from NHSE/I due to pandemic emergency financial regime.	Business planning schedules. Internal audit review of Business Planning process.		None identified
Preparation and sign off of annual Income and Expenditure plan	Unaffordable but necessary revenue developments.	Executive Committee and Board of Directors approved plan. Approved by NHSE/I and ICS.		None identified
Routine monitoring and reporting against I&E plan	None identified	Monthly structured reports provided to; Care Group OAMs, Resources Committee, Financial Review Meetings, Executive Committee, Board of Directors.		None identified
Expenditure control; scheme of delegation and standing financial instructions.	None identified	Board of Directors approved scheme of delegation and SFIs. System enforced delegation and approval management.		None identified
Expenditure control; business case approval process	Investments approved outside of the business case process. Unplanned and unforeseen expenditure commitments.	Business Case Register. Internal audit review of Business Case process. Variance analysis by Financial Management.		None identified
Expenditure control; segregation of duties	None identified	System enforced approval. No Purchase Order No Payment policy.		None identified
Expenditure control; staff leaver process	Management failing to notify Payroll in a timely way of staff leavers	Contract change notification process.		Limited visibility to issue
Income control; income contract variation process	Unforeseen and unplanned in-year reduction in income.	Income Adjustment form register.		None identified
Capital planning process including Trust and Estates Strategy	None identified	Schedules detailing capital investment needs. Backlog maintenance programme. Essential Services Programme for IT.		Limited visibility to investments required but not progressed.
Preparation and sign off of annual capital programme	Unaffordable but necessary IT infrastructure replacement needs and unaffordable estate backlog maintenance needs.	Executive Committee and Board of Directors approved plan		None identified

Routine monitoring and reporting against capital programme	None identified	Routine reports provided to; CPEG, Resources Committee, Executive Committee, Board of Directors		None identified
Overspend against approved scheme sums	None identified	Scheme sum variation process. Scheme expenditure monitoring.		None identified
Preparation and sign off of cash flow plan	None identified	External Audit review as part of Going Concern work. Plan approved by Executive Committee and Board of Directors		None identified
Routine monitoring against cash flow	None identified	Cash committee. Routine reporting to Executive Committee, Resources Committee and Board of Directors.		Under the current emergency fincial regime there is no tracking of cash against plan at Executive Committee or Board of Directors.
Cash flow management through debtors and creditors	Debtor cash flow issues delaying payment to the Trust	Monthly debtor and creditor dashboard to Finance Managers and Care Groups. Trend data reported to Executive Committee, Resources Committee and Board of Directors.		None identified

Action Plan: *flight path to green (target)*

Action description	Progress to date / Status	Lead action owner	Due Date
Awaiting planning guidance and funding allocations for H2. As soon as available plan for H2 will be prepared.	H1 agreed. Awaiting NHSE/I info for H2	A Bertram	**Sep-21**
Quarter 1 review of the capital programme to identify unallocated funds for priority investment.	Review paper to June Exec, Resources & Board.	A Bertram	**Aug-21**
Review cash flow forecasting when H2 allocation details are released.	Awaiting H2 allocation details	A Bertram	**Sep-21**

D1

NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes

Quality Assurance Committee

18 May 2021

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

/ Attendees: Sue Symington (SS), Donald Richardson (DR)

/ Apologies for Absence: James Taylor (JT), Jill Hall (JH)

/ Declaration of Interests

There were no declarations of interest.

/ Minutes of the meeting held on 20 April 2021

P11 – LS requested rewording from 'LS said it was reassuring that there was the same amount of cancer diagnoses last year as in previous years' to 'LS said it was reassuring that there was a comparable amount of cancer diagnoses last year as in previous years for most tumour sites.'

Other than this the minutes of the last meeting held on 20 April 2021 were agreed as a true and accurate record.

/ Matters arising from the minutes

P6 – CJ confirmed that all overdue clinical effectiveness and SI actions are being reviewed for further assurance. The Committee noted the high numbers of outstanding actions but without detail of severity, impact was uncertain and agreed more clarity is needed.

P9 – JM asked whether the issues with documentation of 14-hour reviews are with software or with CPD itself. DR said the issue is that some consultants are not using CPD during ward rounds and confirmed he has a meeting booked with Amanda Vipond (Care Group 3 Director) and Marco Baroni (Consultant Vascular Surgeon) to discuss further and try to facilitate change. The Committee noted that a cultural change rather than technology change is needed.

Action 96 – HM confirmed no further incidents and the Committee agreed to close the action.

Action 99 – the Committee agreed to review once the new Associate Director of Corporate Governance is in post.

Action 103 – HM confirmed a Task & Finish Group has been set up to be headed by Tara Filby (Deputy Chief Nurse) and the first meeting will be in June 2021.

Action 104 – HM confirmed the bid for a 1-year dementia post was not supported. The Committee encouraged resubmission - HM agreed to this and advised that work will start in the meantime.

Action: HM to include details on work to reduce line infections in IPC report

/ Escalated Items

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

IBR Overview to look at Patient Safety, Effectiveness and Patient & Carer Experience

The Committee expressed concern of consistently red areas (e.g. 14-hour reviews) and there was a group discussion about how assurance can best be obtained. The Committee agreed there could be greater triangulation between consistently red risks and how they are reflected in the risk register. JM noted triangulation between some red areas and themes from the Learning from Deaths Group papers and was concerned by no evidence of an action plan to address these.

DR said recording needs to be improved (both electronically and on paper) until the move to digital as well as ensuring the provision of 14-hour reviews by ensuring reliability of proactive in evenings/out of hours (OOH) and job planning for sufficient medical staffing. The Committee noted limited assurance on medical staffing i.e. job planning does not seem robust enough to optimise available medical time. The Committee noted ongoing work by LS and JT on workforce planning for medical staff using the operational plan (based on capacity) and JT will triangulate this with the HR workforce and medical teams. The Committee also noted the difficulty in recruitment for Acute Medicine Physicians on both sites and that Care Group 1 has asked specialty consultants to reduce their specialty commitments to backfill the acute position deficit. HM said there has been a whistle-blower from acute physicians about the safety of the acute floor. In order to get assurance the Committee agreed the need for a clear statement of risks associated with our current position with mitigations in place and a clear plan to ensure risks are sustainably managed. There was a group discussion about the best forum for this to be discussed as there are two main parts – medical workforce issues and the impact on quality and safety – that both Quality and Resources Committees need sight of. The Committee agreed that this should be escalated to Executive Committee as an operational issue for the Quality Committee to seek assurance on.

SH raised concern about MRSA screening and HM suggested discussion with the care groups as an operational issue to try to improve performance.

Action: SH to discuss medical staffing and workforce planning with Polly McMeekin and Care Group Directors

Patient Safety

/ Medical Director's Report

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

An internal audit on DNACPR was requested following CQC safeguarding concerns and we have been assured that the appropriate processes are being followed.

There were 7 falls reported as SIs rather than 4. HM agreed to bring a falls update to the next meeting and confirmed there is now a Falls Practitioner in post. The Committee noted that some falls have been on poorly-staffed wards and asked if the patients have had fall assessments. HM said that feedback from the Falls and Pressure Ulcers Group is that some patients are being admitted late and are already deconditioned possibly as a consequence of the pandemic. CJ added there has been significant progress around the governance on closure of action plans but noted the challenge with handling the backlog of historic non-finalised action plans. The Committee supported this work and discussed the value of a thematic review for assurance on key themes. CJ confirmed this has been done for clinical SIs but that it was not detailed enough to identify root causes so further investigation is needed.

Action: CJ to discuss thematic review of falls with Tara Filby

/ Sepsis Report – Q3

DR gave an overview of the report and stated that performance for screening reliability relates to the overall ED performance, which is a recurring theme in SIs. DR was unable to give assurance on sepsis. The Committee agreed that cultural change is needed to try and move senior reviews closer to the front door in ED to ensure patients are placed on the right pathway from the offset. IT infrastructure is also an issue as 55% of all Trust PC's and laptops are over five years old.

Attention to Executive Committee: SH to escalate in relation to 14-hour reviews and recognition of deterioration

/ QPaS – Escalation and Assurance Report

The Committee raised concern about the potential reduction in service for the chemotherapy nursing workforce (P52). CJ confirmed that we have recruited an additional 3 WTE nursing staff and a clinical educator to support and expedite training. We are also looking at supernumerary care group rotational posts, which will support our long term recruitment strategy. The Committee was assured that the immediate risks have stabilised.

The Committee requested assurance that policies were both up to date and being adhered to. CJ confirmed policies are now being mapped to the appropriate staff groups and there is a robust process for development, management and sign-off of policies.

/ QPaS – Quality & Patient Safety Group Minutes

The Committee received the minutes for information and agreed that these should be included in the purple box once it is incorporated. No further discussion was required.

/ Clinical Effectiveness & Audit Report

CJ confirmed the draft annual report has also gone to Audit Committee. All care groups have been met with to review audit plans for next year and audit delivery will be monitored via Q-Pulse.

JM confirmed that the Audit Committee was assured by the number of audits taking place and that there is a good system in place to produce action plans but was not assured that action plans are being monitored or followed through, so this was referred onto the Quality Committee.

/ Infection Prevention and Control Report

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

C. Diff remains a concern, particularly on the SGH site, and HM gave assurance that the action plan (Appendix 1) has been updated both with closed actions and new ones following the last C. Diff meeting. A national team has come to inspect but they cannot identify any new issues other than the fabric of the building. HM said there is a list of works needed but capital is severely restricted. SH asked if this was accurately represented in the risk register and BA confirmed it has been added as one of three quality risks that will come to the next meeting.

The second maternity theatre on the York site was closed following an inspection to undertake remedial work as a result of surgical site infections. There is mitigation in place to manage this risk.

There was a group discussion about IPC training for medical and dental staff and how compliance can be improved. DR said it was important to make staff available to undertake the training and the Committee noted JT's work on aligning training with the Trust requirements and the staff specialities. The Committee agreed that there is cultural work to do to empower people to challenge non-compliance.

Action: HM to send paper detailing list of works that would make a material difference to the IPC risk in Scarborough through QPaS and then Quality Committee

/ Nurse Staffing

HM confirmed there is a work plan for the investment given this year and that international recruits are still arriving (33 this month.) The Committee agreed we must be mindful of our vacancies and HM said the majority of international recruits were going to SGH but that there is a limit on how many we can support due to a shortage of substantive staff.

Action: HM to provide trajectory once newly qualified nurses start in September to reflect the impact on existing staff and the impact on new establishments in the 2nd half of the year

/ My Perfect Ward Accreditation Process Report

The Committee noted successful engagement with the Perfect Ward app. HM said we have the Perfect Ward data but we need further triangulation with other intelligence such as incidents, complaints and harms to provide further assurance.

/ Ockenden Update

LB and HM highlighted the following key points:

The Committee noted the concern around full CNST compliance. LB said we have requested payment for partial compliance but it has not been accepted. The sonographer shortfall and limited ability to scan high risk women per national guidelines as well as moderate risk pregnancies continues to be a concern re implementing Saving Babies Lives v2 (SBLv2). The Committee noted the link to case #3 and 4 in the PMRT report where lack of scanning capacity was classed as a contributing factor. We will be an outlier against action 6 as Hull and NLAG have confirmed compliance. Although we can scan all high-risk pregnancies we scan against local guidelines that were put in place due to capacity issues - we cannot scan moderate-risk women under SBLv2 due to these capacity issues. The Committee recognised this as a risk, both safety-wise and reputationally.

There was a discussion around whether we would lose the service due to non-compliance and HM confirmed we would not as Hull and NLAG would not have the additional capacity. There is the possibility that some women that are deemed high-risk may choose care elsewhere but the some high-risk women may not be able to make an informed choice. The Committee noted this concern but were assured that a plan is in place around attracting sonographers and the plan to support three midwives to gain their competencies this year.

The Committee was assured by improved training compliance and noted that the Trust continues to aspire to the 90% target, despite the figure being removed as a CNST requirement.

The Committee was assured that the previously referenced SI (where the family declined an HSIB referral) was undertaken with an external overview to ensure maximum learning.

There is continued compliance with the continuity of carer trajectories and the focus on BAME and other vulnerable groups. The Committee noted the link to PMRT case #1 where continuity of carer may have detected medical issues that could have led to a better outcome.

Attention to Board: SH to escalate list of specific issues to Board

Effectiveness

/ Care Quality Commission Report

The Committee noted the report and progress to date, including progress against KLOE's and development of action plans. Formal written feedback on conditions has not been received yet.

Action: CJ to bring update on progress against CQC plan to provide assurance on delivery of 'should do's' and forward plan

Performance and Risk

/ Chief Operating Officer Report including Performance Update & CQUINs

LS shared slides on endoscopy surveillance rates to summarise the volume and extent of wait times. Whilst the majority are green, there are still a significant number of overdue colonoscopy appointments. The endoscopy risk stratification has gone live and the revised process for diagnostic risk stratification has just been received through the national team, so plans will be adjusted to meet the new national criteria. The Committee noted the majority of imaging and physiological modalities are waiting around three months but the wait for most other investigations is approximately 6-8 weeks. The main concern is around non-obstetric ultrasound and endoscopy. There is still a backlog of surveillance from pre-pandemic times as well as the stand-down of endoscopy services in the first wave and redeployment of endoscopy staff in the second wave. The Committee noted this as a significant risk and LS offered a deep dive into diagnostics if there is appetite for it. There was a discussion about consultant visibility of waiting patients and whether there is flex for more assessment based on the wait time. The Committee was assured that the new guidance requires all waiters to have a clinical prioritisation assessment to reassess their position and that this work is due to start at the end of July. The Committee noted the significant scale of the work and WS said there is also the expectation to notify patients of the delay.

Diagnostic issues have triggered a national piece of work around community diagnostic hubs with a 2022/23 expectation that HCV submit a multi-million pound bid for these. Our plan is to submit a joint bid with primary care to provide a hub in both YH and SGH. The aim is to reduce demand on hospital diagnostic services by providing services such as non-obstetric ultrasounds and ECG's that often come through acute sites and join the waiting list. The Committee noted staffing and diagnostic constraint as a potential risk.

WS gave an overview of the report and highlighted the following key points:

The return of service demand is a concern and a risk to the recovery plan and the Committee noted that demand on some specialties has exceeded 2019/20 levels. This is a national concern and Trusts have been asked to do some focused work on primary care around the offer and access.

There will be significantly reduced space in ED on the YH site as a result of the ED build, which has prompted positive discussions on a new model for ensuring patient flow to

specialty areas as soon as possible. One option is for patients to come to ED for resuscitation, sepsis or acute illness only and all other patients be streamed to assessment areas, specialty wards or SDEC areas. We are working with YAS to pilot taking patients to SDEC rather than ED. JM asked if patients are more unwell than they were pre-pandemic and WS said that surgical patients in some specialties are further along in their disease progression and therefore more complex but less so at the front door.

There was a group discussion about widening inequalities across the ICS and the quintile comparison between York and Hull populations as well as the potential risk of this should we need to treat Hull patients. The Committee discussed how we measure/monitor this and what the impact will be. LS confirmed a Health Inequalities Working Group has been set up and a Trust condition is to assess waiting lists against ethnicity and deprivation. There is limited data compliance for ethnicity to date but early analysis has involved looking at the mean time on waiting lists first by ethnicity and then by socio-economic status using a deprivation rating. There are some areas where some ethnic groups are waiting longer across different specialties so this warrants further investigation. LS confirmed that national guidance is pending about whether the end point is to prioritise people on our waiting lists in a different way to tackle health inequalities.

The Committee noted that in our final recovery plan submission, we are proposing to reduce the number of ordinary elective cases based on actual demand pressures. LS confirmed this is going to Board for approval/information.

Action: LS/WS to provide update on widening inequalities work once further data received

/ Quality Priorities & Final Quality Report

The Committee noted the report and agreed to send any comments to CJ in time for the submission date of 30 June. CJ confirmed the report will be sense checked and agreed to add more context re the pandemic. This will go to the next Executive Committee on 02 June.

Action: CJ to email hard copy of Quality Report to Committee members for comment – members to send these before 30 June

/ Corporate Risk Register

There was no further discussion required.

/ Consider other potential or new emerging risks

The Committee acknowledged the following potential or new emerging risks:

- Diagnostic delays
- Increase in service demand

- Medical staffing and the impact on a number of key parameters that are acknowledged as genuine risks as seen in Learning from Deaths reports

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:

- Poor metrics suggest on-going shortfall of medical resource in key areas – to be escalated to Executive Committee

- Chief Nurse – On-going concerns about rate of C diff infections especially in Scarborough and issues around fabric of the building in clinical areas – to be escalated to the Board

- Concerns around long waiting for diagnostics, particularly endoscopes and non-obstetric ultrasound – to be escalated to the Board

- Ockenden (non-compliance with CNST standard – Saving Babies Lives v2 (safety action 6), Continuity of Carer and PMRT Q4) – to be escalated to the Board for information

- Work being done on outstanding clinical effectiveness and SI actions to flag as a concern but acknowledge there is a plan in place to address these – to be escalated to the Board for information

/ Any other business

There was no additional business to discuss.

/ Time and Date of next meeting

The next meeting will be held on 22 June 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	Completed

22.09.20	52	HM to bring accreditation process report which relates to the Perfect Ward	HM	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	Completed
23.03.21	98	HM to provide corrected PPH thresholds for maternity dashboard	HM	Completed
20.04.21	99	NEDs to discuss movement of Board and Committee deadlines to the following week with SS	SH JM LB	Aug 21
20.04.21	100	JT/CJ to include risk summary in next MD report re overdue clinical effectiveness actions	JT CJ	Jun 21
20.04.21	101	HM to include birth rate plus data as part of Ockenden update	HM	Jun 21
20.04.21	102	HM to share results of staff survey re redeployment with Committee members	HM	Jun 21
20.04.21	103	HM to bring update on delirium assessment (4AT) to next Committee meeting	HM	Jun 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	Completed
20.04.21	106	JT to invite general surgical CD (Marco Baroni) to May Committee meeting	JT	Jun 21
20.04.21	107	WS to include quarterly community update in COO Report from June 2021	WS	Jun 21
18.05.21	108	HM to include details on work to reduce line infections in IPC report	HM	Jun 21
18.05.21	109	SH to discuss medical staffing and workforce planning with Polly McMeekin and Care Group Directors	SH	Jun 21
18.05.21	110	CJ to discuss thematic review of falls with Tara Filby	CJ	Jun 21

18.05.21	111	CJ to bring update on progress against CQC plan to provide assurance on delivery of 'should do's' and forward plan	CJ	Sep 21
18.05.21	112	HM to send paper detailing list of works that would make a material difference to the IPC risk in Scarborough through QPaS and then Quality Committee	HM	Jun 21
18.05.21	113	HM to provide trajectory once newly qualified nurses start in September to reflect the impact on existing establishments and the impact on new establishments in the 2nd half of the year	HM	Jun 21
18.05.21	114	LS/WS to provide update on widening inequalities work once further data received	WS LS	TBC
18.05.21	115	CJ to email hard copy of Quality Report to Committee members for comment – members to send these before 30 June	CJ All	Jun 21

D2

NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes

Quality Assurance Committee

22 June 2021

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

/ Attendees: Donald Richardson (DR)

/ Apologies for Absence: n/a

/ Declaration of Interests

There were no declarations of interest.

/ Minutes of the meeting held on 18 May 2021

The minutes of the last meeting held on 18 May 2021 were agreed as a true and accurate record.

/ Matters arising from the minutes

SH suggested that when minutes are received with the action log, it is helpful to respond to Rhiannon re action log so that written answers were received ahead of the next meeting.

Action 88 – LS said one of the capacity issues identified in the SGH Quality Summit at SGH hospital is Geriatrics. The Committee noted that the SGH site is doing a full review of medical support services. Other key areas of concern are Cardiology and Respiratory. The Committee noted that we are unlikely to achieve our desired levels of recruitment on the east coast to meet demand and there is a big piece of work around productivity and using the staff we have, which is due to commence in July. The Committee noted the issues with OOH and weekend working and JT said the current medical current contract does not effectively support the delivery of 7-day services. We are currently incentivising shifts but these are being picked up by the locum workforce. WS said the SGH proposal is based around a revised working model and that we will have hopefully recruited to this model.

Action 101 – HM confirmed that we are still waiting to hear back regarding funding for Ockenden.

106 – JT has spoken to Marco Baroni (MB) who has accepted the shortfall in demonstrating excellence and was disappointed with the audit results. Conversations are being held with the digital team to improve CPD usability for surgical reporting including for elective admissions.

114 – WS said there is a lot of ongoing work around inequalities and linking in with the ICS, and there is a question of the best forum to discuss this as there will be emerging data and analysis that will need to be considered by the Board. The Committee noted the expectation that various Trust Boards as well as the ICS should identify an inequalities lead to link in with different provider organisations.

115 – the Committee formally approved the Quality Report.

Action: JT to provide update around surgical reporting and CPD usability

/ Escalated Items

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

IBR Overview to look at Patient Safety, Effectiveness and Patient & Carer Experience

JT highlighted the following key points:

- There were no recorded Covid deaths in May
- VTE has been flagged as 6 months in red but just under the 95% mark so this is being escalated to the VTE Committee
- There have been some incidents related to heparin around surgery, which is being investigated
- SHMI has reported mortality at 95%

HM highlighted the following key points:

- Complaints response times have declined significantly for May, which is being investigated
- There have been a few incidents of device-related pressure ulcers, which is being investigated

Patient Safety

/ Medical Director's Report

JT highlighted the following key points:

Clinical effectiveness and audit have improved but there is new concern around the fractured neck of femur (NOF) pathway and we are now an outlier on the national audit. A key element of the pathway is to get patients treated in a timely manner, which we have not been achieving. A project group has been set up to address this in line with QI work

and we are already seeing encouraging initial results. Three care groups are involved in this work – Orthopaedics, Anaesthetics and Care of the Elderly.

The Committee was assured by the implementation of a project group and there was a group discussion about the importance of a wider review. The Committee noted the issues with theatre capacity due to Covid and WS confirmed that a full programme of elective orthopaedic work will be commencing on site w/c 05 July. The Committee acknowledged that resources are in place for patients to have the correct ortho-geriatric assessment in order to be in theatre on time for the appropriate anaesthetic cover. HM said there are staffing gaps as Theatre Coordinators and Specialist Nurses only work 4 days a week so there is a need for 7-day service investment.

The Committee agreed that the outcome of this work should go as a paper to the Executive Committee with recommendations on any investment or required changes for sign-off and tracking of progress against plans agreed. The Quality Assurance Committee should track clinical outcomes and progress but identifying a work programme should be agreed elsewhere. JT confirmed there is a plan to improve provision of a 7-day Trauma Coordinator and nursing staff.

There has been improvement in incident reporting around recording of harm. 12% of incidents are recorded at moderate harm or above and there are reviews of harm reporting to validate for assurance. The SI overview shows that these represent less than 1% of all reported incidents.

Duty of Candour is now being embedded within the organisation but we still need to improve timeliness of communication with patients. JM asked if the reason for the delay was known and CJ said it is due to human factors – sometimes there is discussion about the degree of the incident, which can slow the process down. The Committee was assured by progress being made.

Antibiotics usage has reduced by 15% and the Antibiotic Review Kit (ARK) has been relaunched in SGH with early encouraging results.

/ QPaS Update (Escalation and Assurance Report & Quality & Patient Safety Group Minutes – Blue Box)

These papers were received as supplementary reports and no further discussion was required.

/ Overdue Actions Report

JT gave an overview of the report and confirmed that 11 of the 27 high risk actions under clinical effectiveness relate to the lung cancer audit and have been escalated on an individual basis to the senior colleagues involved. There is significant improvement but still work to be done.

The Committee noted Appendix A (Blue Box) re workstreams and acknowledged the QI progress to help us become a learning organisation. CJ also confirmed there is a weekly SI panel that reviews evidence of closures.

The Committee agreed that it was well-sighted on high-risk overdue actions and happy with the arrangement that QPaS has the detail and escalates any high risk outstanding actions of concern.

/ Infection Prevention and Control Report

HM highlighted the following key points:

MSSA and C. Diff continue to be a concern and for the latter, decanting facilities on the York site is a challenge as the site is at capacity. JM raised concerns that the estate will only deteriorate further if we are not able to make infrastructure improvements but that we do not have the capital to do full ward refurbishments, only remedial work.

Line infection seems to be due to the challenges of getting screening and decolonisation correct for some patients.

There have been some issues with water safety at the Community Stadium due to the water coming into the building at too high a temperature and the taps not being run off enough. This has resulted in highly contaminated water, although there is no Legionella, but filters are being utilised and the water is being tested daily. There is a debate around who is responsible for correcting this – City of York Council, who owns the Stadium, or the Trust. HM gave assurance that the correct systems and processes are now in place.

Surgical site infections seem to have settled across all sites.

/ Nurse Staffing

HM highlighted the following key points:

Following conversations about how the vacancy rate would look if it were overlaid with the 2021 nursing investment, HM confirmed it would go from ? is this the other way round (rate will go up) 8.76% to 6.92%. We do have large numbers of new starters but due to establishment increases going forward, the vacancy rate will appear static.

The Committee noted the new t-level qualification being introduced from September 2021, which will aim to prepare young people for entry into healthcare professions.

The University of York failed to fill all nursing places this year despite course oversubscription so it is going through the clearing process. The Committee noted concern that neither York nor Coventry University will be able to fill all nursing placement for September. There was a discussion about whether this was a repercussion of the 1% pay increase compared to speculation of a 5% increase or over in the private sector. There is also currently a nursing debate around the ethics of international recruitment and whether this should continue.

/ Ockenden Update

LB said the overwhelming theme is staffing concerns across all areas, which is impacting all other areas of concern.

The Committee noted the positive work by our new Deputy Chief Nurse around staff experience in light of the feedback received and ensuring staff have a good outlet for expressing their thoughts.

HM shared concern that the CQC inspection lens appears to have changed post-Ockenden and referenced Sheffield's regrading from Outstanding to Inadequate due to systems and processes concerns. We have reviewed the last four CQC reports from maternity units and are running benchmarking exercises, which will be brought back to the Committee once ready for assurance.

Continuity of Carer progress is on trajectory and there are plans to roll out a team for high-risk women and women from BAME communities, but we need significant investment to roll out services to the whole of York.

/ Fire Safety Policy

The Committee agreed that HM would bring this back to the July meeting with relevant updates for assurance that all legal requirements are being met. The Committee also requested assurance that other staff have had sight of the policy as it suggested only the authors have had involvement.

/ Safeguarding Update

HM said Committee approval was required to share the policy outside the organisation due to the multidisciplinary nature of safeguarding as all organisations share their annual reports at the Safeguarding Board. HM also confirmed that we have amalgamated children and adult safeguarding so there is an overarching strategic Safeguarding Board, which is working well.

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

<u>Adult Safeguarding:</u>

There was a noted increase in referrals for domestic abuse, mental health and self-neglect and the Committee noted the new system - Liberty Protection Safeguards - that is currently going through the legislative process (see p109).

The Committee noted the previous issues with DNACPR and patients with learning disabilities, which the CQC have been asked to review to see whether these were incorrectly applied. They are currently undertaking baseline assessments against their findings. SH asked for assurance that our processes are adequate. HM said external scrutiny is undertaken by the Safeguarding Board as part of our multi-agency arrangement and that no issues have been raised.

There was a group discussion about the concerns around low levels of medical and dental statutory and mandatory training (for both adult and children safeguarding). JT confirmed that originally HR had ownership of training but, due to poor compliance, care groups are now taking ownership of it. The Committee expressed concern that this has been raised before but that there does not appear to be any progress and noted that the CQC would flag a lack of compliance as a serious issue. There was also concern about reputational damage. The Committee noted that the appraisal process has been updated to ensure training is up to date, and that staff must have a plan to complete this if they are not compliant at appraisal stage or they risk deferral of revalidation. JT gave assurance that this would be included on the next QPaS agenda to ensure movement.

Children Safeguarding:

There has been a 77% increase in contacts this year. HM commended the team on their hard work but added that our current Head of Safeguarding Children is leaving the Trust in July so there will be a service gap.

There has been a significant increase in serious case reviews and the number of children involved in serious harm in the community has drastically increased (see p130). This will be reviewed to assess whether this was due to Covid or if there is a lack of service provision.

SH expressed concern around children with mental health problems that have long ward stays and HM agreed that this is a national problem, and that they are often waiting for referrals. There was a discussion about how well equipped/supported our nursing staff are to look after these children and whether it was better to provide specialist training or employ nurses from the Mental Health Trust. As the Paediatric ward capacity varies from week to week it was suggested that specialist training would be the better option along with an arrangement with the Mental Health Trust where we can call for advice. The Committee agreed there is a lot of work to be done and CJ said this is being reviewed by the Mental Health Strategy Group. HM said it is also important that we support ED nurses so that children are signposted to the right place instead of being admitted.

/ Falls Report

HM gave an overview of the report and noted that all patient harms have increased due to Covid so there is work being done to understand why this is and improve governance.

The Committee noted the positive reaction to the NAIF pilot, which will hopefully be rolled out if successful.

Effectiveness

/ Care Quality Commission Report

CJ referred to Appendix B and C (Blue Box) and SH said it was a helpful programme of work to encourage quality improvement and monitor it to provide assurance. The Committee noted that Appendix B is not a definitive list (NOF was not included) and that it was important not to lose sight of this. SH expressed concerns about progress and CJ

gave assurance that there been a lot of progress including the effectiveness agenda, identification of higher risk areas and improved incident monitoring so that there are no unseen risks. SH was assured that there are systems and processes in place to capture this information.

There was a group discussion about how to tie all the improvement work together and ensuring governance is consistent. The Committee noted the Executive involvement with the Building Better Care (BBC) programme, which is about recovery post-Covid and a means for moving towards Excellence. LS added that the new Oversight & Assurance meetings are about current actions and delivery against our recovery plan by ensuring all relevant care groups are held to account, and the BBC programme is about the future of our care.

/ 4AT Delirium Assessment (Blue Box)

HM referred to Appendix 1 (Blue Box) and confirmed a task and finish group has been set up, and that we should see improvements in the future.

Action: HM to provide update on 4AT Delirium Assessment work to date in September

Performance and Risk

/ Chief Operating Officer Report including Performance Update & Restoration and Recovery Update

WS highlighted the following key points ahead of the report:

NHSE/I have advised us to prepare for a Covid third wave and suggest it will be approximately 50% of the first wave, which equates to 65 beds at any one time occupied by Covid patients. Any PHE modelling was undertaken prior to further information on the Delta variant and also did not consider the extension of lockdown into July. We have been advised that many Covid patients may be younger, less sick and less dependent on critical care with a shorter length of stay. We have refreshed our surge plan and have potential capacity for 25 patients in Surge Phase 1 – there are currently 8 Covid-positive patents in the Trust. Silver Command meetings have been stepped back up to three times weekly.

Regional data suggests good performance re stranded patients and places us in the top three of Trusts regionally but over the last month we have seen rising numbers of local authority delays, more significantly on the SGH site. Patients are taking longer to be discharged and the main reason is a lack of home care provision relating to workforce issues. National funding for provision of care at home remains in place until the end of Quarter 2 but from 01 July 2021 it will reduce from 6 weeks to 4 weeks. These delays may lead to pressure on our bed base and patient flow.

There is significant pressure on urgent care on both sites. The number of NHS 111 referrals has also significantly increased with a number of patients presenting at ED either having been sent from their GP but with no letter or because they could not get a GP appointment. This is a national, regional and local problem and GP's are also reporting

unprecedented levels of demand. Whilst it has been flagged that patients presenting with lower acuity in ED would be better seen in primary care, there is no capacity for this. There has also been a significant increase in children presenting with low acuity and the primary diagnoses are no abnormality detected and respiratory virus, which was anticipated by PHE. There has been a 34% increase in Paediatric non-elective admissions.

The first BBC Transformation Committee is due to be held on 21 July. The programme structure content and leadership have been agreed and through the Elective Recovery Fund we can support a number of project management posts to drive the programme forward, which will be offered as 12-month secondments. This has been signed off through Board of Directors and Executive Committee.

LS gave an overview of the report and highlighted the following key points:

The 6-week target for diagnostics is recovering but still remains a challenge. Diagnostic issues that were flagged in May about the impact of the capital build on some diagnostic modalities, particularly MRI, remain a risk although additional MRI scanning capacity in place from July 2021 has been approved.

The increase in GP referrals has improved our RTT position but the Committee noted the importance of getting high impact programmes underway to support productivity. WS confirmed work is being done around productivity as historically this was used to model elements such as theatre/clinic utilisation but stopped due to Covid. We have run benchmarking exercises to improve this and it will run alongside BBC as a pivotal part of driving capacity productivity.

The Committee noted the improved position against our plan for 52-week waits, which is being managed through process outsourcing and targeting capacity. There are still a number of 104 week waiters, which is unprecedented for the Trust. The number has increased to 32 patients, 10 of which are mostly P5 patients who have chosen to postpone their treatment until post-Covid or until they have had both vaccinations. These patients are now coming to the end of the timeframe for postponing treatment and are being monitored weekly through the prioritisation process. LS gave assurance that P2 patients are being treated in a timely manner (within 28 days) – our position was 50% at the time of monitoring and at the end of May our position was 67% against a trajectory of 65%.

We are anticipating access to the Elective Recovery Fund potentially within the ICS due to our positive trajectory position for Outpatients and Day Cases.

There was a discussion about how we are tracking harm identified through long waits and the Committee asked what constitutes this harm and how is it determined as Covid-related harm. It was confirmed that anything moderate or above is reported through Datix and that staff are being encouraged to use this and CPD but that it is difficult to formally report anecdotal harm. LS said this links in with the Health Inequalities work and there is also a Waiting Well Board being set up by the system to focus on how we can support patients on the waiting list to minimise harm. The Committee acknowledged that we are lacking some tailored advice and guidance for specific procedures and anecdotal information would help to inform this. The Committee was assured that work is being undertaken.

Action: WS to provide update on Building Better Care following the first Transformation Committee on 31 July

/ Clinical Environment Risk Update

The Committee received this report as assurance that processes are in place for action and prioritisation of backlog maintenance.

/ Integrated Business Report

These papers were received as supplementary reports and no further discussion was required.

/ Quality Priorities & Final Quality Report

The Committee received the report as a fair and accurate description of our Trust position and thanked CJ for her work on this.

/ Corporate Risk Register

The Committee noted 13 risks, 4 of which relate to quality, and was assured that these have been captured in either the CRR or BAF. The Committee agreed quarterly updated to monitor and track progress and any movement in risk ratings. CJ said they are looking into quality risks in care groups and how these are reviewed through QPaS. The Committee was assured that there are a number of forums that will have sight of risks.

Action: BA to provide quarterly update on CRR

/ Consider other potential or new emerging risks

There were no potential or new emerging risks for discussion.

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:

- Ockenden Report Update (for assurance)
- Concerns about levels of StatMan training among medical and dental staff (to Executive Committee for action)

/ Any other business

The Committee agreed to meet face to face in September subject to national guidance. The Trust HQ Boardroom permits 8 socially distanced attendees so there will be a dial-in option available as well.

/ Time and Date of next meeting

The next meeting will be held on 20 July 2021 at 1pm in Trust HQ Boardroom. Dial-in details will follow for those that will be dialling in.

York Teaching Hospital
NHS Foundation Trust

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

Committee/Group: Quality Committee	**Date: 18th May 2021**	**Chair: Steve Holmberg**

Agenda Item	**Issue and Lead Officer**	**Receiving Body, ie. Board or Committee**	**For Recommendation or Assurance to the receiving body**
6 & 8 IBR and Sepsis Report	Exec – Poor metrics suggest on-going shortfall of medical resource in key areas	Exec Committee	Escalation
11 IPC	Chief Nurse – On-going concerns about rate of C diff infections especially in Scarborough and issues around fabric of clinical areas	Board	Escalation
16 Chief Operating Officer Report	COO – Concerns around long waiting for diagnostics particularly scopes and non-obstetric ultrasound	Board	Escalation
14 - Update on Pre-natal Clinical Quality Surveillance (Ockenden)	Chief Nurse – non-compliance with CNST standard – Saving babies Lives (safety action 6) Continuity of carer PMRT Q4	Board	Information

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NHS

York Teaching Hospital

NHS Foundation Trust

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

Committee/Group: Quality Committee	**Date: 20th July 2021**	**Chair: Steve Holmberg**

Agenda Item	**Issue and Lead Officer**	**Receiving Body, ie. Board or Committee**	**For Recommendation or Assurance to the receiving body**
14	Chief Nurse – Fire Safety Policy	Board	Approval
12	Chief Nurse – Ockenden Report Update	Board	Assurance
16	COO – Deteriorating performance indicators at SGH ED CN/MD – Concerns around staffing levels especially at SGH	Board	Discussion

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021 (June 2021 data)
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

The publication of the Ockenden Report (December 2020) and the NHS E&I document - *Implementing a revised perinatal quality surveillance model* December 2020 have led to immediate changes in the way Maternity Safety information is shared with Board. The maternity services will submit to Board the Provider Board minimum data measures on a monthly basis, ensuring that maternity safety is a priority and transparent at Board level within the organisation

/ Executive Summary – Key Points

CNST – non-compliance will be declared to NHS Resolution in July 2021.

Safe staffing for midwifery – the Birthrate plus final report has arrived at the end of June. The Head of Midwifery is undertaking a full midwifery workforce review.

Training compliance in the medical workforce needs improvement. An action plan will be monitored through Care Group Board.

No new HSIB cases reported.

The evidence for the Ockenden portal has been submitted on 30th June 2021. Feedback from the regional team will be shared in this report when received and the subsequent action plans will also be shared in this report.

/ Recommendation

The Board are asked to review the Perinatal Clinical Quality Surveillance on an on-going basis and have oversight of any recommendations from SI reports or HSIB case reports.

Author: Michala Little, Deputy Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: July 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.

2.1 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. The Ask a Midwife service has now been funded centrally by the LMS and will be managed by a dedicated midwife going forwards. 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.

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

Positive feedback received from service user on our Facebook page:

I would like to express my Many Many Thanks to all the Staff on G3, Labour Ward and Mostly SCBU at York.
Needing to be in and out of Hospital during Covid, without my partner was very difficult. The staff on G3 gave me such support and care. At a time when I was worried and frightened, as my waters broke unexpectedly at 32 weeks gestation. The Midwifes on the Labour ward helped me immensely. SCBU staff was beyond like family. Helping me and my husband through one of the toughest times together. After trying for a baby for many years and having Fertility Treatment. Then the complication of a premature baby.
SCBU staff supported us through difficulty feeding, bathing our baby and eventually being able to bring our bundle of joy home.

Positive feedback has also been received through family and friends – see Appendix 1.

The MVP have rated the information we provide to women – see Appendix 2. Action planning will be undertaken in response.

The MVP and LMS have provided an overview of our collaborative approach to working. Appendix 3 shows a summary of ongoing interactions/work with HCV LMS, Provider Trusts and stakeholders

2.2 Staff Safety Forum feedback

There were some concerns raised by staff in maternity areas during the walk around by the Board level safety champion in June, staff were concerned with staffing levels.

Midwifery Unions sent a letter to the executive team highlighting their concerns including safe staffing levels, roster management, admin and midwifery management structures, recruitment, continuity of carer plans and equipment. A meeting to address concerns and provide a response was held with the Union representatives and the Chief Nurse, Care Group 5 Associate Chief Nurse, Head and Deputy Head of Midwifery. Ongoing meetings with the Unions will be undertaken.

Appendix 4 details previous concerns raised and acted upon. The next Safety Champions meeting is in July.

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 interested staff received QI training. Following feedback from a staff survey, they have decided upon a QI project around the clerking of women for caesarean section; currently undertaken on the antenatal ward (G3), the feasibility of undertaking this in clinic will be considered. Take up of interest in the Quality Council is building and one more midwife and a HCA were offered training in June.

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%

2.3 Safe staffing levels

Midwifery:
Escalation guidance is in place to cover any rise in acuity and dependency or shortfall in staffing levels. Acuity is measured throughout the day on labour, antenatal and postnatal wards cross-site. June saw the introduction of twice daily staffing safety huddles to identify and action plan for any issues. In June there were no labour ward closures on either site.

Fill rates for Midwifery shifts at York site in June 2021 were 80.9% (84.6% in May) and for Scarborough site 89.3% (95.8% in May).

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 June there were no occasions where safe medical staffing was not met.

2.4 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 in place for an organisation-wide CQQ deep dive to be undertaken with the Safer elements completed by August 2021. Benchmarking against 5 recent Maternity CQC reports from other organisations is planned in addition to this.

2.5 Coroner Regular 28 recommendations

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

2.6 Incident reporting

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

Serious Incidents(SI): One new SI declared, jointly with Care Group 6, regarding a medication reaction (platelet transfusion) on an outpatients ward at Scarborough site.

Incidents declared as 'moderate harm' or above: none

PMRT: Monthly PMRT meetings are held on both sites and any cases meeting the criteria are reviewed. The Q1 report will be submitted August 2021.

2.7 Training compliance

Action planning for midwifery training compliance with a clear route of escalation is in place and will be monitored by the Quality & Governance Team. Staff are given rostered time to complete and all PROMPT training has been virtual since the Covid 19 pandemic commenced; virtual PROMPT training is now being planned to include the MDT. See Appendix 5 for CNST Action Plan.

There remains challenge around medical staffing compliance with training. This will be escalated monthly via care group board.

Fetal monitoring training rates are increasing with full compliance expected 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.

Assurance around training will form part of the Deputy Head of Midwifery report to care group Quality & Resource Committee going forwards.

York Midwifery

Face to face training	Neonatal Life Support	Annual	% of staff trained	≥85%	61%-84%	≤60%	91	93	96	96	99	96
	Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	88	93	95	96	99	93
	Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	88	92	98	94	96	92
	Perinatal Mental Health	2 yrly	% of staff trained	≥85%	61%-84%	≤60%	98	99	93	96	96	95
E-learning	PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	78	86	90	91	93	92
	PROMPT - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	88	92	88	86	96	93
	COVID in pregnancy - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	45	63	76	86	90	90
	COVID in pregnancy - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	13	25	44	57	79	93
	Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	91	91	90	92	92	89
	Maternal Obesity	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	94	94	93	94	95	94
	Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	32	30	25	26	29	28
	Substance Misuse	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	94	94	93	93	93	93
	Mentorship	Annual	% of staff trained	≥85%	61%-84%	≤60%	26	29	24	24	25	27
	Customised Growth Chart	Annual	% of staff trained	≥85%	61%-84%	≤60%	31	35	26	26	29	31
	Bereavement update	Annual	% of staff trained	≥85%	61%-84%	≤60%	88	88	88	90	90	86
	e-lfH National Bereavement Care Pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	2	3	5	8	11	11
	K2 - New Starter pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	27	0	0	0	0	29
	K2 - Intrapartum CTG Chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	88	83	76	76	85	77
	K2 - Intrapartum CTG Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	82	84	81	82	83	81
	K2 - Intrapartum Intermittent Auscultation chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	86	83	81	81	85	86
	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	89	84	81	81	83	85
	K2 - Full Midwife pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	43	38	37	37	43	44
	SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	79	81	78	83	82	79
	SBLCB - Detection and surveillance of growth restriction	Annual	% of staff trained	≥85%	61%-84%	≤60%	11	47	66	74	84	83
	SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	16	52	69	79	87	88
	SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	11	49	68	74	82	84
	SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	10	49	67	76	86	86
Ad hoc training	Bereavement Workshop - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	75	75	64	64	82	82
	2 day BFI - Midwives/MSWs/HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	88	87	91	86	85	89
	SBLCB - Fetal Monitoring (with Becky Galloway)	Annual	% of staff trained	≥85%	61%-84%	≤60%	7	14	22	26	36	41
	BLS - Midwives	3yrly	% of staff trained	≥85%	61%-84%	≤60%	94	96	95	95	95	96

York Medical Staff

Attendance	Course	Frequency	Measure	(green)	(Amber)	(Red)	January	February	March	April	May	Jun
E-learning	PROMPT	Annual	% of staff trained	≥85%	61%-84%	≤60%	65	73	74	74	77	84
E-learning	COVID in pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	55	63	65	68	80	87
E-learning	Antenatal Screening	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	20	20	16	16	17	19
E-learning	Customised Growth Chart	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	16	16	13	13	13	15
Face to face	Fetal Monitoring (with Becky Galloway)	Annual	% of staff trained	≥85%	61%-84%	≤60%	19	20	35	42	63	68
E-learning	SBLCB - Supporting a smoke free pregnancy	One off	% of staff trained	≥85%	61%-84%	≤60%	19	40	48	48	73	74
E-learning	SBLCB - Detection and surveillance of growth restrictions	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	16	43	42	39	63	71
E-learning	SBLCB - Reduced Fetal Movements	One off	% of staff trained	≥85%	61%-84%	≤60%	16	37	42	42	70	71
E-learning	SBLCB - Effective continuous fetal monitoring	One off	% of staff trained	≥85%	61%-84%	≤60%	13	40	39	39	63	68
E-learning	SBLCB - Reducing Pre-term birth	One off	% of staff trained	≥85%	61%-84%	≤60%	13	33	39	42	63	68
E-learning	K2 - Intrapartum CTG Chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	68	63	48	58	62	67
E-learning	K2 - Intrapartum CTG Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	62	67	58	71	79	70
E-learning	K2 - Intrapartum Intermittent Auscultation chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	35	33	29	42	59	63
E-learning	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	38	40	39	52	66	67
E-learning	K2 - Full Medical Staff pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	23	17	19	31	33	33

Scarborough Midwifery

Face to face training	Neonatal Life Support	Annual	% of staff trained	≥85%	61%-84%	≤60%	89	85	90	96	96	97
	Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	89	84	87	80	89	92
	Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	86	86	86	90	87	87
	Perinatal Mental Health	2 yrly	% of staff trained	≥85%	61%-84%	≤60%	95	91	94	94	92	92
E-learning	PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	81	76	81	83	82	82
	PROMPT - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	65	71	76	72	65	76
	COVID in pregnancy - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	58	52	70	77	80	85
	COVID in pregnancy - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	12	18	41	45	47	65
	Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	86	81	86	88	87	86
	Maternal Obesity	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	85	86	85	87	89	90
	Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	33	18	24	20	19	23
	Substance Misuse	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	81	83	81	83	84	82
	Mentorship	Annual	% of staff trained	≥85%	61%-84%	≤60%	29	16	24	19	18	20
	Customised Growth Chart	Annual	% of staff trained	≥85%	61%-84%	≤60%	36	19	27	26		22
	Bereavement update	Annual	% of staff trained	≥85%	61%-84%	≤60%	86	86	87	89	90	90
	e-lfH National Bereavement Care Pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	4	4	4	5	8	8
	K2 - New Starter pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	9	0	0	0	0	25
	K2 - Intrapartum CTG Chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	82	76	81	85	87	80
	K2 - Intrapartum CTG Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	62	70	76	87	95	87
	K2 - Intrapartum Intermittent Auscultation chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	78	78	81	78	91	89
	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	76	78	85	82	91	90
	K2 - Full Midwife pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	33	41	41	41	48	47
	SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	81	83	76	62	81	71
	SBLCB - Detection and surveillance of growth restriction	Annual	% of staff trained	≥85%	61%-84%	≤60%	20	55	64	53	77	76
	SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	25	59	68	55	80	81
	SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	16	36	65	53	78	80
	SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	20	58	69	56	81	82
Ad hoc training	Bereavement Workshop - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	88	88	88	100	100	88
	2 day BFI - Midwives/MSWs/HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	89	94	92	92	95	93
	Fetal Monitoring (with Becky Galloway)	Annual	% of staff trained	≥85%	61%-84%	≤60%	5	10	14	21	28	29
	BLS - Midwives	3yrly	% of staff trained	≥85%	61%-84%	≤60%	98	96	91	92	92	94

Scarborough Medical Staff

Training Attendance	Course	Frequency	Measure	(green)	(Amber)	(Red)	January	February	March	April	May	June
E-learning	PROMPT	Annual	% of staff trained	≥85%	61%-84%	≤60%	55	55	53	53	56	47
E-learning	COVID in pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	38	50	42	53	50	53
E-learning	Antenatal Screening	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	10	10	11	11	11	13
E-learning	Customised Growth Chart	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	15	0	0	0	0	0
Face to face	Fetal Monitoring (with Becky Galloway)	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	5	47	11	11	11
E-learning	SBLCB - Supporting a smoke free pregnancy	One off	% of staff trained	≥85%	61%-84%	≤60%	90	35	16	22	22	37
E-learning	SBLCB - Detection and surveillance of growth restriction	One off excl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	95	35	21	22	22	37
E-learning	SBLCB - Reduced Fetal Movements	One off	% of staff trained	≥85%	61%-84%	≤60%	95	30	21	22	22	32
E-learning	SBLCB - Effective continuous fetal monitoring	One off	% of staff trained	≥85%	61%-84%	≤60%	95	35	26	22	22	37
E-learning	SBLCB - Reducing Pre-term birth	One off	% of staff trained	≥85%	61%-84%	≤60%	95	35	21	22	22	32
E-learning	K2 - Intrapartum CTG Chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	85	73	53	68	78	58
E-learning	K2 - Intrapartum CTG Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	80	73	42	63	72	53
E-learning	K2 - Intrapartum Intermittent Auscultation chapter	Annual	% of staff trained	≥85%	61%-84%	≤60%	35	33	26	58	78	74
E-learning	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	% of staff trained	≥85%	61%-84%	≤60%	30	33	26	63	78	74
E-learning	K2 - Full Medical Staff pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	25	27	47	50	61	53

2.8 CNST

The Trust will not be declaring compliance with CNST and the board declaration, with associated action planning is currently being populated for executive sign off this month.

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	COMPLIANT	A paper detailing compliance in relation to clinical work force and action plans for Neonatal medical and nursing workforce was agreed by board in April 2021 and forwarded to the ODN for information. Business case to fulfil actions required for full compliance.
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 – the offer by an external scanning company to resource this was unfortunately withdrawn and a paper sent to the clinical network requesting further action planning agreement has been declined. The clinical network have asked to review our compliance towards SBLv2 in 3 and 6 months. The training and recruitment of midwifery sonographers is ongoing with agreement for 4 midwives. The timescale for this is 12-18 months.
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

3. Next Steps

- New format for this report to be established by the Head of Midwifery.
- Progress with CNST actions, relating to areas of non-compliance, to be shared with the Trust Board.
- The on-going progress with evidencing compliance with the Ockenden report to be shared with the Trust Board
- Integrate the continuity of carer dashboards and progress within this report.

4. Detailed Recommendation

For the board to acknowledge and discuss the data required.

York and Scarborough Teaching Hospitals NHS Foundation Trust

Board of Directors
28 July 2021
Implementing Continuity of Carer in midwifery services

/ Trust Strategic Goals

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

/ Recommendation

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

/ Purpose of the Report

The purpose of this report is to provide the Trust Board with a detailed plan for a stepped approach for implementation of continuity of carer teams in compliance with national principles and standards, outlined in the *NHS England 2021/22 priorities and operational planning guidance: implementation guidance*. This plan will reflect a phased approach and give consideration to the need for maternity staff to be supported to recover from the challenges of the pandemic. The plan aims to deliver quality patient care, support an engaged, healthy and resilient workforce and ensure financial sustainability.

The plan will provide a detailed timetable of the building blocks needed by March 2022 to best achieve continuity of carer as the default model of care offered to all eligible women by March 2023. An early aim is to prioritise those most likely to experience poorer outcomes including ensuring most women from Black, Asian and mixed ethnicity backgrounds and those women from the most deprived areas is placed by on a continuity of carer pathway by March 2022.

/ Executive Summary – Key Points

There is strong evidence, along with many national drivers, to support the implementation of Continuity of Carer in maternity services as an operating service model and choice for women. In addition, NHS England and NHS Improvement are committed to working with regions, systems, providers and partners to implement the actions from the initial Ockenden report published in December 2020.

Transformation objectives remain committed to women receiving continuity of carer as set out in the NHS Long Term Plan. Some potential barriers need tackling at the outset. These include; engaging the midwifery workforce, putting adequate staffing in place, ensuring that the model is based on a team approach with a named obstetrician linked to each team and ensuring training and equipment needs are considered.

Maternity services have been asked to demonstrate a plan, approved by Trust Board by July 2021 that will;

- Put in place the building blocks by March 2022 to ensure that continuity of carer is the default model of care offered to all women by March 2023.
- This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.
- Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds, most deprived areas are placed by on a continuity of carer pathway by March 2022.
- Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.

/ Recommendation

The Trust Board is requested to review the Maternity Services plan to deliver Continuity of Carer in conjunction with *NHS England 2021/22 priorities and operational planning guidance: implementation guidance.* We request support and financial investment from the Trust Board to support a stepped implementation plan that aims to maintain quality and safety. The detail of the midwifery workforce requirement to deliver the action plan for continuity of carer is being progressed by the Head of Midwifery following the recent Birthrate plus report. This will enable wholescale change across the maternity service to ensure that continuity of carer becomes the default model of care offered to all eligible women by March 2023.

Author: Lynda Fairclough, Named Midwife for Safeguarding Children

Director Sponsor: Heather McNair, Chief Nurse

Date: 01 July 2021

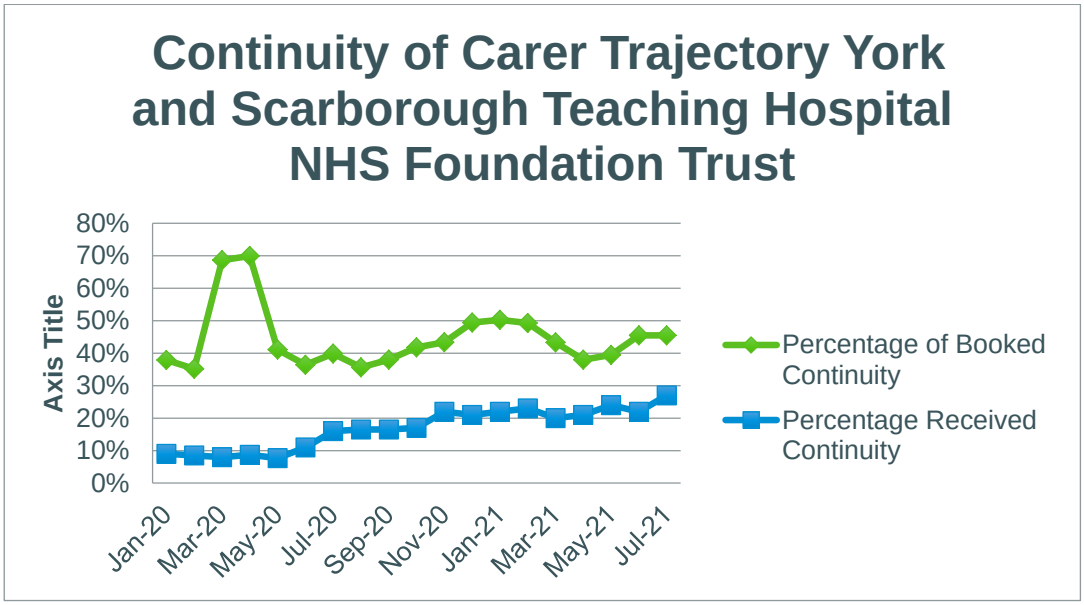
1. Introduction and Background

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

Maternity Transformation objectives are to make maternity care safer, more personalised and more equitable, kinder, professional and more family friendly, “and for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries”.

2. Detail of Report and Assurance

2020	SGH bookings onto CoC pathway	York bookings onto CoC pathway	Total bookings onto a continuity pathway(A)	SGH transfers onto pathway <29w	York transfers onto pathway <29w	Total transfers (B)	A + B	Total Trust wide bookings (C)	B + C	Percentage of women booked onto pathway	Total Trust Births	Percentage of Women receiving Continuity of Carer	Comments
January	185		185			0	185	488	488	37.9%	364	9%	
February	154	3	157			0	157	446	446	35.2%	329	9%	Sapphire team launched - not on call
March	166	29	195	100	36	136	331	482	618	68.7%	370	8%	
April	188	27	215	136		136	351	502	638	69.9%	326	9%	
May	139	18	157			0	157	382	382	41.1%	360	8%	
June	128	17	145			0	145	398	398	36.4%	338	11%	Sapphire team relaunch
July	168	19	187			0	187	469	469	39.9%	367	16%	Jasmine Team launch
August	137	14	151			0	151	424	424	35.6%	341	17%	
September	121	18	139			0	139	366	366	38.0%	375	17%	
October	168	8	176			0	176	421	421	41.8%	381	17%	
November	164	25	189			0	189	436	436	43.3%	264	22%	Malton Team Launch as on call
December	156	25	181			0	181	366	366	49.5%	333	21%	1.0 WTE Sapphire team with caseload
2021													
January	169	21	190			0	190	378	378	50.3%	322	22%	
February	151	17	168			0	168	341	341	49.3%	332	23%	
March	178	22	195			0	195	450	450	43.3%	358	20%	
April	158	22	180			0	180	474	474	38.0%	337	21%	Awaiting Birth Rate Plus Results
May	110	26	136			0	136	344	344	39.5%	318	24%	
June	160	22	182			0	182	400	400	45.5%	349	22%	Recruit Staff
July	160	22	182			0	182	400	400	45.5%	349	27%	Continuity of Carer Plan



Current Trust Position

Booked onto a continuity of carer Pathway Statistics – May 2021

Total Trust bookings for May = 344
Scarborough bookings = 110
Sapphire team bookings = 26
Percentage booked onto a CofC pathway for May= 39.5%
Black, Asian and mixed ethnicity backgrounds booked = 43 %
Postcode for top decile for deprivation booked CofC = 92.3%

	Scarborough Site Bookings	York Site Bookings	Trust Total Bookings	Percentage
BAME	3	3/11	14	43%
Deprivation	11	1/2	13	92 %

Received Continuity of Carer Statistics – May 2021

Total Trust Intrapartum care received for May = 23.6%
Intrapartum CofC received in Scarborough = 63.3%
Intrapartum CoC received in York = 8%
Black, Asian and mixed ethnicity backgrounds received = 50%
Postcode for top decile for deprivation received CofC = 37%

	Scarborough Site Received	York Site Received	Trust Total Received	Percentage
BAME	2/3	0/1	2/4	50%
Deprivation	7/17	0/2	7/19	37%

3. Next Steps

CONTINUITY OF CARER IMPLEMENTATION PLAN TRUST BOARD JULY 2021 Maternity Transformation – Priorities for 2021/2022 to achieve the national ambition by March 2023	
Purpose:	The purpose of this report is to provide The Trust Board with a detailed plan for a stepped approach for implementation of continuity of carer teams in compliance with national principles and standards, phased alongside the fulfilment of required staffing levels in order to maintain quality and safety. This plan will give consideration to the need for maternity staff to be supported to recover from the challenges of the pandemic. The plan working in line with Maternity Transformation Priorities 2021/2022 aims to achieve the national ambition where continuity of carer is the default model of care offered to all eligible women by March 2023. The plan sets out a detailed timetable to put in place the building blocks, so by March 2022 aims to prioritise those most likely to experience poorer outcomes including ensuring most women from Black, Asian and

	mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.
Background	Better Births: Improving Outcomes of maternity services in England (2016), the report issued from the National Maternity Review, outlined the Five Year Forward View for NHS maternity services in England. NHS maternity services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be: continuity of carer**,** to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. A continuity of carer model is defined as those that provide a woman with care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period with referral to specialist obstetric care as needed. This involves care co-ordination, provision and a relationship over time. Team of six to eight midwives, one of whom take responsibility for the woman's care if her midwife is not available; Continuity of carer and the relationship between care giver and receiver has been proven to lead to safer and better outcomes for women and baby. A more positive and personal patient experience, Better postnatal and perinatal mental health care, multi-professional working can be achieved and is likely to offer reduction in requirements for epidural analgesia, instrumental birth and Caesarean birth. It is seen to be a key tool in meeting the target of reducing stillbirth, neonatal death, maternal death and brain injury during birth. Continuity of carer is known to significantly improve outcomes for women from Black, Asian minority ethnic groups and those living in areas of deprivation (Homer et al 2017)
Current Position	Currently there are six established continuity of carer (CoC) teams across York and Scarborough Teaching Hospitals NHS Foundation Trust. Whilst 100% of eligible women on the Scarborough site are booked onto a continuity pathway, the York site currently only has one continuity team 'Sapphire' offering a continuity pathway for 8% women and families These teams have been developed with midwifery staffing from the existing establishment supported by non-recurrent funds from transformational monies. In 2020/21 the Trust regionally performed very well, despite the additional challenge of a pandemic, and has been able to offer assurance to both the LMS and regional bodies. Despite the challenges of staffing and sickness and the ongoing pandemic, the Trust in May 39.5% of women booked onto a continuity pathway, including 43 % Black, Asian and mixed ethnicity backgrounds, and 92.3% postcode for top decile for deprivation who will receive care from a continuity team. .
Financial	£43,000.00 2021/22 LMS Transformational Funds (pending) £135,000 has been made available across all 3 Trusts aimed at enhanced care for women with vulnerabilities and those women from Black, Asian and ethnic minority backgrounds.

	Awaited outcome from Ockenden Bid
Risk	The strategic context, current situation and case for change all demonstrate that doing nothing would be high risk and in breach of The NHS priorities set out in the operational planning guidance for 2021/2022 to ensure the actions from The Ockenden Report are satisfied as well as the commitments set out within the NHS Long Term Plan. Any potential quality improvements, improved patient experience, improved staff satisfaction or financial saving linked to the implementation of CoC would not be met.
Recommendation	We ask the Trust Board to consider additional investment to further progress and plan development of the CoC model. By supporting a stepped implementation plan will enable wholescale change across the maternity service to ensure that continuity of carer becomes the default model of care offered to all eligible women by March 2023.
	THE PLAN FOR IMPLEMENTATION OF COC
Communication and Engagement	• Plan ongoing engagement events across site with staff, service user representatives, stakeholders, LMS and MVP to ensure the plan for transformation is co-produced. • Planned hospital-based staff engagement sessions – LMS Midwife to visit and engage with staff re role of LMS and Continuity of carer – TBA • Consideration to be given to current restrictions and plan video/webinar information events for staff and service users • Trust website to offer a dedicated site to include FAQ, information and resources • Communication with senior leaders – Attend monthly senior team meeting • Trust Communication Team – Trust Website and Social Media • Use of LMS and MVP websites to highlight planned events and progress • Co-produce a monthly staff newsletter with staff, service user representatives
Consult with HR	• Review the process of wholescale change - 8.7.2021 • Options appraisal required for changes in remuneration (on call/standby) • Develop a formal agreement for travel time/expenses • Plan to offer 1:1 staff meetings to identify health issues/working restrictions that may affect ability to work within the CoC teams • Include union representation to offer transparency - TBA
Workforce	• Agreed workforce planning tool to be undertaken - 11.8.2021 • Explore the role of the MSW, produce an LMS agreed SOP – LMS work ongoing. • Review midwifery scrub role – Labour Ward Matron • Review Escalation Policy • Review Home Birth provision

	• Birthrate Plus recommendations to be worked through • Ockenden bid outcome awaited for more midwives and obstetricians • Development of Business Case to support workforce requirements
Collaborative working	• Meeting with MVP Chairs – Monthly 10.8.2021 • Involvement of Trade Union TBA • Regular communication with LMS Midwife and other trust implementation leads including wider regional/national network • Lead Consultant obstetrician for CoC – Requested
Staff Training	• Bespoke training sessions. New starter day is provided • Development of a further training day including community skills/home birth/roster and time management skills – community Matron/continuity lead midwife • Development of home birth skills workshop – Working Group 5.7.2021 • Training Needs Analysis (TNA) – Completed • LMS Agreed Bespoke TNA – Meeting with LMS and Trust Leads 12.7.2021. • Review clinical supernumerary time for existing staff –HOM & Matrons • Induction and Preceptorship of newly qualified staff.- Completed
Guidance & Patient Leaflets	• Guideline to include team face book TOR – Awaiting approval • CoC teams information leaflets – On going
Implementation of new teams	• Assess current caseloads and prioritise new teams in areas of high deprivation, ensuring Black, Asian and minority ethnic communities are placed onto the pathway- Information request submitted • Email staff re proposal to outline plan to implement CoC teams offering opportunity to work within the teams • Identify numbers of women booked not eligible to be included on a CoC pathway – Information request submitted • Review ongoing impact on current community services (on call for home births) • Ensure each team has a linked obstetrician – Discussed at cross site consultant meeting 2.7.2021 • Ensure each new team should have 6.8 WTE midwives • Develop a Business Cases with CG5 for two teams based in York and Selby • Develop a plan of required teams to achieve ambition of all women booked on to a CoC pathway by March 2023 • Provide further business cases to look at stepped approach to implementation of further teams.
Pandemic Recovery	• Ongoing Pandemic recovery - The removal of restrictions on women's access to support in line with local risk assessments - IPC • Support staff by taking active steps to help the maternity staff recover from the pressures the pandemic has caused. – OH,
Equipment	• Identify equipment required and costings -

	• Source Equipment • Identify community hubs consider cost and availability- Ongoing • Consider staff travel requirements and use of Trust approved pool cars
IT Services	• Provision of Mobile phones • Provision of Lap Tops • CPD
Community Hubs	• Scope availability of office and clinical community space • Consider cost and availability • Business case if required
LMS and Trust Assurance	• Planned National Team Assurance Visit – TBA HOM • Submission of Monthly Board Reports • Submission of Monthly statistic and progress report to the LMS • Attendance at Board - HOM

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021
Infection Prevention and Control Annual Report – 2020/21

/ 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 summarises the Foundation Trust's end of year surveillance information on *Clostridium difficile*-associated diarrhoea, Methicillin-resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and bacteraemia due to the three Gram Negative Blood Stream Infection (GNBSI) which are part of the national surveillance; *E.coli, Pseudomonas aeruginosa* and *Klebsiella* for 1st April 2020 to 31st March 2021. The report also highlights antimicrobial stewardship, SARS COV2 (COVID-19) and important incidents and outbreaks for the same period. Finally, this report presents the IPC annual plan for 2021/22.

/ Executive Summary – Key Points

1. All infection prevention and control activities are monitored by the Trust Infection Prevention and Control Steering Group (TIPSG).

2. The *Clostridium difficile*-associated diarrhoea objective for 2020/21 was not set but the trust worked on the objective for the previous year (61) minus 1 which meant having no more than a combined total of 60 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 78 COHA+HOHA cases in the current financial year.

3. MRSA bacteraemia target is that of zero tolerance. There were 0 Trust-assigned cases for the 2020/21 financial year.

4. There was no official MSSA bacteraemia target for 2020/21. There were 63 Trust-apportioned MSSA bacteraemia cases.

5. Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2022/2023. There were 690 cases of the three GNBSI organisms, 234 of which were classed as trust-apportioned.

6. An international pandemic of a novel coronavirus began in December 2019. COVID-19 started to affect the Foundation Trust during February and March 2020 and caused significant operational and clinical challenges throughout 2020/21.

7. During the winter months of 2020/21 there were a total of 0 patients with influenza who required critical care.

8. A number of antimicrobial stewardship initiatives are in place in the trust.

9. The overall average of compliance with the 5 moments for hand hygiene across the organisation is 97% according to the data submitted by clinical staff.

10. Cleaning standards have been maintained on all of the trust hospital sites over 2020/21 with the majority of cleaning scores above the amber Key Performing Indicators (KPI).

11. The trust continues to see cases of *C.difficile* ribotype 001 at Scarborough hospital with the last case identified on 26/03/21. This signifies an on-going issue with C-difficle on the Scarborough site.

/ Recommendation

The Board of Directors is asked to note the year end position in respect of HCAI and for their support for the actions being taken to maintain high standards of care.

Authors: Paul Rafferty, Deputy Chief Nurse; Dr Damian Mawer, Deputy Director IPC/ Infection Control Doctor and Microbiologist; Astrida Ndhlovu, Lead Nurse IPC: York & Andy Whitfield, Lead Nurse IPC: Scarborough

Director Sponsor: Heather McNair, Chief Nurse

Date: 07 July 2021

1. Introduction and Background

This annual report summarises information on healthcare-associated infections (HCAI) for the period 1st April 2020 to 31st March 2021. It includes information on Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and *Clostridium difficile*-associated diarrheoa including a summary of other important organisms. The report also highlights environmental cleaning and staff training in relation to HCAI management. Any outbreaks and adverse incidents that occurred from 1st April 2020 to 31 March 2021 are summarised in this report.

2. Surveillance data

2.1 Recent changes in *C.difficile* and MSSA reporting

Prior trust exposure

From 2020/21 the classification of *C. difficile* and MSSA bacteraemia cases that were to be determined as trust-apportioned changed (Table 2). This means that cases that were not previously reported as trust-apportioned in 2019/20 were now included.

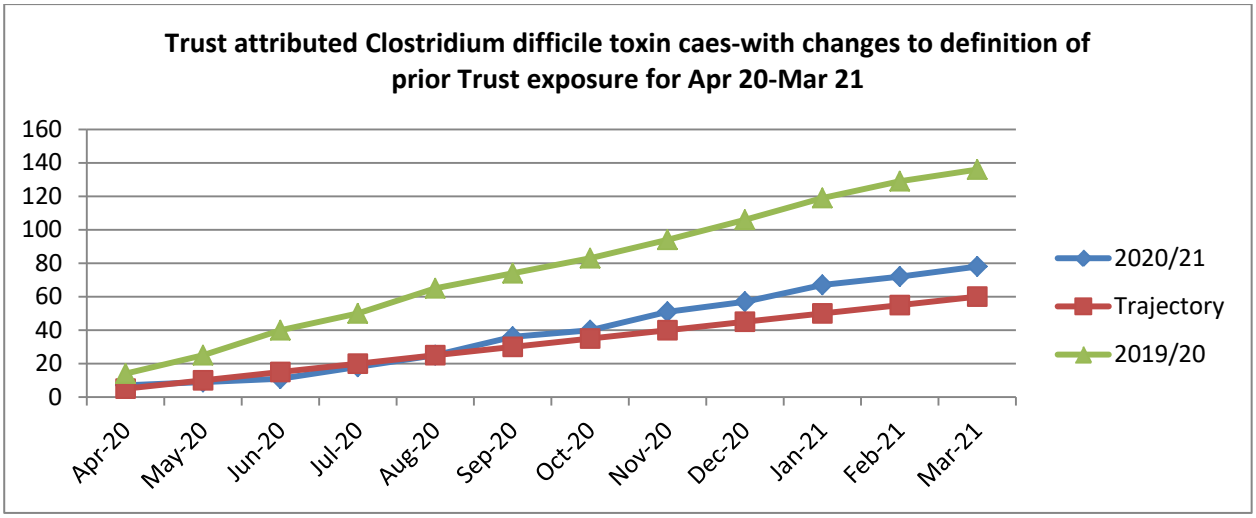
The patient's admissions that should be included must meet all of the following: • admitted to the acute trust that reported the infection case • admission either inpatient, day patient, regular attender or emergency assessment admissions The following patient care episodes are excluded: • all outpatient episodes should be excluded

Table 1. Prior trust exposure definitions 2020/21

In 2019/20 *C. difficile* definitions changed as follows: a) Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission. b) Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. c) Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks. d) Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Table 2. 2019/20 *C. difficile* definitions

The total figure for *C. difficile* cases from April 2020 to March 2021 was 158. In 2019/2020 there were 205 cases so there has been a 22.93% decrease in total cases this year compared to last year.



Graph 1. Trust-attributable *C.difficile* toxin positive cases with new definition

The annual objective for 2020/21 was not set but it was expected to be the objective for the previous year (61) minus 1 which means having no more than a combined total of 60 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years.

There were 78 trust-apportioned cases according to the new definition in table one:

- **COHA = 28;**
- **HOHA = 50.**

In comparison, between April 2019 and March 2020 the Trust had 136 cases of Trust-apportioned *C. difficile* infection. The high rate of cases in 2019/20 was largely due to the *C.difficile* outbreak in Scarborough.

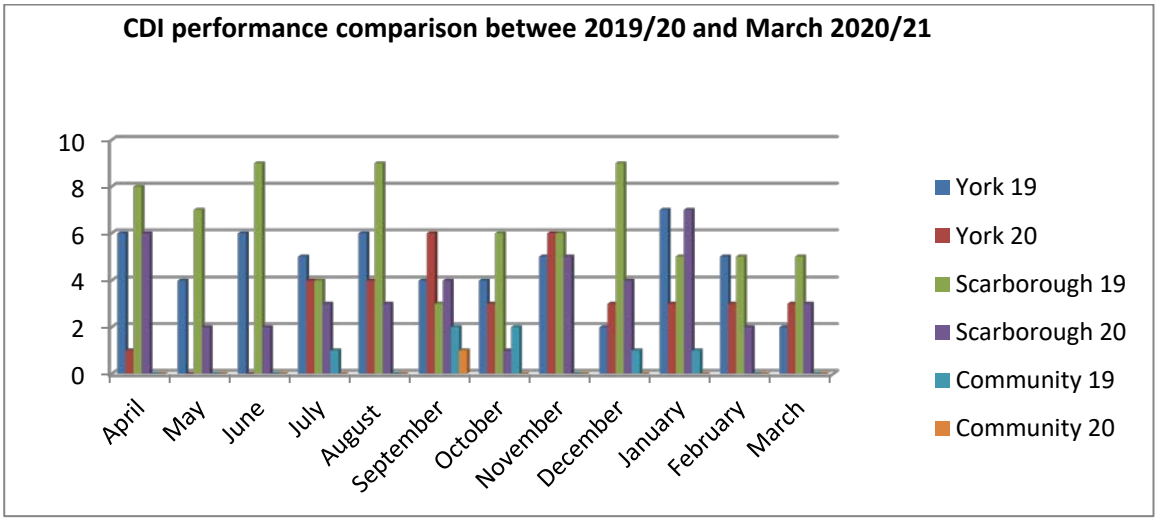
The most significant change in definitions occurred in 2019/20.The additional changes in 2020/21 were relatively minor by comparison, but will have had the effect of increasing the number of cases attributed to the trust in 2020/21. Despite that there were 58 fewer trust-attributed CDI cases in the last financial year, compared to 2019/20. That represents a 43% reduction. Part of the reasons for the reduction will have included reduced patient activity due to the COVID-19 pandemic, and the success of interventions introduced in response to the Scarborough outbreak.

A cluster of *C. difficile* is described as two or more cases which may be linked. During 2020/2021 the Trust had 2 clusters affecting ward 32 at York, and White Cross Court. The poor fabric of the building was among the findings during the investigations of these two clusters with recommendations to change the worn wooden nurses' station on ward 32.

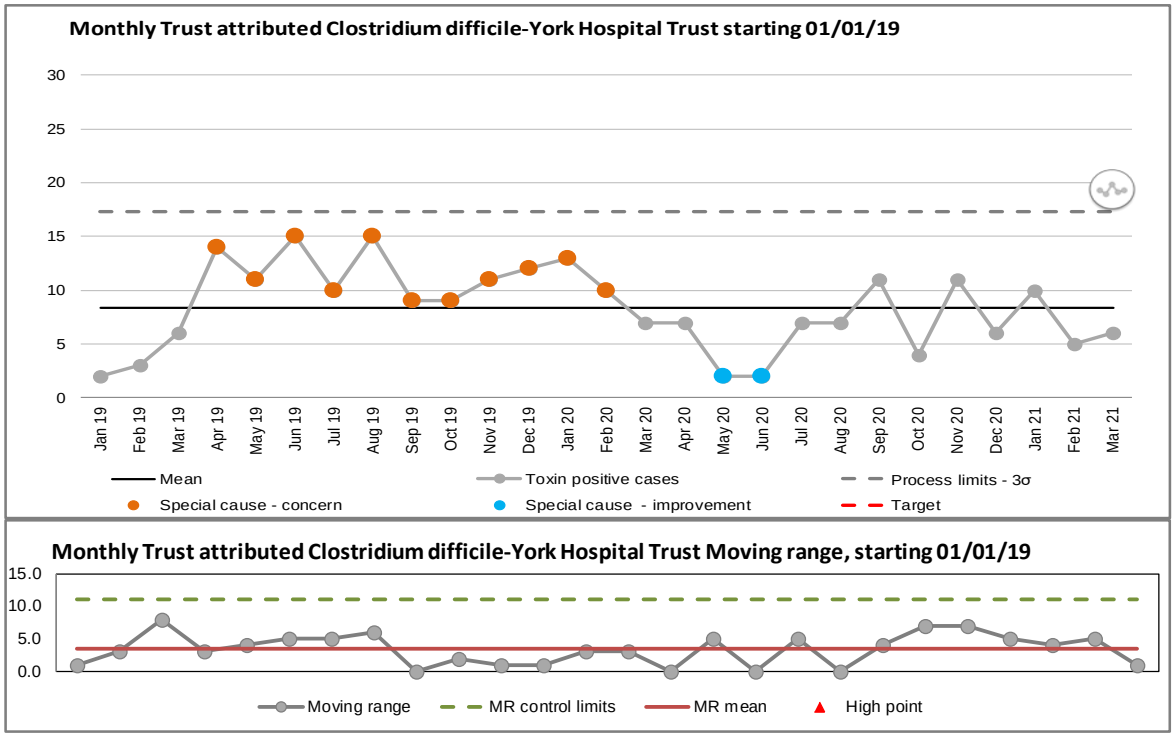
A *C. difficile* action plan detailing control measures that have been put in place in response to the *C. difficile* outbreak in Scarborough has been developed (appendix 1); and is monitored through TIPSG and the *C. difficile* control group. In December 2020 PHE agreed to declare the *C. difficile* outbreak in Scarborough closed. However, there were 6 further cases of Type 001 in January, 2 cases in February and 2 cases in March 2021.

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 and incorporated into the DATIX system in 2020/21. It is intended that this process will highlight action plans on Care Group dashboards, enhance learning from PIR outcomes

and sustained improvement in practice. The process was first trialed in December 2020 on ward 32 in York following a cluster of cases on the ward.



Graph 2. CDI performance comparison between 2019/20 and 20/20/21

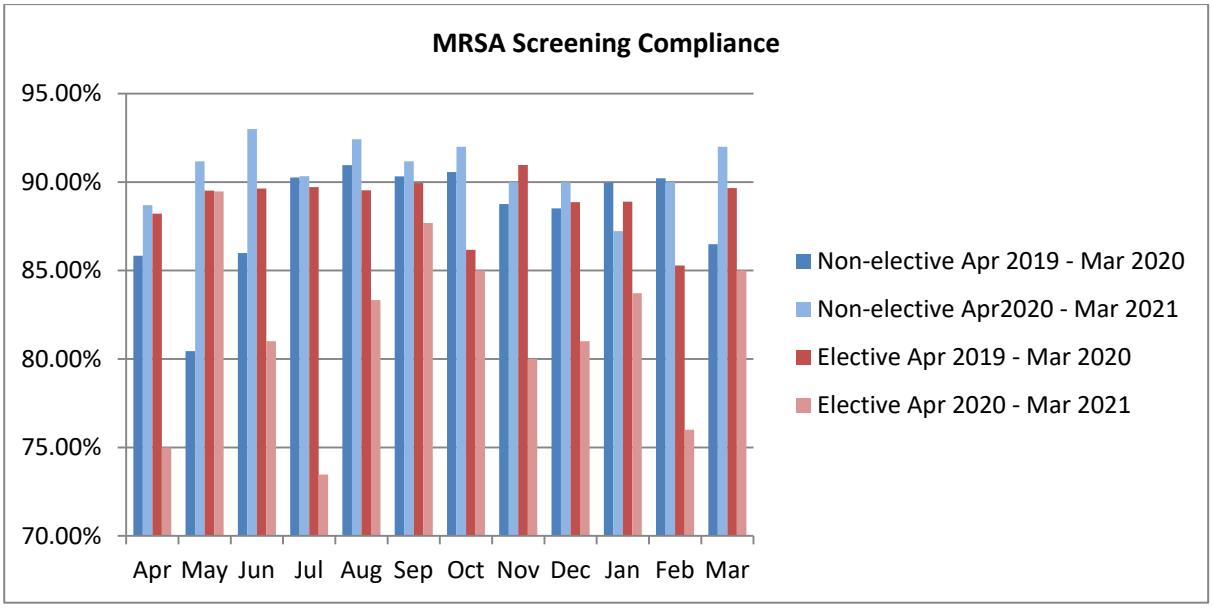


Graph 3. Monthly Trust attributed *Clostridium difficile* January 19 – March 2021

2.2 MRSA bacteraemia

The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There were 0 cases of Trust-assigned MRSA bacteraemia and 1 community case in 2020/21. In comparison there were 5 cases of MRSA bacteraemia in 2019/20 of which 2 were classed as Trust-assigned. This is 80% decrease in total cases.

Every episode of MRSA bacteraemia requires investigation as a clinical incident to help identify lessons to be learnt and to guide improvements in practice; and has helped the Trust to focus attention on avoidable causes of MRSA bacteraemia.



Graph 4. MRSA screening compliance for Elective and non-elective April 2020-March 2021

Central to the control of MRSA is the identification of both elective and acute admissions of patients who are colonized with the organism. This is achieved through screening. Positive patients are isolated and offered decolonization treatment. MRSA screening compliance for non-elective patients has 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 the end of 2021. The low screening compliance for elective patients was escalated to Care Group (CG) 3 Clinical Governance meeting in January 2021, at the senior sisters meeting in February 2021 and again at the CG3 meeting in March 2021.

The MRSA screening compliance for parents in Special Care Baby Unit (SCBU) also dropped to 67% in February 2021. This was escalated to Care Group 5 Quality Committee meeting in February 2021.

MRSA screening for electives and for parents in SCBU will require further action in order to see improvement.

2.3 MSSA bacteraemia

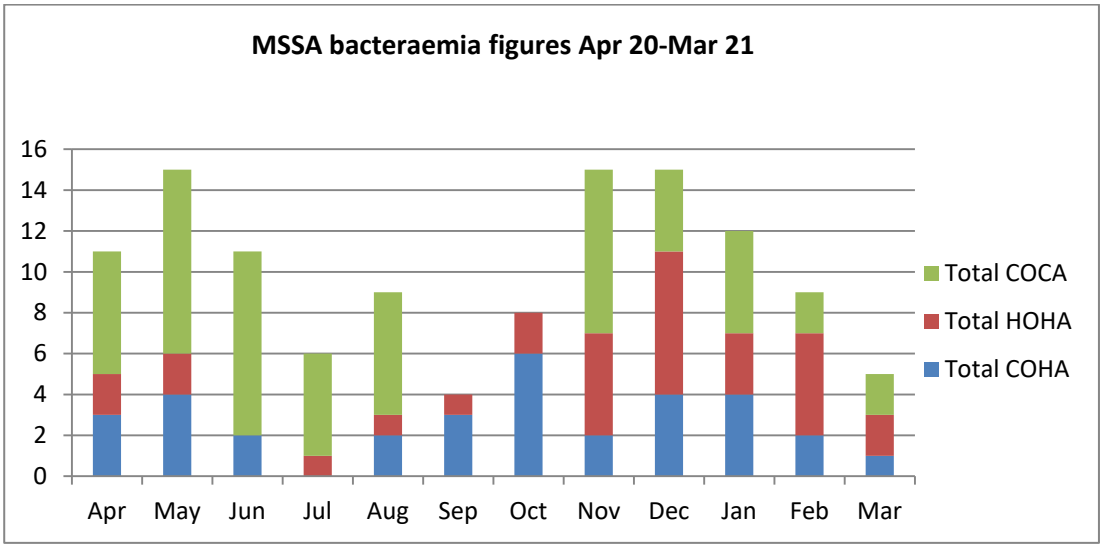
Between April 2020 and March 2021 there were 136 cases of MSSA bacteraemia. 63 of these cases were classed as Trust-apportioned, using the definitions in tables 1 and 2. In contrast, there were a total of 172 cases of MSSA bacteraemia in 2019/20, of which 47 were classed as Trust-apportioned.

Direct comparison with 2019/20 is difficult due to the changes in definitions for Trust-apportioned cases. However, the number of HOHA cases, for which the definition has not altered, reduced from 47 cases in 2019/20 to 33 cases in 2020/21. This represents a 30% reduction.

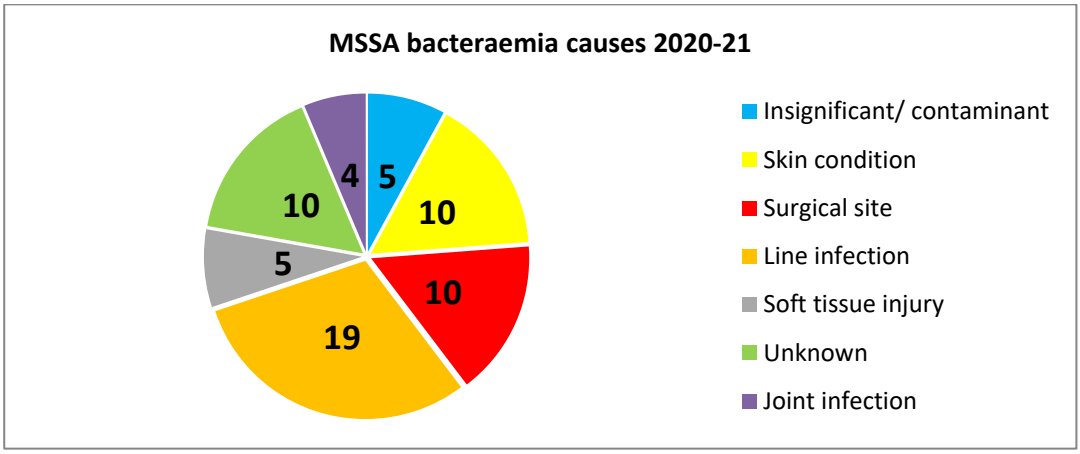
Whilst there was no external target for MSSA bacteraemia, the trust set an internal target of 30 of trust-apportioned cases for 2019/20. This target was only for HOHA cases and does not apply when using the new definition in table 2 which includes COHA cases.

Since 07 November 20210 there have been six cases of MSSA bacteraemia in ICU at York. A recommendation to review the line management documentation and Standard Operating Procedure (SOP) for line insertion was made at the post infection review for these cases.

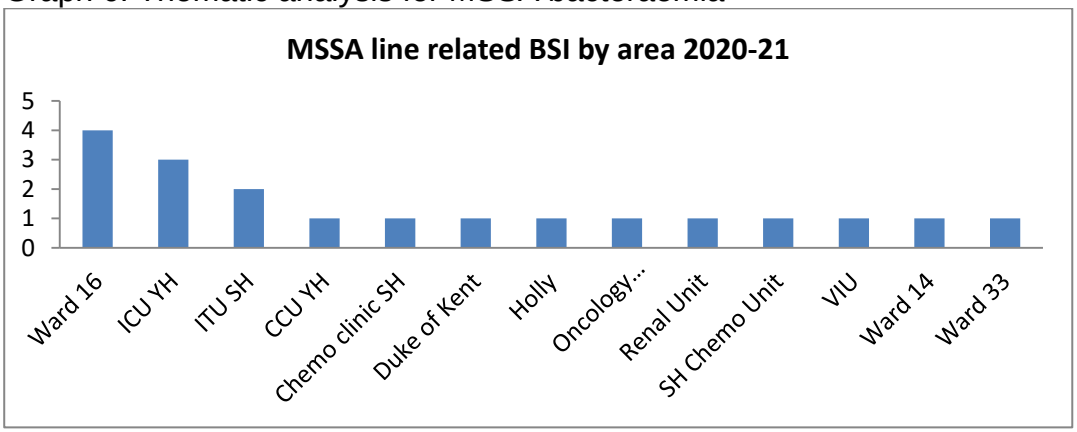
There is also work by clinical teams in Critical Care to implement new ways of taking blood cultures and will be rolled out in 2021/22, with the help of the clinical educators.



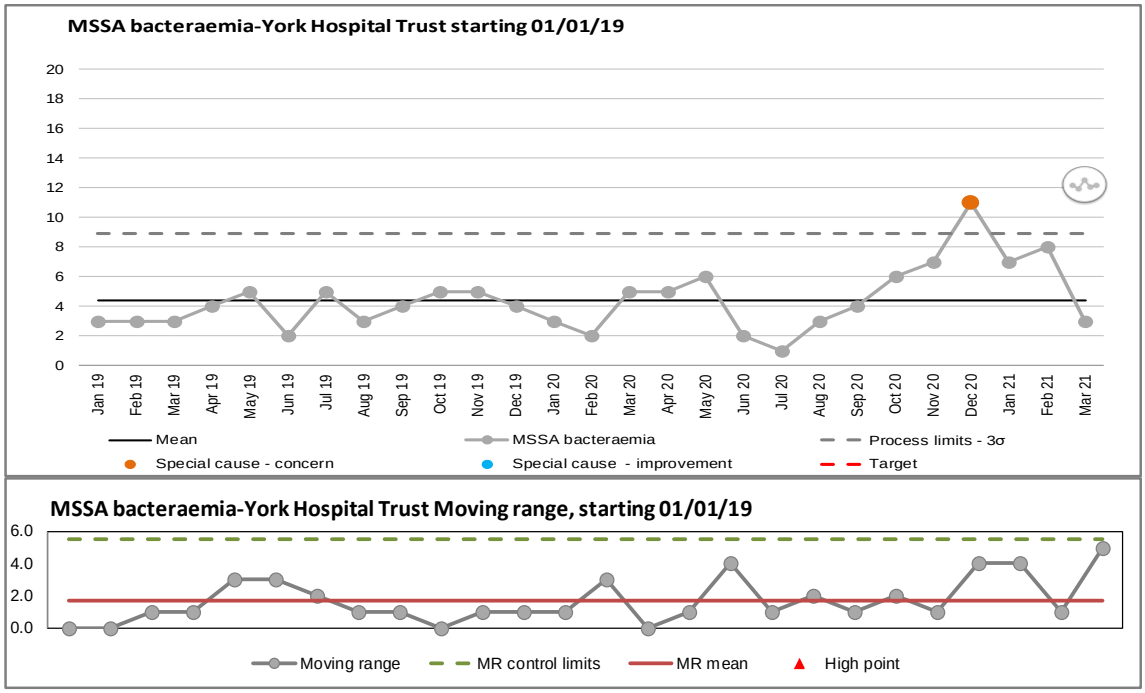
Graph 5. MSSA bacteraemia cases April 2020-March 2021



Graph 6. Thematic analysis for MSSA bacteraemia



Graph 7. MSSA bacteraemia by clinical area - 2020/21



Graph 8. Monthly Trust attributed MSSA January 19 – March 2021

In total 29 MSSA bacteraemia cases were related to invasive procedures. The trust continues to sustain Aseptic Non-Touch Technique (ANTT) practical training for all relevant staff groups 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. Reports from the medical rostering team have stated that there is no budget for bank locum doctors to undertake mandatory training including ANTT. Furthermore, ANTT has also been removed from the required learning mandatory subjects in our Trust. Both of these situations represent risks to the trust.

The HSCA code of practice for Infection Prevention (guidance) states that "6.3 Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently." The Trust does not currently meet this requirement.

Care group 3 are looking to develop a line insertion and removal service in 2021 as this presents a significant gap within the Trust. Poor standards of flushing, cleaning the lines and key parts, as well as leaving old blood around the line under the dressing, all increase infection risk. The Out Patient Antibiotics Therapy (OPAT) nurses have reported that CG1, 2 and Orthopaedics from CG3 are not performing a good standard of line care on the wards. Examples include lack of flushing, resulting in a patient who had to have their line replaced after 3 days of admission. The OPAT nurses in both York and Scarborough have indicated that they have the capacity to train the nurse educators from the different Care Groups. An OSCE has been developed and approved. A short video has been developed with medical education demonstrating the care and removal of midlines, in preparation for the training.

2.4 Gram Negative Blood Stream Infections (GNBSI)

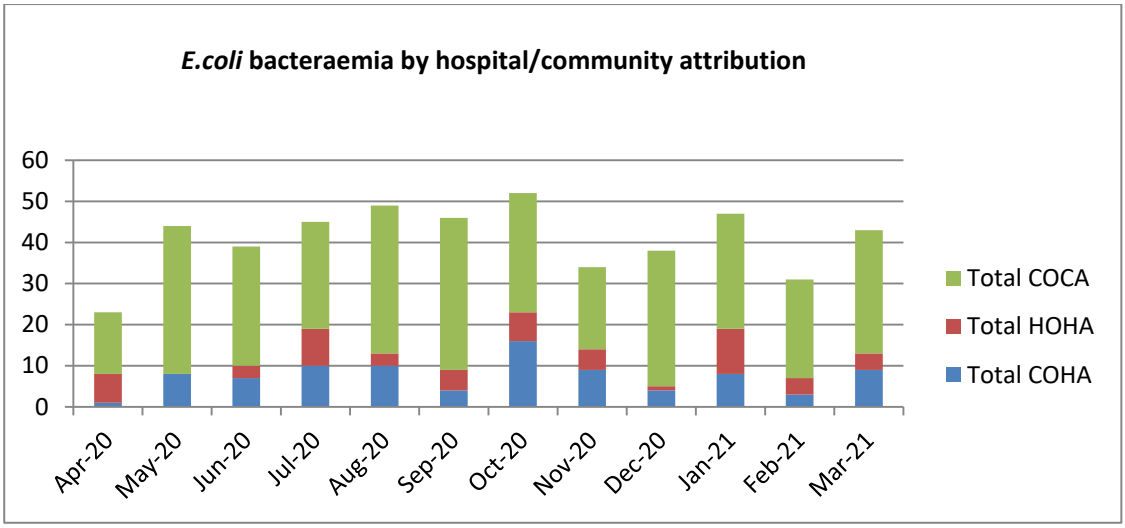
Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in healthcare associated GNBSI by 2022/2023.

In 2020/21, 234/690 (34%) GNBSI cases were classed as trust-apportioned (E.coli 158; *Klebsiella* 56; *Pseudomonas aeruginosa* 20). 2019/20 117/752 (15.6%) were classed as trust-apportioned (*E.coli* 71; *klebsiella* 23; *Pseudomonas aeruginosa* 23). This represents an increase in the rate of trust-apportioned GNBSI for 2020/21 compared to 2019/20.

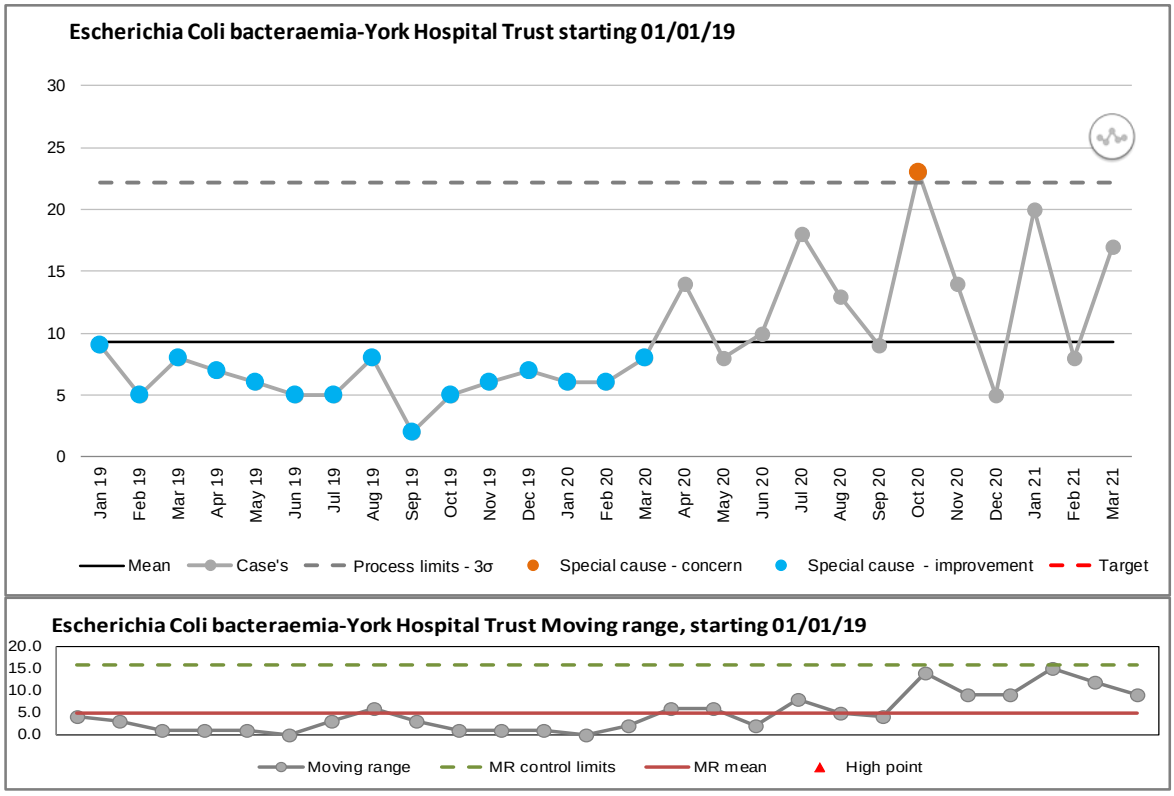
The 2021/22 annual plan includes initiatives to reduce GNBSI including line management, oral care, hydration and catheter management.

The trust saw 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 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 to the same period in 2019/20.

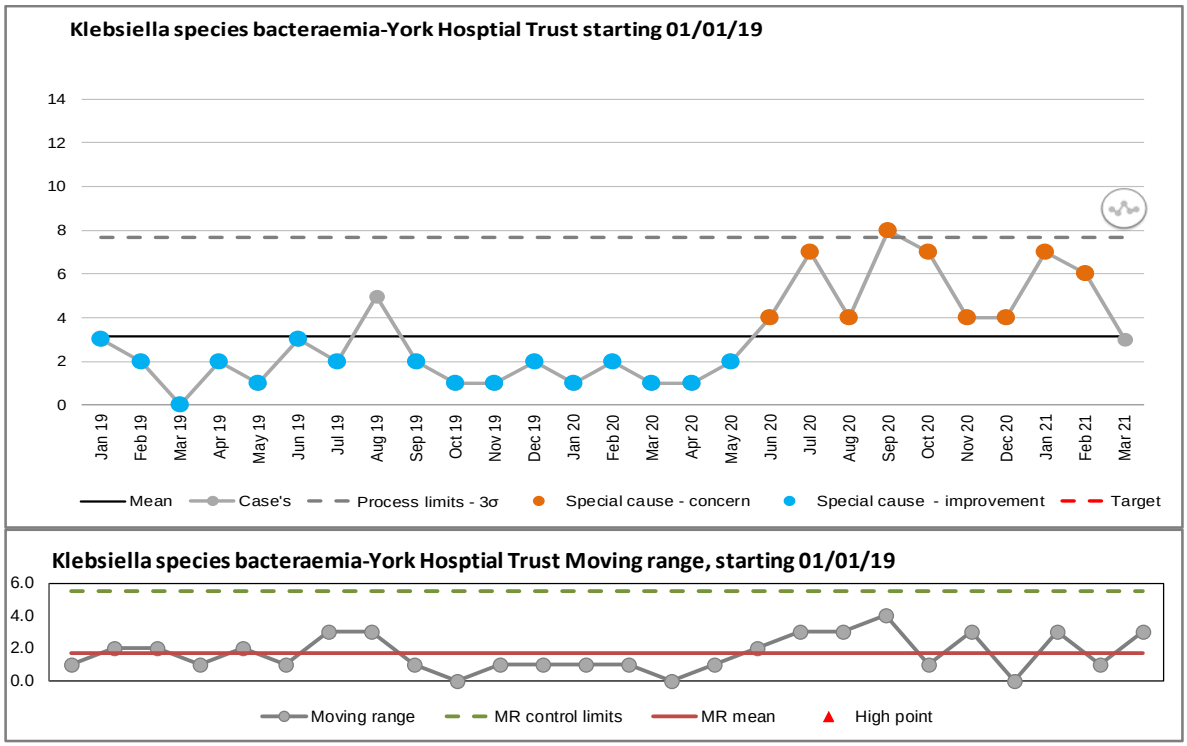
The trust's GNBSI annual plan for 2020/21 focused on ongoing reduction of healthcare associated GNBSI and included introducing initiatives around promotion of hydration, urethral catheter care audits and training and education for staff. However, it has been challenging to undertake these initiatives due to competing priorities of managing the COVID-19 pandemic in 2020/21.



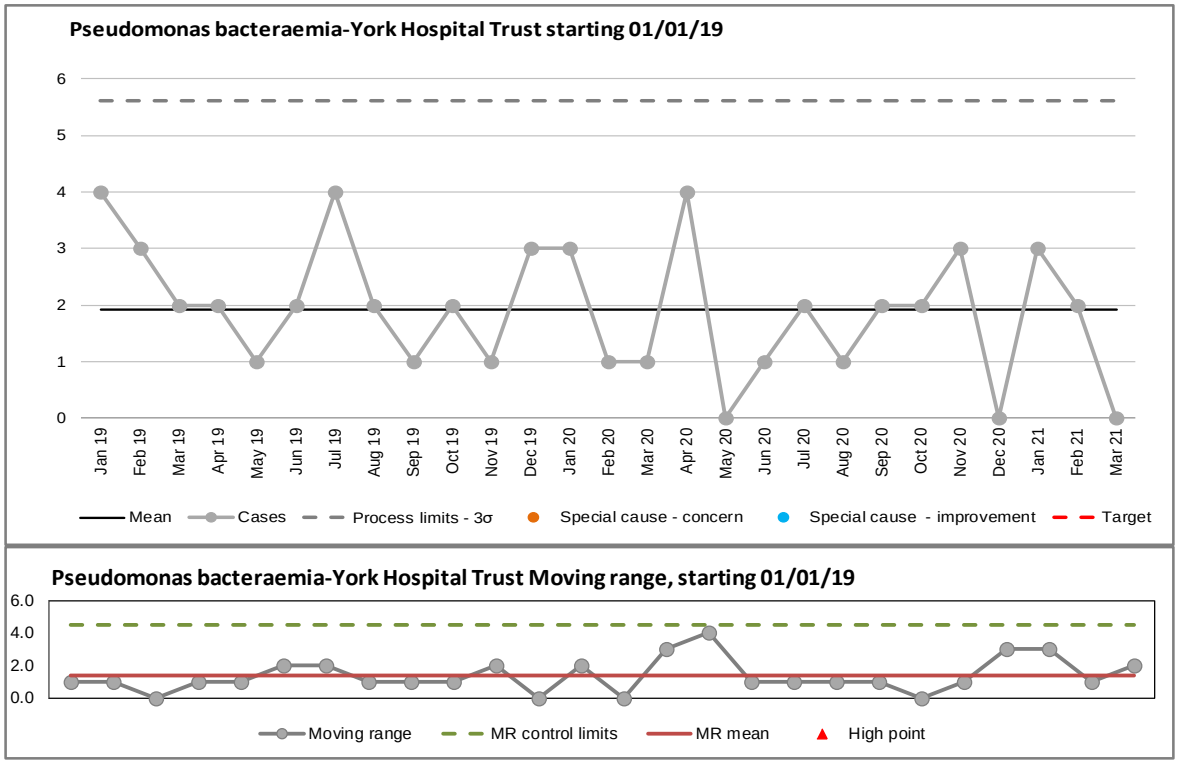
Graph 9. *E.Coli* by attribution bacteraemia April 2020-March 2021



Graph 10. Monthly Trust attributed *Escherichia Coli* bacteraemia January 19 – March 2021



Graph 11. Monthly Trust attributed *Klebsiella species* bacteraemia January 19 – March 2021



Graph 12. Monthly Trust attributed *Pseudomonas* bacteraemia January 19 – March 2021

2.5 COVID-19

The global pandemic of COVID-19 originated in China in December 2019 and rapidly spread across China and many other countries and was declared a Public Health Emergency of International Concern by the World Health Organisation in January 2020. On 11th March 2020, the World Health Organization declared COVID-19 a global pandemic. The pace of COVID-19 has been unprecedented and has stressed our healthcare system. The pandemic was driven by the high infectivity of the SARS-CoV-2 virus, infectivity pre-symptom onset, and an initial lack of understanding of the virus transmission routes.

There were 2756 cases of COVID-19 admitted to the Trust to the end of March 2021. 605 (22%) of these patients died.

2.5.1 COVID-19 Healthcare-Associated Infections (HCAI) Reporting

COVID-19 positive swabs taken 8-14 days post admission and positive swabs taken 15 or more days after admission are classed as probable hospital acquired and definite hospital acquired respectively. These cases are investigated through a post infection review (PIR) process.

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; in line with 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 using the "Checklist and monitoring tool for the management of COVID-19" published by NHS England 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 the York and Scarborough sites. The Sani Stations were installed on both acute sites in March 2021. These are branded to the Trust, a visual representation can be found in Appendix 2.

NHS England has developed a Board Assurance Framework (BAF) to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance, and to identify risks. The IPC team, and other relevant stakeholders, update this document quarterly and share it with the DIPC, for escalation to Executive Board as required.

3. Outbreaks and incidents

3.1 Outbreaks

3.1.1 COVID-19

A total of 36 outbreaks of COVID-19 have been investigated since the start of the pandemic. 6 of these were staff outbreaks: 5 occurred in non-clinical areas and 1 in a clinical area. 30 were patient outbreaks in clinical areas, where some staff were also affected. Serious Incident investigations have been conducted for outbreaks clustered in Scarborough Hospital between October and December 2020, and in York Hospital between December 2020 and February 2021.

There was a member of staff who tested positive to COVID-19 on CCU in Scarborough in October 2020. This member of staff had contact with 13 other members of staff on the unit whilst there was a significant breech of PPE. At the time these staff contacts were not correctly identified and continued to work for 4 days. This incident resulted in 13 members of staff being sent off to self-isolate and 44 patients placed on a 14 day watch list as they had contact with some of these 13 members of staff in the timeframe they should have been self-isolating. One of the 44 patients tested positive in November 2020 and died. The positive swab was taken just beyond the 14 day period. A PIR was held on 18 November 2020 to investigate this case. Covid-19 was not the cause of this patient's death.

In a separate incident on CCU in Scarborough, an outbreak of COVID-19 was identified and the ward was closed on 31 October 2020. The outbreak affected 3 further wards as a result of patients transferring from CCU to other wards. Staff on the affected wards; (CCU, Cherry, Oak and Chestnut) were screened as part of the outbreak management from October to November 2020.

A total of 98 patients were affected with the last case reported on 30 November 2020. 41 patients died of COVID-19 and this was investigated as a Serious Incident (SI).

Outbreaks of COVID-19 were identified in non-clinical areas affecting staff in York from the beginning of January 2021. 12 staff were found to be positive in the Patient Access team, 2 staff in the Neurosciences reception team, 7 on ward 35, 4 staff in the District Nursing team at Acomb and 2 in the Vascular imaging department. These staff outbreaks were closed in February 2021.

An outbreak of COVID-19 was identified on Johnson Ward at Bridlington Hospital in December 2020. 21 patients out of 24 were affected. Actions to control the outbreak included 72 hour staff screening from 5 December 2020; and an extended period of ward closure which resulted in positive patients being transferred to red areas at Scarborough Hospital. The last positive case was on 15 December 2020. Staff screening identified 3 positive staff out of 50 swabs. Staff swabbing ceased on 29 December 2020.

Five members of staff in Scarborough Emergency Department tested positive to COVID-19 in December 2020. This outbreak was discussed and managed as part of the SGH/BDH COVID-19 outbreaks. The last positive case was on 21 November 2020.

Seven members of staff in York Endocrine department tested positive to COVID-19 positive from 20 December 2020 to 29 December 2020. The outbreak control group (OCG) found that transmission amongst staff occurred between two individuals and the rest of the staff had most likely acquired the infection outside of the work environment. Actions to prevent further transmission included providing extra room for reception staff to allow for 2 meter social distancing. The last positive case was on 29 December 2020.

Outbreaks of COVID-19 affected 6 wards on the York site from 02 December 2020. An outbreak control group was formed to manage all the outbreaks as a whole. The OCG included representation from PHE and the CCGs in some of the meetings. All the wards were re-opened by 30 December 2020 but continued to be monitored up to 28 days; being the end of an outbreak as stipulated by PHE. 52 patients were affected. 21 patients died within 30 days of the positive result. 14 patients were positive 15 days and over of admission (definite hospital acquired) whilst 21 patients were classed as probable trust attributed (swabbed 8-14 days of admission). Out of the 14 definite cases 6 had COVID-19 stated as 1a or 1b on the death certificate. This was escalated to the Quality and Safety group on 04 January 2021 for consideration of appropriate investigations.

An outbreak of COVID-19 was identified on Cherry ward in Scarborough from 15 January 2021. The outbreak affected 10 patients of which one patient was a definite hospital acquired case. There have been no further positive cases on Cherry ward since 02/02/2021.

Outbreaks of COVID-19 affected ward 39 on the York site and Nelson's Court 2 in February 2021. A total of 14 patients were affected in the outbreak of which 8 were classed as definite hospital acquired cases.

Outbreak meetings were held for all patient and staff outbreaks with recommendations as outlined in the trust IPC COVID-19 guidance, which was updated in January 2021 in line with the national COVID-19 guidance.

A further outbreak of COVID-19 involving 2 patients was identified on Coronary Care Unit (CCU) in Scarborough in March 2021. No further cases have occurred since 23 March 2021. The ward was under IPC restrictions such as reducing footfall to prevent any further transmission; but was not closed. This outbreak was closed on 20/4/2021.

All COVID-19 outbreaks were reported to the NHSE/I using their online portal and followed up to 28 days after the last case, as stipulated by PHE. A summary of all the outbreaks from November 2020 has been submitted to the Patient Safety team, to be able to accurately apportion harm and ensure Duty of Candor has been exercised where required.

3.1.2 C. difficile

Thirteen cases of *C.difficile* Ribotype 001 have been identified in stool samples since September 2020 in Scarborough. Following an agreement with PHE to close the *C.difficile* outbreak in Scarborough in December 2020, ten further cases had been identfied.

Two cases of *C. difficile* with the same ribotype were identified on ward 32 at York hospital. A PIR was held with action plans around changing damaged commodes and improving the general estate of the ward. Ward 32 was escalated for consideration for the backlog prioritisation funds to have the nurses' station replaced by April 2021.

The Trust continues to face challenges regarding the estate and the remedial actions due to financial pressures and the lack of decant space to allow for refurbishments. There are plans to undertake formal risk assessments of all clinical areas in 2021 to identify major outstanding works that can be completed using backlog prioritisation funds. There is a significant risk that wards will not be refurbished during 2021/22 due to the expected demand.

A proactive decant and HPV plan has been developed for Scarborough with the aim of commencing by June 2021 as part of a wider *C.difficile* reduction strategy. The Deputy Chief Nurse for Infection Prevention and Control is working with the Lead Nurse (York site) to develop a proactive plan of education and training for 2021/22.

3.2 Incidents

On 31st December 2020, an incident of non-adherence to IPC precautions in the Endoscopy department at York resulted in 15 members of staff being advised to self-isolate after one member of staff tested positive to COVID-19. This incident was escalated through to Quality and Safety group. No other staff tested positive.

An incident involving a patient with Carbapenamase Producing Enterobacteraese (CPE) occurred on ESA and ward 14 at the York site in March 2021. Eight other patients 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.

A case of Varicella zoster was identified in a bay on ward 31(Haem/Onc ward). The incident involved 7 patient contacts and 3 staff who were deemed to be at risk. These patients and staff were screened and had bloods taken. All 7 patients were VZV IgG positive. An incident meeting was held on 19 March 2021 with no further actions required from the incident.

Cesarean section Surgical Site Infections (SSI) on the Labour ward at York in March 2021 has prompted investigations into the root causes. Preliminary investigations, including an assessment by the IPC team, have revealed concerns with the poor state of the maternity theatre. Recommendations have been made and actions will be followed up through care group engagement. Also see appendix 3.

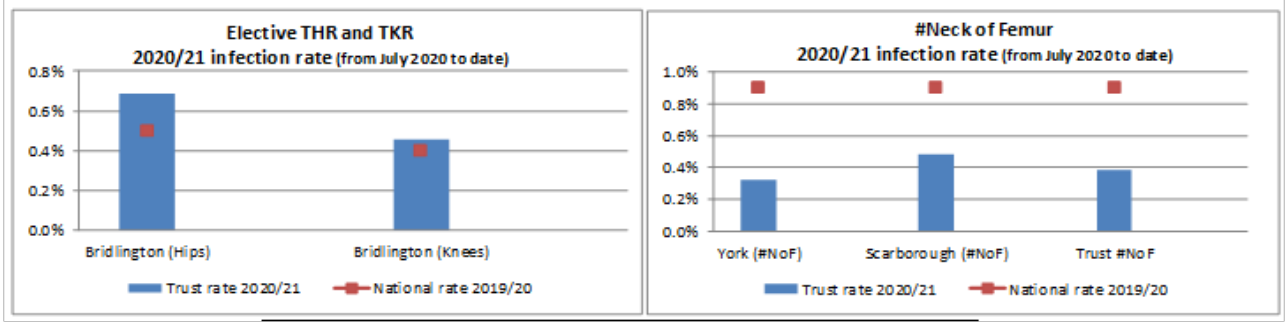
Three surgical site infections have been identified for the period of January and February 2021 for patients who had their orthopaedic surgery whilst an inpatient on Kent ward in Bridlington Hospital. Post infection reviews are underway to establish cause and an IPC visit is planned for April 2021 to assess practice and support staff.

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	YTD
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	0	1
Scarborough (#NoF)	0	0	1	0	0	0	0	0	0	1
Trust	**0**	**0**	**1**	**1**	**0**	**0**	**2**	**1**	**0**	**5**

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

	Bridlington (Hips)	Bridlington (Knees)	York (#NoF)	Scarborough (#NoF)	Trust #NoF
Trust rate 2020/21	0.69%	0.46%	0.32%	0.49%	0.39%
National rate 2019/20	0.5%	0.4%	0.9%	0.9%	0.9%



Picture 1. Orthopedic surgical site surveillance data-July 2020 to March 2021

In March 2020 an inpatient was unexpectedly diagnosed with tuberculosis in York Hospital. As the diagnosis was not suspected on admission several patients and members of staff were exposed. An incident meeting was held at the time but the contacts identified were not informed or offered screening. This omission came to light in February 2021. Investigation identified the pressures of the COVID-19 pandemic 'first wave' and the lack of a clear action plan as the root causes for the delay. The four contacts have now been identified and informed. This included a letter of apology for the delay. This incident was reported to the Quality and Safety group and through DATIX in February 2021. All 4 contacts were screened by the TB team and discharged. A tracking process (RAG rate system) has now been developed within the IPC team to ensure that significant incidents are followed up appropriately.

Another patient with military TB was identified on ward 34 at York Hospital in February 2021. The patient was in a bay and this resulted in 4 contacts who have since been informed.

There were no Influenza cases reported in Critical Care across the organisation in 2020/21.

4. Antimicrobial Stewardship

The core business of the antimicrobial stewardship group is to review the medication incidents linked to the use of antimicrobials, focusing on high risk drugs such as gentamicin, vancomycin, allergies and missed doses of antibiotics as critical medicines. The group also approves guidelines and protocols. Other duties of the group include:

- Review of audits and their recommendations
- Review of progress with EPMA to support stewardship
- Review of progress with CQUINs and reduction in antimicrobial consumption and campaigns to improve stewardship such as ARK. Please note that the CQUINS have been abandoned for 20/21 and 21/22

- Identifying lesson learned and information to share with medical, nursing and pharmacy staff.
- Identifies items to escalate to the Medicines Management Group.

During 2020/2021 Covid 19 prescribing guidance has been updated with guidance developed for the use of Remdesivir which was subsequently abandoned and guidance developed for the use of Tocilizumab. Data has been collected as part of the International Severe Acute Respiratory and Emerging Infection Consortium (ISARIC) study.
Various audits and action plans have been carried out and developed around antimicrobial prescribing for pneumonia in patients diagnosed with Covid 19.

5. Risks

5.1 COVID-19

Social distancing remains the cornerstone of the government's policy for containing the COVID-19 pandemic. Rising admission numbers (bed occupancy of 22,240 in March 2021, versus 13,126 in April 2020) are putting pressure on bed capacity, particularly on amber (medium risk) wards. As a result, the beds removed from bays to support social distancing during the height of the pandemic have had to be put back in place on most wards. There is a significant risk across that the Trust cannot always provide socially distanced beds in all wards and bays across all hospital sites. This has been escalated via the silver and gold command structure and also shared in all monthly IPC reports with the Trust's Quality Committee.

To mitigate this, Quality Impact Assessments (QIA) of the use of these non-socially distanced beds have been 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 assessments for the use of these beds, with their de-escalation whenever possible. In addition, there has been a renewed drive to deliver social distancing on all wards across the Trust. This is being led at Care Group level with reporting to Silver Command for any issues that require escalation. This remains challenging due to operational pressures. 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 has been highlighted to Public Health England (PHE) and the local Clinical Commissioning Groups.

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.

The COVID-19 pandemic brought to light the lack of mechanical ventilation in clinical areas across the organization. Clinical areas relied on natural ventilation from open windows (less than the 6 recommended air changes) in amber wards during the pandemic;

and mobile air handling units were placed in high risk areas and areas were Aerosol Generating Procedures (AGP) were being undertaken.

The decision by the Trust to remove ANTT from mandatory training makes it challenging to impose this training on staff who undertake invasive procedures. However, ANTT is still added to profiles of staff groups who undertake invasive procedures.

5.2 C. difficile

Despite several attempts it has not be possible to sustain a proactive ward decant program at either main hospital site over the past few years, however, Scarborough has successfully completed a full proactive clean of all wards including the A&E with the exception of Lilac Ward in 2020/21. This process is crucial, as it allows terminal cleaning, the deployment of HPV and refurbishment of the ward. These interventions contribute to the removal of *C. difficile* spores and makes future cleaning of the environment more effective. Without this work *C. difficile* reservoirs in the environment cannot be effectively eradicated, creating an on-going risk of transmission, including of the 001 ribotype in Scarborough.

Despite the challenges of the pandemic all general adult in-patient wards at Scarborough Hospital received proactive HPV cleaning on an ad-hoc basis 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 June 2021; this is being reviewed and requested to be brought forward due to recent increased incidence of *C. difficile*. It is particularly important that this work includes the emergency department and admissions areas. This should be facilitated by the refurbishment of Ann Wright Ward, whose 11 side rooms are to be used as a decant space.

5.3 Other risks

Scarborough ICU ventilation remains non-complaint and a risk. Care Group 3 is looking into more robust interim solutions; working with the Ventilation Steering group.

The lack of a dedicated service for long term intravenous access devices (“lines”) across the trust is associated with an increased risk of MSSA, MRSA and Gram negative blood stream infections. Whilst services exist, or are being set up, for line insertion and removal there is no effective process in place for the ongoing management of these devices.

Inappropriate and prolonged use of antibiotics, particularly broad spectrum agents, has been identified in post-infection reviews as a factor contributing to a significant number of Clostridium difficile cases. This is a trust-wide risk but there are particular concerns at Scarborough hospital due to the current *C. difficile* outbreak. The trust has multidisciplinary antimicrobial stewardship team working to support improved prescribing. Current work streams include the roll out of the ARK (Antibiotic Review Kit) project, and the education of junior doctors.

The lack of effective surveillance systems in the IPC team is also a risk. This is required as stated in NICE PH 36/QS 3, that states there should be evidence of fit-for-purpose IT systems to support surveillance activity. This includes evidence of validation processes that ensure data accuracy and resources that can analyse and interpret surveillance data in meaningful ways. IT options being investigated include ICNet, or CPD solution. There is a significant financial constraint associated with ICNet; this must link with the implementation of the telepath solution. This has been included in the Trust’s annual IPC plan for review in quarter four.

There is risk to patients and staff from not consistently identifying individuals at high risk of carrying organisms which are a particular infection prevention risk. A request has been submitted to IT to enable easy identification of patients with infection alerts. Action from this will be followed up in 2021.

Sluice hoppers present a risk of contamination from body fluids and transmission of infection from aerosolisation. Costings for the hoppers were sought in 2019/20 and a risk assessment was produced in 2020/21 to progress with the work of removing hoppers from clinical areas. This work was put on hold because of the complexity of the work which may affect other parts of the system such flooring, pipe-work and cost.

There is a significant and material risk of outbreaks of infection resulting from insufficient isolation facilities throughout inpatients areas and ED. It is not currently possible to isolate all appropriate patients. Outbreaks of COVID-19 highlighted transmission from patients who were moved into main bays after one negative swab following admission in contrary to advice from PHE to keep patients isolated until they have had a second negative screen. This was also partly due to operational pressures.

Six office spaces in York were converted back to isolation rooms and in Scarborough Ann Wright ward and Haldane ward that were Nightingale style wards were converted into side rooms in 2020/21. However, side room capacity still remains a challenge.

New builds of Emergency Departments on both York and Scarborough sites are at planning stages; with consideration for isolation capacity. Building works will commence in 2021. There are IPC risks associated with these plans which includes shared entrances to areas on the first floor. These have been escalated to the capital planning team who have identified potential mitigations.

6. Successes for 2020/21

The IPC team recruited to all vacancies in 2020/21; and this will enable the team to undertake projects and initiatives that were challenging to move forward due to staffing issues.

There have been 28 side rooms created in 2020/21; 11 on Ann Wright ward, 11 on Haldane ward and 6 across the York site. This will alleviate some of the challenges with isolating patients with infections.

Twenty items on the *C. difficile* action log were successfully completed. These included the formation of a transfer team on the Scarborough site to ensure patients are transferred on trollies and not beds to reduce the risk of transmission of infection. The trust moved to the use of microfiber mops on the Scarborough site as a standard which was implemented alongside staff training in their use. This means both main hospital sites are now using the same process.

All wards on the Scarborough site, including the ED underwent HPV disinfection apart from Lilac ward which is now on the HPV priority list for June 2021. There was no proactive HPV disinfection carried out in York due to the lack of a decant space.

7. Environmental cleaning and decontamination

The trust continues to monitor monthly cleaning scores through the Cleanliness Monitoring Group 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 14 August 2020. Exception and risk escalation from EMG are expected to be through TIPSG. Follow on meetings and review of meeting structures is being arranged. The main functions of the group would be:

- 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

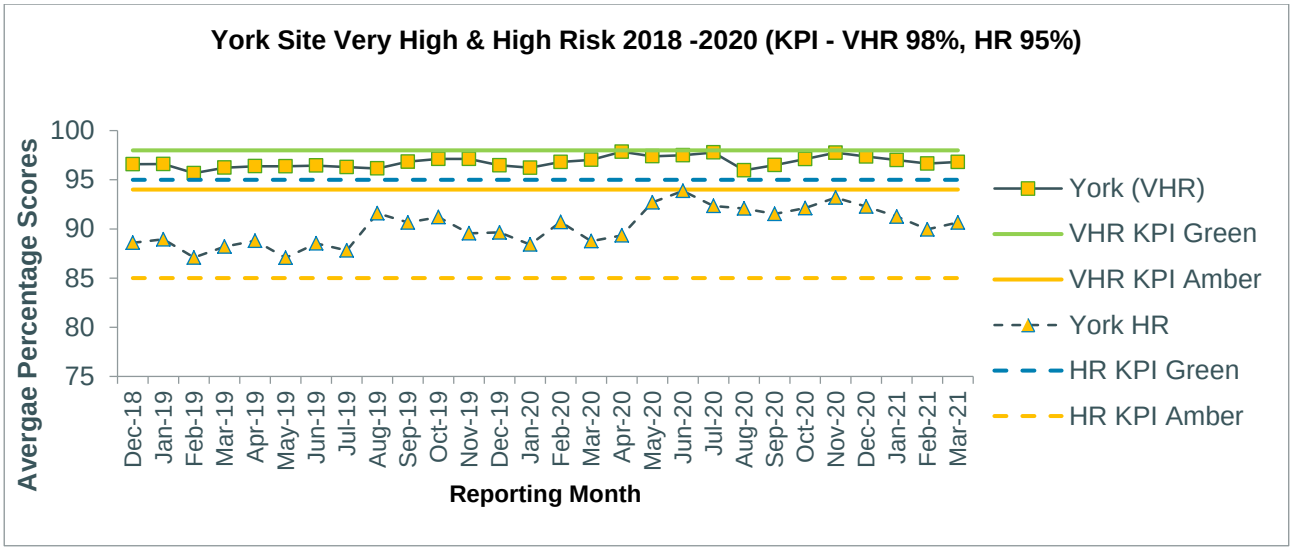
The trust introduced an electronic system of auditing the environment on 4 September 2020 as part of an integrated audit of care elements through a computer application (app). The IPC team monitors the weekly and twice weekly audits from the app and shares any concerns escalated via Bronze commands and to TIPSG.

In response to the CAS alert from 24 December 2020 for frequent decontamination of high touch surfaces and items, including enhanced cleaning of communal toilets after each use; it was agreed that this would be picked up with Matrons in each Care Group to provide an individual response to the cleaning alert at ward level. Assurance for completion of this action was provided at the Quality and Safety group.

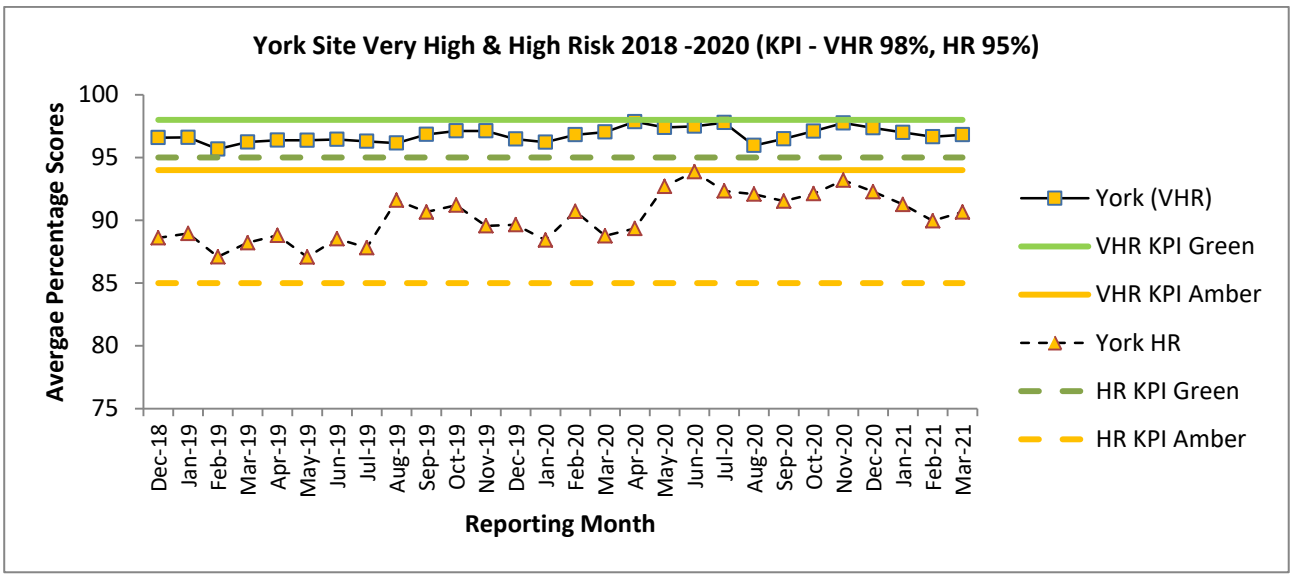
Date	York	Scarborough	Bridlington	Selby
Apr-20	97.85	98.51	99.40	96.47
May-20	97.39	98.11	98.63	97.44
Jun-20	97.49	98.41	97.73	96.22
Jul-20	97.78	98.04	98.84	97.38
Aug-20	95.96	97.65	99.00	96.95
Sep-20	96.49	98.14	98.61	96.10
Oct-20	97.10	98.27	98.15	99.01
Nov-20	97.75	97.96	98.59	97.38
Dec-20	97.36	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

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

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



Graph 13. York Site Very High & High Risk 2018 -2021



Graph 14. Scarborough Site Very High & High Risk 2018 -2021

The Decontamination Steering group has escalated items to TIPSG in 2020/21 including the completion of the endoscopy decontamination centralisation project in Scarborough and replacement of autoclaves for York as enhancement to the decontamination work in the organisation.

8. Water Safety

On 1 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 had come back clear with the exception of 3 outlets; which all showed significant reduction in counts. The Trust's water safety plan was followed ensuring appropriate mitigations for the level of identified risk for these remaining 3 outlets were in place. 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	Room Description	Outlet	Result	

No.				
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 February 2021 and a flushing regimen of the tap put in place. Pre and post flush samples after one week showed no growth.

There have been failings in pre and post water tests on Ann Wright ward and Haldane ward since the refurbishment of the two wards in December 2020. The tests have shown high Total Viable Counts (TVC). Filters were placed on the taps to facilitate opening of the wards to patient care, however it is believed that the issue of the failures could be from the water tank where works are planned to be carried out in the new financial year.

Due to ongoing failings of the hot water tap within the Oncology kitchen at York, an agreement with the department is to be reached about completing a full refurbishment of the kitchen. The Estates department will organize the works to fit new pipe-work and taps on a weekend to avoid disruption within the department.

Abnormal water test results were received from the Community Stadium in York in August 2020 prior to the Trust services moving in. The Estates team is working on gaining an understanding of what processes were followed on receipt of the failed results; and to get an understanding of the role of the Trust in water management at the Community Stadium.

9. Staff training

Staff training during the COVID-19 pandemic has been carried out in conjunction with the Clinical Skills team for donning and doffing of Personal Protective Equipment (PPE); and the Health and Safety team for FFP3 fit testing and use of respirators. Training records have been reflected in the BAF for assurance.

Seven mandatory training sessions were delivered to the band 5 preceptors in 2020/21. In October 2020 sixty six band 5 preceptors were trained. From July to April 2021 ten HCA training sessions and 1 international staff training were conducted. A total of 151HCAs were trained in 2020/21. The small number of staff trained reflects the requirement for social distancing during face to face training due to the COVID pandemic. Short COVID training sessions were delivered to a further 17 staff from April 2020 to June 2020. Mandatory training was delivered to 8 Dental staff in February 2021.

The focus of the training in 2020/21 has been on COVID-19 IPC precautions including the appropriate use of PPE, social distancing, hand hygiene and the importance of ventilation in work places.

PPE refresher training was conducted in October 2020 capturing all the in-patient wards on the York site and some community sites; targeting 4-5 staff on each ward with the aim of a cascade type of training by staff that received training. This training remains on-going for both Scarborough and York sites; and is carried out as part of the IPC clinical visits.

IPC mandatory training trust-wide compliance is 90% for level 1 and 85% for level 2. The low IPC mandatory training compliance was highlighted to the senior nurses meeting in February 2021. Medical and dental staff mandatory IPC compliance remains low around 79% for level 1.

The IPC level 1 face to face training presentation has been revised and submitted to the Work Based Learning team in readiness for the new fiscal year.

Other planned staff training programs based on the IPC annual plan for 2020/21 have been challenging to achieve due to priorities being given to managing COVID-19 across the trust and staffing challenges within the IPC team.

The IPC team has arranged a one day in-house Water Safety training to be delivered by the Health and Safety team. The training will be completed in May 2021 for both IPC York and Scarborough sites. This training meets the requirement of Health and Safety Executive (HSE) for any person responsible for water safety in a healthcare setting.

The overall average of compliance with the 5 moments for hand hygiene across the organisation is 97% according to the data submitted by clinical staff. Peer hand hygiene audits by the IPC team are planned for 2021/22 to gain assurance of the data being submitted by clinical staff.

10. 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.
- Incorporate cleaning competencies in the IPC training program with a focus on commode and bed cleaning as part of a wider *C.difficile* reduction strategy.
- Gain assurance of the hand hygiene audit scores presented by clinical teams through comparable peer hand hygiene audits by the IPC team.
- 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 the 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.
- Respond to CAS alerts and aim for improvement in practice.
- Working with the tissue viability team to relaunch annual mattress audits.
- Audit invasive device management with a focus of reducing HCAI bacteraemia related to invasive devices**.**

11. Detailed Recommendation

QPAS group are asked to note the trust position of HCAIs; and to gain assurance from the actions within the *C. difficile* action plan.

QPAS group are asked to acknowledge and support initiatives to reduce other HCAIs.

The IPC mandatory training compliance for medical and dental staff is low. QPAS group are asked to gain assurance that the trust is aligning the IPC statutory and mandatory program to the Skills for Health Core Skills training Framework (CSTF) which will reduce unnecessary duplication of learning for medical staff who are moving from other trusts and ensure a true reflection of staff that have completed training.

The outbreaks of COVID-19 among patients and staff remain a concern. The IPC team advises that QPAS acknowledges the risks of inadvertent transmission of COVID-19 to staff or patients as a result of relaxing social distancing within clinical environments. The Board should gain assurance that the mitigations are in place to reduce the risk of COVID-19 transmission on wards where social distancing is not possible.

Infection Prevention and Control team

Annual Plan 2021/22

This plan may change if significant risks or issues are identified and will depend on the progress of the COVID-19 pandemic.

Introduction

Welcome to the 2021/2022 York and Scarborough Teaching Hospitals NHS Foundation Trust Infection Prevention and Control annual plan. This plan has been developed on behalf the Foundation Trust's Infection Prevention and Control (IPC) team and the Trust's Infection Prevention Strategy Group and is split into seven key areas of work:

1. **Infection Prevention and Control Systems and Processes**
2. **Improving our environment**
3. **Reducing antimicrobial prescribing**
4. **Information for people who use our service**
5. **Identification of people with infection**
6. **Staff engagement and Care Group Assurance**
7. **Reducing Healthcare Acquired Infections**

The plan has been developed to clearly demonstrate the work of the Infection Prevention and Control group and teams in preventing and controlling infection through targeted programmes of work that will aid effective communication, education, audit, surveillance, risk assessment, quality improvement and development of policies and procedures. The plan is based on the national and Trust priorities for infection prevention and control, the delivery of this plan will be regularly monitored and reviewed via the Trust's Infection Prevention Strategy Group (TIPSG).

A key component to the successful delivery of this work plan is the collaborative working throughout the Trust with Care Group teams, those teams range from the senior leaders to the staff delivering care on the frontline. Another key component to help deliver this plan is the relationship and symbiotic working with York Teaching Hospitals Facilities Management Team (LLP). The Infection Prevention and Control teams will co-ordinate delivery of this plan and will work closely with care group leaders to ensure the objectives are achieved.

Objective	Action	Key Stakeholders	When
1. IPC Systems and processes			
Development of IPC Team	Work with the Trust ODIL team to implement a team development programme. Review the IPN specialist skills training and identify staff to attend regional training sessions linking to CPD availability. Development of QI and change management skills for IPNs. Review the IPC team to ensure that staffing is sufficient to meet demand. Re-Implement Care Group IPN link strategy and communicate this to across the Foundation Trust.	• Deputy DIPC • Deputy Chief Nurse • ACN (Workforce) • IPC Lead Nurses • IPC Team • ODIL Team	Quarter 2-4
Staff training (Trust-wide)	Care Group IPN links to work with Care Group Matrons to review training compliance. Care Group IPN links to work with Care Group teams to identify any specific learning from CGs. IPNs to link together	• IPC Lead Nurses • IPC Team • Care Group Leadership teams including ACNs and Matrons • Trust communication team	Quarter 1 – 4 Quarter 1 – 4

	to share and spread learning particularly from PIR and outbreak processes. Increase IPC in-reach to the community sites		Quarter 2/3
Care Plans	Develop care plans for all organisms that pose IPC concern to provide guidance to clinical staff of effective and safe management of patients. Forms part of the e-documentation project.	• IPC Lead Nurses • IPC Team • Wider IP Team • Lead Nurse - Documentation	Quarter 3
Policy Management	Implementation of quarterly policies and guidelines group to review and update policies with stakeholders	• Deputy DIPC • Deputy Chief Nurse • IPC Lead Nurses • Wider IP Team • Trust patient safety team	Quarter 2
PIR Process	Complete handover of PIR ownership to Care Groups for HOHA cases and development of the SOP associated with this. Share and spread of learning. Briefing to be created and shared with CGs. Implementation of the PIR process for COHA to match HOHA process	• Deputy DIPC • IPC Lead Nurses • Datix Manager • IPC Team • Care Group Leadership teams, including ACNs, Matrons and CG Facilitators.	Quarter 1
Reporting	Review report structure and	• Deputy Chief Nurse	Quarter 1

	content in light of BAF and other COVID reporting requirements. Daily/ PRN SitRep internally. Including outbreak reporting process.	• IPC Lead Nurses	
Up to date and easy to navigate websites	Update internet and intranet pages	• IPC Lead Nurse • IPC Team • Trust Communications Team	Quarter 3
Audit and Surveillance review	Improve systems for ensuring staff gain feedback on performance related to IPC guidance	• Deputy DIPC • IPC Lead Nurses	Quarter 2
Improve IT systems to share, monitor and report on IPC information	Business case for ICNet.(Dependent on Telepath implementation)	• Deputy DIPC • Deputy Chief Nurse • Digital Director • IPC Lead Nurses • Finance Manager	Review in Quarter 4
2. Improving our environment			
CDI Reduction Plan	Monthly meetings and progress tracking for CDI reduction. Re-instigate shared learning across CCG and PHE. Implement CDI action plan. Develop a CDI focus month event. Improve awareness across the	• Deputy DIPC • Deputy Chief Nurse • IPC Lead Nurses • CCG/ PHE Colleagues • LLP Colleagues • Care Group Leadership teams • Medical staff	Quarters 1-4

	Foundation Trust of cases and performance. Robust proactive HPV programmes.		
Ensure that cleaning standards are reviewed strategically across the Foundation Trust.	Develop and implement Trust-wide Cleaning Services Group	• Deputy Chief Nurse • IPC Lean Nurses • LLP Colleagues	Quarter 1
Ensure that high risk equipment is labelled as clean to use.	Undertake QI approach to implementing "I am Clean" stickers. Following QI approach (PDSA) make decision to implement.	• Deputy Chief Nurse • IPC Lead Nurses • Care Groups	Quarter 1 and 2
Ensure support for IPC improvements within the LLP and Capital Planning team including ward refurbishment and back log maintenance.	Develop engagement with LLP and Capital Planning within IPC governance framework. Review of all areas using a risk based approach to identify wards and departments that require refurbishment using backlog maintenance money.	• Deputy Chief Nurse • IPC Lead Nurses • LLP Colleagues • Care Group Senior Leadership and Operational Teams • Trust Operations teams	Quarter 1 and Quarter 2
3. Reducing antimicrobial prescribing			
Improving antimicrobial stewardship at Scarborough	Introduce ARK-hospital project	• Deputy DIPC • Deputy Medical Director – East Coast • Deputy Chief Pharmacist • Deputy Chief Nurse • Medical staff across East Coast Care Groups	Quarter 1
4. Information for people who use our service			

Visitors and service users are aware of IP guidance, and there is a mechanism to communicate changing advice to the public	Review visitor and patient information leaflets Update external website	• IPC Lead Nurses • Wider IP Team • Trust Communications Team	Quarter 2
5. Identification of people with infection			
CPE screening of at risk patients Identification of individuals at high risk of carrying infectious organisms	Introduce new CPE guideline Development of electronic admission documentation	• Deputy DIPC • Care Group Senior Leadership teams • Information Technology	Quarter 2
6. Staff engagement and Care Group Assurance			
Develop a comprehensive and robust assurance system for IPC, that is regularly reviewed, and which enables performance issues and risks to be addressed	Embed IPC performance reviews in to CG quality committee meetings and flow to TIPSG.	• Chief Nurse • Deputy Chief Nurse • IPC Lead Nurses • Care Group Senior Leadership teams	Quarter 1-4
Reinvigorate IPC champions programme	Secure Executive level support. Develop IPC champion job description and refresh training programme. Recruit and train IPC champions.	• Deputy Chief Nurse • IPC Lead Nurses • Care Group Senior Leadership teams • LLP	Quarter 2-3
7. Reducing Healthcare Acquired Infections			
Ensure that there is an effective system for monitoring COVID related issues, surge, outrbreaks and learning ensuring that the Executive	Implement a regular review process for the BAF with appropriate reporting arrangements implemented.	• Deputy DIPC • Deputy Chief Nurse • IPC Lead Nurses • Deputy Chief Operating Officers	Quarters 1 – 4

are well cited on the Board Assurance Framework.	Ensure IPC invitation to all Trust-wide operational command meetings (silver process). Communicate COVID system learning within the IPC team.	• Wider IP Team • Care Group Senior Leadership Teams • LLP Colleagues	
Clostridium difficile (links to section 2)	Reduce unnecessary ward moves Delays in stool sampling and patient isolation Implement the CDI action plan and any newly identified actions	• Deputy DIPC • Deputy Chief Nurse • IPC Lead Nurses • Deputy Medical Directors • Deputy Chief Operating Officers • Wider IP Team • Care Group Senior Leadership Teams • LLP Colleagues	Quarter 1 – 4
Promote system wide learning from avoidable HCAIs.	Implement HCAI system partnership group across the healthcare system.	• Deputy DIPC • Deputy Chief Nurse • IPC Lead Nurses • CCG Colleagues • PHE Colleagues	Quarter 1
Gram Negative Blood Stream Infections	Complete project to introduce gentamicin prophylaxis before high-risk catheter changes E.coli bacteraemias to identify themes and trends. Drive initiatives to help in reducing the incidence of GNBSI .	• Deputy DIPC • IPC Lead Nurses • Deputy Medical Directors • Deputy Chief Operating Officers • Wider IP Team • Care Group Senior Leadership Teams • LLP Colleagues	Quarters 2 – 4

Methicilin Sensitive Staphylococcus aureus (MSSA)	Re-establish Staph aurues bacteraemia reduction group Develop ANTT theory training platforms to sustain learning	• Deputy DIPC • Microbiologists • IPC Lead Nurses	Quarter 2/3
Methicilin Resistant Staphylococcus aureus (MRSA)	Change to Octenisan for decolonisation	• Deputy Chief Nurse • IPC Lead Nurses • Procurement Team	Quarter 3

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 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 of communication between the Trust and the Care Quality Commission (CQC), as well as action plan progress for regulatory requirements and outlining next steps in achieving excellence.

/ Executive Summary – Key Points

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. The Trust has been notified that 5 of the 7 conditions associated with registration have been removed. This demonstrates significant improvements in safe care delivery. The CQC acknowledged that improvements have been made in relation to the remaining 2 mental health conditions, and will review the appropriateness of removing these following further audits to provide assurance that the practice is embedded.

It is anticipated that providing consistent audit results are demonstrated over the next 3 months, notifications can be submitted in September 2021 to request the removal of the remaining Section 31 conditions of registration. This is reliant upon consistent delivery reflected in audit results, whilst also recognising the length of time it can take to process the notifications. There is currently variation in consistency of audit results, and work is ongoing with the teams to support consistent delivery.

An improvement in action delivery is noted within the paper across the Section 31, Section 29A, and Must-Do action plans. Five actions are behind delivery-ongoing, all of which have a plan in place to address compliance. One of the five overdue actions presents a high risk for the Trust – this relates to the recruitment of a Paediatric Emergency Medicine (PEM) consultant for Scarborough Emergency Department. There are currently several mitigations in place and this is demonstrated through the risk register, however there is still a risk that non recruitment into this role could result in regulatory action from the CQC,

namely a Section 31 condition notice. The existing mitigating actions require a review and refresh to ensure mitigations are effective and appropriate and this will be undertaken in July 2021.

Safe “deep dives” are underway across all Care Groups, broken down to specialty level. Care Groups have the opportunity to present their findings at Quality & Regulations Group in August / September 2021, followed by a summary paper to Executive Committee in October 2021. Well-Led deep dives will be initiated by the end of July 2021, with a summary paper to Executive Committee in November 2021. This is in line with the schedule submitted to the last committee. Outputs will then feed to Trust Board of Directors through this bimonthly report.

/ Recommendations

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: 15-07-2021

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 CQC 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.

Following the last CQC inspections, York & Scarborough Teaching Hospitals NHS Foundation Trust developed a comprehensive action plan. Excellent progress has been demonstrated with the CQC action plan and further improvement work has commenced with oversight from the Quality Committee. 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, with effect from 1st March 2021. The Trust has been notified that 5 of the 7 conditions associated with registration have been removed. This demonstrates significant improvements in safe care delivery. The remaining 2 conditions associated with registration are as follows:

York Hospital
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.

Scarborough Hospital
The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at Scarborough Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.

The CQC acknowledged that improvements have been made in relation to the remaining 2 conditions, and will review the appropriateness of removing these following further audits to provide assurance that the practice is embedded.

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 in order to work towards excellence.

2. Detail of Report and Assurance

2.1 Engagement Meetings

In line with the expected schedule, one engagement meeting has taken place since the last summary report to Executive Committee. Engagement meetings have not required any escalation. CQC recognised the increase in attendances for Emergency Departments across the region and have expressed the opportunity for Trusts to feedback any potential causes of the increased attendances. The most recent engagement meeting had representation from the Head of Quality Improvement discussing progress with the Quality Improvement Strategy. The next engagement meetings will include representation from the Chief Digital Information Officer to discuss the digital work-stream and the Deputy Chief Nurse to discuss the pressure ulcer improvement agenda.

2.2 Notifications

No notifications have been submitted to the CQC since the last report. It is anticipated that providing consistent audit results are demonstrated over the next 3 months, notifications can be submitted in September 2021 to request the removal of the final Section 31 conditions of registration. The Clinical Effectiveness Team have been working with key stakeholders across the Trust to standardise the audit tool being used to measure compliance with mental health risk assessments. The initial meeting took place on 6th July with the final meeting scheduled for 15th July. The expectation moving forward is that both Emergency Departments submit their audit results by 10th of each month to be incorporated in monthly committee reports and held as evidence. The Trust aim for 2021-22 is that both Emergency Departments will achieve 85% compliance with completion of Mental Health Risk Assessments. May data demonstrates Scarborough Emergency Department at 81% compliance and York Emergency Department at 58%. June data for Scarborough Emergency Department is currently being collated, with York Emergency Department demonstrating a significant improvement at 92% compliance.

2.3 General Updates

During the month of June the CQC have released the following updates, summarised for ease of reading with links available for full content:

- **Emerging Concerns Protocol**

The CQC have updated the “Emerging Concerns Protocol”, the key updates from the 2018 version include: the addition of the General Optical Council, General Chiropractic Council, General Osteopathic Council & Social Work England, the message that the protocol can be used at any point and that no piece of information is too small has been strengthened and an addition of a quick guide. The protocol allows regulatory organisations the opportunity to raise concerns about organisations at any point, which could prompt a regulatory review panel meeting.

- **COVID-19 Insight: Issue 11**

This month's report includes the publication of the provider collaboration review of how services across seven local areas in England have worked together for people with a learning disability during the COVID-19 pandemic. This has been shared with the Learning Disability Team for review and consideration.

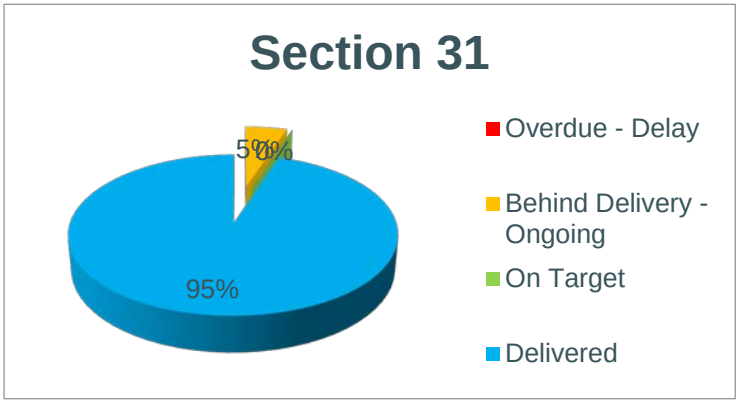
- **Monitoring Approach**

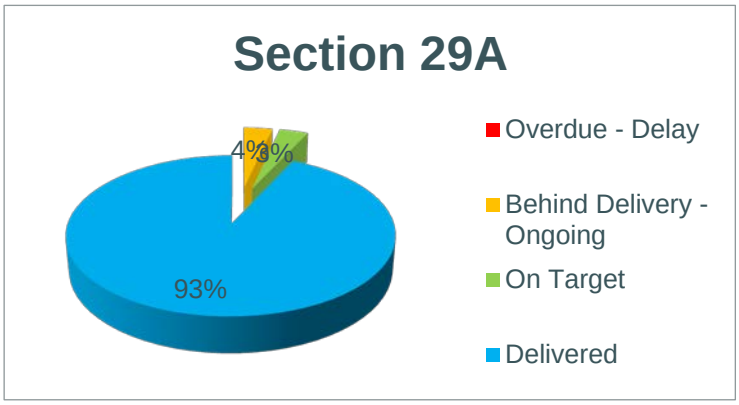
A statement from the CQC Chief Inspectors was released in June 2021. The statement relates to monitoring and inspection approaches. In March 2020 routine inspections were suspended and a transitional monitoring approach (TRA) was developed, the intention is that this will continue through regular reviews, and this will be used to determine any risk areas for inspection.

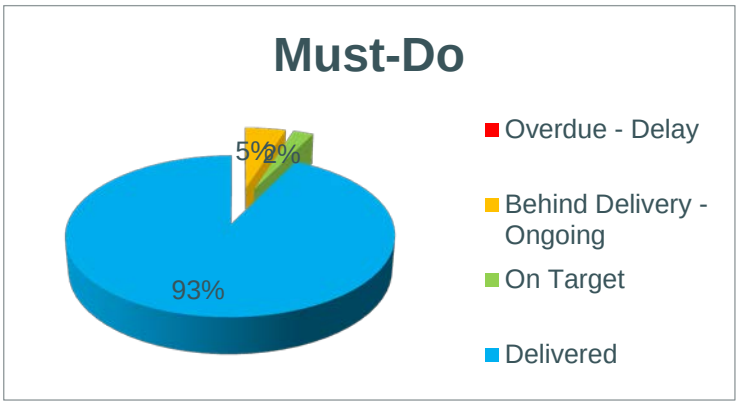
3. Regulatory Action Plan Update (Appendix A)

3.1 Overview

	Overdue - Delay	Behind Delivery - Ongoing	On Target	Delivered
Section 31	0	1	0	19
Section 29A	0	1	1	27
Must-Do	0	2	1	38







3.2 Exception Report (Appendix B)

Behind Delivery – Ongoing Actions

- PEM Consultant

The recruitment of a Paediatric Emergency Medicine Consultant for Scarborough Hospital has been overdue since November 2020. Several recruitment campaigns have been instigated with no eligible applicants received. Mitigating actions require a review and refresh to ensure mitigations are effective and appropriate, this will be instigated by the Head of Compliance & Clinical Effectiveness. There are currently several mitigations in place and this is demonstrated through the risk register, however there is still a risk that non recruitment into this role could result in regulatory action from the CQC.

- Mental Health Assessment Suite SOP

The completion of this SOP was scheduled for the end of June 2021; work has been ongoing to complete the SOP and continues to do so. A version of the SOP has been shared with the Chair of the Mental Health Steering Group and the Head of Compliance. Final comments are being considered before submission to QPAS for final ratification in August 2021. The risk associated with action being delayed is low.

- Safe-Care App Re-Launch

The completion of this action was scheduled for the end of June 2021, and whilst work is ongoing, it is not yet completed. It is suggested that an improvement plan around safe-staffing, including how this is demonstrated through evidence, is created and monitored through QPAS on a monthly basis. This proposal will go to the Deputy Chief Nurse for workforce to review and consider. The risk associated with this action being delayed / not completed is moderate.

- Privacy Screens / Computer Locking Function

The final two actions which are behind delivery – ongoing relate to the stretch actions which were established to reduce the risk of recurrence. One action requires consideration for the use of privacy screens whilst the other action relates to the timeliness of the automated lock function for computers which are inactive; the aim being to reduce the risk of patient identifiable information being exposed. Both actions are scheduled to be completed by the end of July 2021.

On Target Actions

- Training Passport Implementation

The action to implement the training passport was scheduled for completion at the end of June 2021, however in line with the national work-stream this has been extended to the end of August 2021. The team leading on this work feel confident that the delivery at the end of August is a realistic one and will improve overall Trust compliance for statutory and mandatory training.

4. CQC Insight Report

4.1 Overview (CQC National Comparison)

Classification of Indicators	Number of Indicators
Much Worse	**5**
Worse	**25**
About the Same	**174**
Better	**7**
Much Better	**2**

CQC Insight reports are released bimonthly and benchmark Trusts against previous internal performance and against national performance / quality indicators. The 5 “much worse” indicators have been reviewed by the Trust and determined that 2 of the indicators have a more recent data set to demonstrate an improvement. This data will be shared with CQC to demonstrate openness and excellence. The “worse” indicators are currently being reviewed against current data sets, enabling the Trust to share improvements in quality & performance. The findings will be summarised in

the next report. In addition there are 174 indicators which demonstrate the Trust are either comparable nationally or have remained the same in terms of previous performance. Finally, there are 9 indicators to suggest the Trust has performed better than previous years and/or better than the national picture.

5. Next Steps

The review of the Transitional Monitoring Approach (TRA) which was initially completed and submitted in January 2021 is underway across the Care Groups. Care Groups have the opportunity to present this at Quality & Regulations Group in July / August 2021, followed by a summary paper to Executive Committee & Quality Committee in September 2021. This will then be shared with CQC as per the January submission.

Safe “deep dives” are underway across all Care Groups, broken down to specialty level. The emphasis of the benchmarking assessments is to highlight areas of good practice for sharing, whilst also identifying areas for improvement. The overall aim is to increase quality assurance, impacting on patient care throughout the Trust. Care Groups have the opportunity to present their findings at Quality & Regulations Group in August / September 2021, followed by a summary paper to Executive Committee & Quality Committee in October 2021.

Care group well-led deep dives will be initiated by the end of July 2021, with a summary paper to Executive Committee & Quality Committee in November 2021. This is in line with the scheduled work-plan. (Appendix C). A corporate well-led deep dive assessment will be undertaken in Q3 of this financial year.

6. Recommendations

Board of Directors are requested to consider and accept this report as an updated position for the Trust in relation to CQC action plans (Section 29A, Section 31, & Must-Do actions).

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NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes

Resources Assurance Committee
18 May 2021

Attendance: David Watson (DW) (Chair), Lynne Mellor (LM), Jim Dillon (JD), Andrew Bertram (AB), Polly McMeekin (PM), Dylan Roberts (DR), Bobby Anwar (BA), Joanne Best (minute taker)

Welcome and Introductions

The Committee Chair welcomed everyone to the meeting.

Apologies for Absence:

Jill Hall (JH)

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 18 April 2021

The minutes of the meeting held on 18 April 2021 were approved as a correct record.

Matters arising from the minutes

Action log updates:

Item 70 – Will be revised for the June meeting.
Item 69 – Bi annual Research Report included on RC work plan.
Item 51 – Review to include digital asset tracking ability

Integrated Business Report (Finance Indicators)

AB presented the finance section of the IBR, noting at the end of the first month of the new finance year a surplus of £1m had been delivered along with £.5m of the efficiency requirement, highlighting the following which support the £1m surplus:

- Income is running ahead of plan, relating to excluded from plan drugs and devices
- £.5m under spend on Covid due to reduced Covid numbers
- £1.5m of Covid budget to be shared with Care Groups to align their operational budgets for the emergency regime

AB confirmed the Treasury had not indication unspent Covid funding should be returned.

LM asked if it would it be possible to use the unspent Covid funding to expand the continuation of essential services updates which had been developed throughout the pandemic period or to support transformational programmes.

AB confirmed if funds remain later in the financial year and with the support of the ICS these funds could be accessed to support transformational programmes.

Covid Spend Review / Lessons Learned

AB introduced the Covid review paper noting the majority of spend related to staffing which with the exception of one area was deemed appropriate. Sickness absence due to Covid had been recorded within the guidance issued by NHSE/I and no staff member's salary had been reduced as a result of Covid sickness regardless of the length of absence. Findings within this report will support the Covid spend public enquiry which will take place during spring 2022.

Action 72 – PM, Analysis of Covid Sickness absence spend.

In addition to the Covid funding of £12m for the first six months of the year additional funding will be issued to support vaccination requirements, costs will be reviewed at the end of the second vaccination programme.

LM asked if funding had been made available to support staff experiencing mental health issues due to the pandemic. Confirming no funds had been made available AB discussed the Trust's investment in additional Psychological support for staff.

Under the Building Better Care programme work streams are reviewing transformational projects developed during the pandemic which support efficiencies.

In response to pre meeting questions from DW, AB confirmed there is a programme to roll out the use of un-used half face PPE masks to appropriate areas. With regard to the requirement of £15m identified to support the continuation of pathways which had been put in place to support Covid, this had been shared with NHSE/I and the ICS, noting no information is currently available as to how this will be funded.

Integrated Business Report (Workforce and OD Indicators)

PM presented the Workforce and OD section of the IBR, highlighting vacancy fluctuation in two areas;

- **Registered Nurses**, the apparent increase in vacancy rates for registered nurses is due to the additional nurse establishment being included in numbers not to issues with nurse retention.

- **Allied Health Professionals,** 6 Physios and 5.4 wte of Radiographers have left the Trust noting the main reason for leaving as their work life balance. This is being explored further with the Care Group.

- **Staff absenteeism** had reduced significantly recording 3.9% which is the lowest seen for 2 years; resulting in a reduction of un-filled shifts and on demand for temporary nursing staff.

- **Staff Training**, compliance amongst bank Staff is currently poor, to address this issue a number of actions had been agreed with the Quality and Safety committee, these actions include a simplified version of the Corporate Induction programme which can be accessed remotely. From 1st September 2021 all staff training must be up to date to allow access to work. Scoping work is underway to explore a similar approach for bank medics.

- **Covid vaccine trial** has been halted after a week as GlaxoSmithKline had not produced enough vaccine for all UK trials. The Trust had vaccinated 54 people without any side effects therefore will receive a third of the planned funding. The second vaccine dose will be given to these 54 people; if more vaccine becomes available the Trust will re energise the programme.

LM, noting the number of live grievance cases and asked for an explanation.

Discussing the grievance relating to recruitment in Scarborough Theatres PM noted although this was one incident six individual grievances had been raised, also noting previous low numbers of grievances related to the agreement with Trade Unions not to undertake investigations in to staff if possible during the pandemic period.

Responding to JD's enquiry in relation to higher staff vacancy rates at Scarborough Hospital PM discussed the number of newly qualified student who will commence employment in Scarborough Hospital in the Autumn of this year, noting overseas recruitment had been impacted due to Covid restrictions.

People Plan update

Referring to the NHS People plan published in July 2020, PM discussed the required 110 actions which have now been split into 9 pillars, delivery of these actions was delayed due to the second wave of Covid. NHSE/I have highlighted three key actions which should be addressed and delivered before the end of June 2021 also discussing their advice to pause other actions.

In support of these action's PM highlighted the following;

- Vaccinations including Covid vaccine had been offered to all staff
- Health and wellbeing included at Induction, all staff to have annual health and wellbeing conversation included in their appraisal discussions, for medical staff this is undertaken by their line managers when discussing job planning.
- Quality and diversity data published

Referring to succession planning, PM discussed the talent management process and how it is used to inform workforce planning, succession planning for the leadership group will be discussed at the June Board. Highlighting the Equality and Diversity section PM confirmed issues which are impacting on delivery of this item do not related to race.

With the removal of the temporary marquees used during the pandemic as staff breakout areas alternatives options are being explored with charitable funds already accessed to support garden areas for staff.

It was noted that no consequence for non-delivery of the actions from the People plan had been highlighted.

Further updates will be shared with the Resources Committee three times a year; the next update will be in September.

Action 73 – JH to update annual work plan

Staff Survey update

Giving an overview of the report PM discussed expectations to address highlighted issues noting the submitted plan is a Corporate action plan and supports CQC requirements. Care Groups will produce individual action plans allowing specific issues to be addressed locally. The committee discussed the timing of the survey noting Covid could have impacted on some staff responses. The LLP staff survey results are not included in this report but returned very disappointing results, these will be compared with the LTHT Estates and Facility survey results aiming to share best practice.

Digital and Information Report Update

Delivering an overview of the report DR noted tangible progress had been made notably with the appointment of Simon Hayes to support the essential services plan update and Rebecca Bradley as Head of Information Governance and Data Protection officer who has developed a draft strategy and plan for information governance.

Discussing requirements which could allow the Trust access to funding from NHSX and NHS Digital it was noted a consultancy agency 'Ethical' had been appointed to review the Electronic Patient Record service, exploring ICS requirements and to develop a strategic outline case for the Trust which will be available at the end of June.

Procurement to appoint a partner allowing access to technology skills as required is underway, reminding the Committee that the £2m allocation from the Capital spend programme falls short of the required amount to update the Digital and Information systems DR noted discussions are progressing to access the Digital Aspirant fund while also exploring the possibility of accessing funding via NHSE's Unified Tech Fund which supports infrastructure.

Following review of the Digital prioritisation plan 49 priority 1 significant programmes have been highlighted with 350 removed.

LM asked if the relevant support is available for the planned service changes which will support the Trust building better care.

Confirming the Digital and Information service plan links to the Trusts transformation programme and clinical strategy DR noted all changes link to building better care and minimum service standards and are being assured by NHS Digital. Also ensuring the Trust's IT system aligns with the ICS's whilst exploring the possible sharing of resources.

EPAM Minutes and assurance escalation report

This paper was submitted for information only. No items were discussed.

Corporate Risk Register

BA discussed the recent review of the Corporate Risk Register noting 12 risks complete with scores/target scores are recorded and will be submitted to the Resources Committee from next month. Cyber is recorded as a high risk.

Revised Terms of Reference

Updates for this paper will be submitted to the next Resources Committee at least twice a year. LM requested the Resources Committee work plan be updated to include time to allow in-depth conversations covering the Strategy and Digital Transformation also to include Research and Development updates twice a year.

Action 74 – JH to update RC annual work plan to twice a year.

Documents for consideration

There were no further items for consideration

Reflection on the Meeting

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

- Additional time required for transformation
- Agenda to be rotated allowing regular substantive update/ brief update
- Timings to be included on the draft agenda
- JB to be copied into pre meeting email from Chair
- Papers to be uploaded to the Trust Web

AOB

No other business was discussed.

Time and Date of next meeting

The next meeting will be held on 22 June 2021

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Resources Assurance Committee
22 June 2021

Attendance: Lynne Mellor (LM) (Chair), Jim Dillon (JD), Andrew Bertram (AB), Polly McMeekin (PM), Dylan Roberts (DR), Jill Hall (JH), Bobby Anwar (BA), Adrian Shakeshaft (AS), Simon Hayes (SH), Rebecca Bradley (RB), Joanne Best (minute taker)

Welcome and Introductions
LM welcomed everyone to the meeting confirming she is the new Chair of the Resources Committee and thanked the previous Chair David Watson for his contribution and support especially relating to Governance and Risk.

Apologies for Absence:
No apologies were recorded.

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 18 May 2021

The minutes of the meeting held on 18 May 2021 were approved as a correct record once typing errors are corrected.

Matters arising from the minutes

Action log updates:

Item 72 – Additional costs to the Trust to cater for the uplift in Covid sick pay following Government instruction is £66k.

Item 70 – BAF has been updated.

Digital and Information Update

DR introduced Simon Hayes, Interim Infrastructure and Transformation Service Manager, Adrian Shakeshaft, Head of IT Infrastructure and Rebecca Bradley, Head

of Information Governance & Data Protection Officer to the Committee noting they will be supporting delivery of today's update.

Essential Services Programme

SH discussed the development of the Essential Services Programme and the current status, future plans and aspirations for the service with core programmes to be delivered this year. Third party partners had been appointed to provide an independent view.

A presentation was shared with the Committee to support a visual understanding of the discovery exercise which had been undertaken to validate critical risk, the outcomes and future plans. A large proportion of system failure is due to technical debt (old equipment which no longer receive updates including security updates); end user issues were discussed noting poor efficiency rates for clinicians and long waits to gain access to the service desk which result in high level efficiency waste. The 3 year plan is to mitigate Trust level issues and risks, remediate the technical debt developing a high level service which will have a positive impact on user experience with a number of smart foundation end pieces such as Cloud, virtual desktop and unified communications.

The Trust's strategies will link to ICS strategies along with a number new capabilities supporting improved customer experience resulting in a Digital and Information Service which is fit for purpose. The planned changes have to be managed within the parameters of the investment funds received, currently £2m from the Trust; therefore priority planning had been adapted.

The plan indicates approximately 25% of the 220 risks will be mitigated in the first year which in turn will support an improved services and a reduction in revenue costs. Noting within the remaining risks the technical debt will continue with minimal impact on the risk rating and gaps in security remaining. The expectation is during year two and three the remaining risks will increase as equipment deteriorates further. In discussion it was confirmed the number of outstanding risks will not reduce until a high percentage of the Essential Services plan had been delivered.

Discussions with NHSX and NHS Digital are ongoing to access additional funding, allow access to this funding the Electronic Patient Record (smart foundation) requires updating, the consultancy agency 'Ethical' had been appointed to undertake this review along with ICS requirements.

Noting concern in the vulnerability of the Trust's system, JD asked if a leasing model for equipment had been explored which may ensure the Trust's current situation is not repeated, also asking for assurance that the DIS plan aligns to the Trust's Transformational plans.

Confirming discussions are underway with third party partners to explore leasing options, DR also assured the Committee the DIS plans provide resilient flexible solutions also exploring products which could be re utilised within the ICS and fully relate to the Trust's Transformational plans.

LM asked for more detail on benefits for patients and staff and suggested that communications are shared to support the impact of planned changes for both patients and staff. She also requested architectural assurance both logical and physical, suggesting that for example a solution architecture map could be developed. LM also referred to the operating model in the paper which is mentioned but has no detail. LM asked could the Board be appraised of the operating model and how it impacts on the Trust's operating model given this has strategic consequences.

Action 75: SH/DR develop Comms for changes, produce a solution architecture map and update the Board on the operating model alignment

LM noted concern of the 220 highlighted risks only 25% will be impacted on during the first year of the plan and referring to the number of risks mentioned in the report should additional risks be included on the BAF register?

Cyber risk is the highest level risk for the Trust and monthly reviews are undertaken with risks escalated to the ICS with a request for funding to support the mitigation of these issues if necessary.

BA added, the BAF risk related to current data, a review of Care Group risks is underway acknowledging these results may impact on the present situation. Risk appetite will be discussed at the July Board; risk target scores will then be set.

LM, referring to the long waits for patients and staff to access IT front line services and high abandoned rates asked if users had been asked for their perception of this issue. Surveys will be undertaken to support assurance of service improvements.

Acknowledging the Essential Services programme plan is working with financial restraints, LM discussed the need to produce both quantitative and qualitative evidence to support all planned changes.

AB acknowledged discussions had taken place with regard to this evidence, moving forward both quantitative and qualitative evidence will be included in post implementation reviews.

Action 76: SH/DR – ensure include quantitative and qualitative evidence in business case and post implementation reviews.

DR assured the Committee the £2m planned capital spend for digital this year will be achieved with the support of interim staff and third party partners.

DIS Risk update - Cyber risk mitigation and recovery

AS presented an overview of the above paper which provided assurance in relation to what DIS is doing to mitigate cyber-attack and cyber risk, and included recovery plans in the event of a major cyber incident. Noting a large volume of the equipment across the Trust and its operating systems, such as CPD, are aging and are not able

to be updated with new security patches which leaves them vulnerable. Learning from the WanaCry cyber-attack is that all PC's should be security patched within 14 days. Although patching processes are in place this target is not always achieved. The WanaCry attack caused disruption to services as all pc's had to be re-imaged. Under phase 1 of the Essential Services plan, 300 virtual pc's will be installed in ward areas, noting if a cyber incident occurred following their installation the disruption would be much less as re-imaging would take place from the server. A cyber incident table top exercise will be undertaken later this summer; outcomes will be shared with the Resources Committee.

Action 77: AS/DR following desk top cyber incident present report to the RC

JD discussed his assurance that cyber incidents and planning to alleviate disruption to the Trust is planned, but noted concern in relation to the impact to CPD if a cyber-attack occurred.

Although the CPD system is aging the expectation is if the infrastructure around it is refreshed it will be able to be used for the next 3-4 years, noting a case for change is underway to move to an ICS level platform.

LM said she was not assured by the paper on cyber security for the Trust. She asked for two key areas to be addressed 1) a clear and more comprehensive report on the different types of cyber-attacks and the steps to mitigate for the Trust, noting the cost of these attacks is not just monetary but also has potential severe impact to patient care 2) assurance that clear processes are in place to do a real test and deal with an attack scenarios. Also expressing concern that due to lack of funding 75% of the highlighted risks will remain and potentially increase, asking which are the biggest risks in jeopardy and how big will they be allowed to escalate if the Trust is to tolerate them.

Action 78: AS/DR – develop further data explaining what steps will be taken to mitigate individual types of cyber-attacks and test and demonstrate the ability to handle an attack and / explore tolerance levels of outstanding risks

Information Governance Strategy 2021-2023

Rebecca Bradley gave an overview of the Information Governance Strategy outlining the Trusts lack of compliance with regard to Data Protection Legislation. Lack of data ownership / responsibility were highlighted as issues, noting asset ownership will be introduced over the next two years to support the Trusts compliance with legislation.

The project brief will be developed and outcomes delivered prior to 2023, all high risk area will be addressed. It was acknowledged due to lack of resources within the IG team some lower risk areas may take longer to deliver. Confirming staff training to inform individuals of their responsibilities is a key aspect to achieving staff ownership for all information assets.

LM requested assurance for the following;

- clearer plan of the top level milestones which will be achieved
- how success will be measured
- how will data sharing be monitored and will data flow also be monitored
- Anonymisation and pseudonymisation when sharing patient data.

RB recorded that success will be measured via the IG tracker which records compliance data which will be reviewed regularly. The information asset register will also record associated data sharing / associated contracts and will be a key element supporting the Trust achieving compliance, also confirming the policy relating to anonymisation and pseudonyminisation is currently under review. Noting if the Trust was to undertake a voluntary audit by the ICO currently it would not be able to provide evidence of use of information compliance.

RB, AS, SH left the meeting.

Integrated Business Report (Finance Indicators)

AB presented the finance section of the IBR, noting at the end of month two the Trust is reporting a surplus of £1.9m against the system plan submitted to NHSE&I. Operational expenditure is in line with the plan, there had been some underspend along with overspend for high cost tariff drugs which the Trust had received £1.2m compensation. Covid spend had reduced as facilities were stood down, noting this could change if the hospital Covid admissions increase.

The forecast out turn position at the end of H1 suggests a surplus balance of £8.5m. Discussions between NHSE/I and the ICS have taken place noting the assumption is the Trust's position will normalise over the next few months therefore the plan will be revised to deliver a balance position at the end of H1 with any surplus funds most likely being retained by the ICS to support system pressures and possibly transformational non recurrent schemes across Humber Coast and Vale integrated care system.

Capital Planning

Discussing updates made to the Capital Programme AB noted as at the end of quarter 1 there will be a surplus of approximately £0.5m remaining un-committed. Care Group Directors / Managers will submit a list of critical priorities for their areas to be considered by Executive Committee with funds released in the second half of the financial year. The expectation is the critical list produced will require more than £0.5m, therefore the ICS have been approached for additional funds, noting there are no guarantees of additional funds.

Properties owned by the Trust which could potentially produce additional funds if sold will be discussed at next month's Resources Committee along with the backlog maintenance programme which received £1m funding this financial year.

A discussion took place in relation to surplus cash and how this could be used to support the Trust's infrastructure if support from the ICS is achieved.

Following JD's enquiry with regard to funding allocation for the second half of the financial year, AB stated that although confirmation had not been received the assumption is H2 funding will be similar to H1 but with increased efficiency requirements.

Referring to page 42 of the RC pack, AB discussed an additional £1.2m capital spend required to support York ICU modular extensions completion, noting this scheme was supported by Covid fund and costs had to be submitted at speed, this had impacted on the actual cost.

Integrated Business Report (Workforce and OD Indicators)

PM presented the Workforce and OD section of the IBR, highlighting an increase in sickness absence in all areas. Stress, anxiety and depression is stated as the most common reason for absence with musculoskeletal the second most common reason. There had been a rise in temporary staffing demand, also noting a 31% reduction in staff working overtime, this is being covered by bank and agency staff.

Medical suspension due to Covid - 3 members of staff are still suspended and 19 staff continue to work with significantly reduced duties, a national steer to support their return to duties is expected imminently.

Staff Networks – two additional staff networks had been launched, Enable which support staff with disabilities and serious or long term health conditions and the Caring4Carers network to support staff who provide unpaid care for family or friends.

Reverse mentoring scheme – additional mentors are being recruited as the mentees demand was high.

Good Business Charter – the Trust had been accredited with the Good Business Charter and is the first NHS Trust to receive this. PM discussed requirement to achieve the accreditation noting there are still areas which require improvement.

Responding to JD enquiry in regard to the decrease in staff working overtime, PM confirmed it was not the usual pattern for this time of year and the thought is the pressure staff have worked under during the pandemic had had an impact, monitoring of the situation will continue.

The committee discussed support for staff wellbeing which includes the appointment of additional psychologists, The Big Thank You scheme and ice-creams for staff scheme. Concern was raised in relation to the rise of aggressive behaviour and poor attitude from patients toward staff which has occurred across the NHS since the Pandemic. Staff are encouraged to report these incidents.

EPAM Minutes and assurance escalation report

This paper was submitted for information only. No items were discussed.

PM left the meeting.

Corporate Risk Register

Following review of the risk register BA confirmed he is confident all scores are correct, a number of risks had been identified at less than 15. The escalation score will be reviewed as the Trust's framework indicates risks rated at less than 15 should be escalated. It was confirmed all medical equipment is covered under risk 5 and is recorded by the electrical medical engineers on an asset register. Visibility of equipment has increased with a priority replacement scheme still to be established.

LM noted her concern in relation to the IT risk score, noting the impact to the Trust if the IT system failed.

Documents for consideration

There were no further items for consideration

Reflection on the Meeting

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

- Rotation of agenda items to continue
- Crucial for Executives to attend the full meeting to support triangulation and interjection of reports
- Well chaired
- Positive move to have main area of focus
- Attendance of SME's to support the delivery of report, positive
- Executives to express how long they would like for each paper
- Terms of Reference under review, structure may need amending as the meeting moves forward

AOB

The July meeting will be held face to face, with the minute taker in the room and any guest attendees via webex (current restrictions allow 8 people in the Board room)

No other business was discussed.

Time and Date of next meeting

The next meeting will be held on 20 July 2021

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York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Committee/Group: Resources Committee	Date: 22 June, 2021	Chair: Lynne Mellor

Agenda Item	Issue and Lead Officer	Receiving Body, ie. Board or Committee	For Recommendation or Assurance to the receiving body
Digital	The Committee welcomed the Digital deep dive across three separate, but very much interconnected areas: Essential Services, Cyber Security and Information Governance 1) **Essential Services Programme:** Simon was applauded for the work him and the team have done to provide a very comprehensive discovery and analysis of the Trust's IT/Network estate, with an accompanying high level business plan. The Committee requested visibility of the roadmaps and strategic fit of the proposed operating model. However, the Committee seeks further assurance on a)Clarity on benefits including cost/benefit analysis b) Risk mitigation – There are significant gaps across the entire estate including end user, infrastructure and network, with only 25% of the 220 risks uncovered to date to be met by the current affordability envelope. The impact to the patient, staff and wider stakeholders including regulatory bodies needs to be fully understood with clearer plans and priorities.	BOARD	ACTION
Digital	2) **Cyber Security mitigation and recovery** – Adrian was told the Committee welcomed this paper as concern has been expressed previously about lack of information on the Trust's capability and plans on cyber security. However, the Committee overall expressed low assurance with the Trusts ability to deal with the numerous types of cyber threat	BOARD	ACTION

	emanating from various sources e.g. infrastructure/IT or human related. The Committee requests a clear plan with actions to provide assurance on the process around prevention and recovery. This is to include the plans to address gaps and mitigate risks. Together with assurance on tests performed should a cyber-attack occur. Backed up by informed expert independent advice.		
Digital	3) **Information Governance** – Becky outlined that the Trust has limited assurance in adherence with the Data Protection Legislation. The Committee welcomed plans to establish asset owners in Care Groups and Departments. Assurance is sought around next steps including how success will be measured.	BOARD	INFORMATION
Finance	Andy outlined the overall financial status of the Trust with a month 2 reported surplus of £1.9Magainst a balanced plan. Andy updated on the forecast outturn for H1 and noted that whilst the IBR suggested an £8.5m forecast surplus he had since revised this down to balance following conversations with the ICS and NHSE/I given the uncertainty surrounding the operation of the ERF. The Committee noted some overspending in drugs but this is offset by underspending in other areas. The lack of ERF funding to cover the whole of the ICS was discussed and any surplus will likely be clawed back for transformational funding.	BOARD	INFORMATION
Finance	Andy presented the Capital paper – the Trust currently has £500k of uncommitted funds with all Care Group and Corporate directors reviewing their capital plans. The Committee was pleased to note Andy is in early discussions in trying to secure potential 'emergency capital' for the Trust.	BOARD	INFORMATION
Workforce	Polly highlighted the increase in sickness to 4.3% with the largest proportion down to stress. A spot month reduction in staff willing to do overtime noted by the Committee given historic trends show this is unusual – one to monitor. Both of the above were discussed in the light of the pressures of Covid. Concern was also raised by the Committee of violence towards staff and the lack of reporting of this in some areas – the Committee asks for further assurance on how the Trust plans to address. Two areas of note which were pleasing for the Trust: 1) The Trust has been awarded a 'Good	BOARD	ACTION

	Business Charter' the first Trust in the NHS which is great for the local area linkages too, and secondly 2 network groups have been set up one for Disability and the other for Carers.		
Risk	Bobby outlined the next steps on Risk will be to determine the risk appetite. Cyber remains the single greatest threat to the Trust in the new CRR.	BOARD	ACTION

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CHAIR'S LOG: Assurance summary

Committee/Group: Resources Assurance Committee	Date: 20 July, 2021	Chair: Lynne Mellor

Agenda Item	Summary	Receiving Body, i.e., Board or Committee	For Recommendation or Assurance to the receiving body
LLP	The Committee welcomed the LLP quarterly deep dive. Four key reports were covered: 1) **New Start Programme:** Penny was thanked for providing assurance that progress is being made particularly with the People initiatives, including the revision of the Master Services agreement between the Trust and the LLP. The Committee raised concerns about reporting gaps in performance including with the CAFM programme and its slow progress. The Committee requested that a progress report is provided for the next meeting for all the initiatives particularly those with reporting gaps such as clear forecast milestones, RAG status and risk plans.	BOARD	INFORMATION
LLP	2) **Annual Compliance** – Penny provided a comprehensive report of progress. The Committee acknowledged that 89% of the KPIs are green, providing assurance that the LLP has made some significant improvements, with a real turnaround over the last 12 months. The Committee did ask for further assurance on areas of concern including i) sickness – the high rates are a risk across catering, domestic service, portering and waste with other areas such as grounds and switchboard 'teetering-on' the verge of becoming high risks. The Committee did recognise improvement plans are aligned to the Trust activities on physical/mental well-being for staff. However, given Covid is a	BOARD	INFORMATION

	key factor in sickness absence the Committee has asked for a review of the vaccination take-up which has dropped to 74.5% for the second jab as opposed to 82% for the first jab.		
LLP	3) **Surplus Land and Property Disposals** – Andrew outlined a comprehensive review of 8 properties. The Committee was concerned about the potential paucity of income generated from the sale of properties this fiscal and asked for assurance on decision making aligned to risk appetite and prioritisation on benefits across the 'Total Cost of Ownership' of the pending business cases. 4) **Backlog Maintenance** - Andrew also outlined the spend required to maintain the Trust Estate including a projected 5-year view for the first time. The Committee welcomed the report but expressed concerns with £14M of the £37M needed in 2021 being in the high-risk category affecting patient safety, fire safety and statutory safety.	BOARD	INFORMATION
Digital	Dylan introduced the SIRO report. The Committee welcomed the report and its alignment to the information governance report last month. Becky was thanked for providing for the first time a comprehensive view of the risks and gaps in data governance, such as the need for an Information Asset Register and for Information Asset Owners (IAOs) to be appointed from within Care Groups and Corporate Departments (agreed by the Executive Committee). The Committee has asked for clear plans to be produced with updates quarterly and for the Board to endorse the Report.	BOARD	ACTION
Finance	Andy outlined the overall financial status of the Trust with i. month 3 reporting an income and expenditure surplus position of £10.6M of which £7.8M is attributed to the ERF and £2.9M is an operational underspend, of which £1M is Covid related. ii. H1 is projected to close with a small underspend, and as for H2 the financial regime, it is still unknown and will likely become clearer in September from central NHS Finance. The Committee noted the risks of clawback by the ICS of any surplus and the ramp-up of the demands for Efficiency programme to deliver in H2.	BOARD	INFORMATION

Workforce	Polly highlighted a significant increase in absence from 4.57% (sickness only in May) with the trend continuing to rise. Notable upturn since early July. Covid was highlighted as an increasing concern due to staff isolating as a result of the App and also childcare home schooling Covid related issues. The Committee continues to be concerned about staff sickness, staff mental well-being and the availability of clinical staff to fill vacancies. Some assurance was provided that the Trust is reviewing new ways of tackling these issues such as where possible not asking staff to do overtime but using bank/agency and taking learning from elsewhere e.g., using the Newcastle Trust where staff are asked not to isolate if they are double vaccinated and meet certain caveats such as daily testing. Staff absence was compounded by international nurses (who the Trust welcomed in June), not all passing their OSCE first time – the Committee was assured that the latest cohort assessed mid-July all passed. Learning has been taken from Frimley NHS Foundation Trust where it consistently has 100% OSCE pass rate. The Committee welcomed the focus on Bank staff completing their mandatory training and the focus on communicating to staff the importance of reporting violent incidents.	BOARD	INFORMATION
Risk	The Committee discussed the interconnection of the risks presented across the papers and the competing priorities for the sale of assets and funding for example for staffing, backlog maintenance and Digital plans. The Committee asks the Board to discuss these risks taking into account for instance • its risk appetite, • the strategic context, and • the balance of priorities both short and long-term.	BOARD	ACTION

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021
Guardian of Safe Working Hours 2021-2022 Q1 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 Guardian of Safe Working Hours (GoSWH) was introduced into the Trust as part of the 2016 Terms and Conditions for Junior Doctors and is required to report to the board on a quarterly basis. The report aims to provide the board with oversight into compliance with safe working hours and assurance that issues raised in exception reports are escalated appropriately

/ Executive Summary – Key Points

1. We continue to see relatively low rates of exception reporting although feedback via the Junior Doctor Forum and other soft intelligence suggests areas of significant understaffing, particularly within General and Elderly Medicine. There is potential for this to affect the ability to deliver safe care.

2. Staffing shortages are being compounded by the lack of robust systems and development opportunities encouraging non-trainee doctors to remain within the organisation.

3. The management of junior doctor rosters is moving to an electronic portal. The choice of provider means our platform for Exception Reporting is going to change in August 2021.

/ Recommendation

The Board of Directors is required to receive and note the report.

Author: Dr Ruwani Rupesinghe, Guardian of Safe Working Hours

Director Sponsor: Mr James Taylor, Medical Director

Date: 15 July 2021

1. Introduction and background

This is the 2021/2022 Q1 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training.

The quarterly report is for 1 April 2021 to 30 June 2021 and summarises key findings from the Junior Doctor Forum (JDF) and Exception Reporting.

The GoSWH holds the position of Chair of the JDF. Monthly meetings recommenced via WebEx in October 2020.

Exception Reporting is via an online tool. All junior doctors are given access and are able to highlight variation in working hours, missed breaks and missed training opportunities. These reports are sent directly to the doctor's supervisor who can award Time Off in Lieu (TOIL), payment for additional hours worked, or close the report with no further action. Certain breaches to contractual working hours or adequate rest result in a Guardian fine payable by the relevant Care Group.

2. Detail of report and assurance

2.1 Exception reporting and guardian fines

2.1.1 Summary of fines for quarter 1

The balance of Guardian funds is currently £807.56

Although the balance of Guardian funds in cost centre 113003 is currently £807.56, £500 has been ring fenced for use towards the York Doctors Mess and £300 has been ring fenced for use towards the Junior Doctor Awards. **This means that the actual available balance is just £7.56.**

Zero fines were levied in Q1.

2.1.2 Exception reporting trends

Thirteen exception reports were submitted by eight doctors in Q1.

All reporters were Foundation Year doctors.

All of the reports highlighted issues related to working hours and rest; twelve documented a late finish with six also expressing an inability to achieve a break during the entirety of their shift.

The primary reasons were cited as "perceived staff shortage" and "unavoidable delay" such as a patient deteriorating or liaising with a family towards the end of a shift.

Seven reports (53.85%) were received for care group 2 at Scarborough Hospital:

- 6 from Elderly medicine
- 1 from Diabetes and endocrinology.

From August changeover the Elderly Medicine team will return to a pre-COVID system of getting the team together every morning and deciding on the most appropriate ward allocation to maintain patient safety and ensure juniors are well supported.

Five reports (38.46%) were received from Trauma and Orthopaedics at York Hospital.

In 2020/21 exception reporting identified a staffing shortfall in Scarborough Hospital within Trauma and Orthopaedics. The reports from York were unexpected but demonstrated the limitations of employing Physician Associates to 'replace' rather than support staff with prescribing capabilities and who meet IRMER criteria to request tests. This intelligence has been fed back to the department as a caution for their plans to improve staffing in Scarborough. It is of vital importance that the longstanding non-training, Trust Grade post is filled again soon and further consideration given to employing an Advanced Clinical Practitioner.

2.1.3 Psychiatry, TEWV:

The Trust remains lead employer for junior doctors during their placements in psychiatry at Tees, Esk and Wear Valley Trust.

The Q4 2020/21 report detailed newly identified gaps in the pathway managing payment for extra hours (non-locum) worked in psychiatry as their exception reports do not automatically feature on our system. After meeting with representatives from Tees, Esk and Wear Valleys Trust we have designed a simple process that ensures we can share reports with Educational Supervisors who are usually based in YSTHFT (contractual requirement) and arrange timely, auditable payments.

2.1.4 E-roster exception reporting platform

The Trust is in the process of expanding e-rosters across the medical workforce. The software purchased includes a new exception reporting tool and from August we will no longer be using DRS4. We are in the process of redesigning pathways and support tools to align with the new platform. These will be publicised widely to raise awareness of the impending change which may be particularly disconcerting to supervisors. They may only be familiar with DRS4 as exception reporting has only been in place since the 2016 contract was negotiated. The new software might inadvertently reduce reporting rates and/or increase the timeframe in which they are closed. We hope to combat this via the publicity drive and up-to-date resources.

2.2 Junior Doctors' Forum

Meetings have recommenced via WebEx and are held on the second Tuesday of every month. Invitations are sent to all junior doctors in the Trust via Outlook and the WebEx application.

2.2.1 Annual leave

An item was raised at the Forum expressing difficulties getting leave approved amongst doctors based in General and Elderly Medicine (York). Impassioned personal stories of frustration and exhaustion were shared. A detailed review was carried out by the rostering team unveiling a significant backlog of untaken leave among junior doctors of all grades. Due to previously established 'minimum staffing levels' and the necessity for a COVID roster, opportunities for leave have been sparse. This led to a combination of requests

being declined and doctors eventually not pursuing time off. As most trainee junior doctors will rotate on 4th August there is limited time in which to incorporate their leave.

Since the issue was initially identified, great strides have been made in reducing the quantity of untaken leave. This will naturally leave departments with lower staffing ratios than is ideal and bring with it alternative risks to those generated by the presence of tired, demoralised doctors.

Given the possibility similar backlogs developed in other specialties primarily affected by COVID, a wider review of outstanding leave was completed. A few doctors scattered across Emergency Medicine and General and Elderly Medicine (Scarborough) were identified. They are also being supported to achieve adequate rest and financial reimbursement if necessary.

We anticipate the gradual rollout of e-rostering will reduce the chances of this incident recurring as the system is designed to make information more visible and generate alerts in a timely manner.

2.2.2 Locally employed doctors

Doctors in non-training, non-consultant posts regularly attend the Forum. Many of them have been employed by the Trust for several years on 12-monthly fixed term contracts. This system allows the individual and organisation a degree of flexibility. Doctors can dip in and out of training while departments can respond to variable trainee allocations. In some areas these doctors are essential to maintain safe staffing levels irrespective of whether a full complement of trainees have been allocated to the Trust by Health Education England.

Representatives from this cohort of doctors report significant challenges in receiving confirmation from the organisation as to whether their contracts are going to be renewed. There is no clear pathway of review or robust channels of communication in each Care Group. The uncertainty over future employment has contributed to several finding posts elsewhere thus compounding staffing shortages. More concerning is that doctors have felt it necessary to explore their legal rights as long term employees on annual contracts, demonstrating the level of anxiety being felt.

The Workforce and Organisational Development directorate are conscious of the need to improve how this group are supported and are exploring ways in which to best do so.

2.2.3 Junior Doctor Awards

As highlighted in the previous board report the Awards are continuing in a COVID safe manner. Judging is complete and the finalists have been invited to receive their awards. This year's finalists are:

Compassionate Care:
Dr Susie Hart
Dr Mohamed Idris
Dr Ruairidh Kerrigan

Educational/Clinical Supervisor:
Dr Rachel Davidson
Mr Matthew Harbottle
Mr Antoine Kass

Outstanding contribution to QI or research or teaching:
Dr James Finnie
Dr Mohamad Kajouj
Dr William Lea
Ms Luisa MacDonald

Rising Star:
Dr Sarah Burn
Dr Adam Ferguson
Dr Thomas Holder

Team Player:
Dr Thomas Holder
Dr Claire Kershaw
Dr Kiandokht Rostami Monjezi
Dr Hannah Townsend
Dr Lewis Warnock

The Communications Team will share details of winners and images more widely after the event.

2.2.4 Annual Guardian Survey

The annual Guardian of Safe Working Hours Survey opened on 10 June 2021 and will close on 19 July. Results will be presented in the Q2 Board report.

2.3 Summary of rota gaps

	Covered by trainee/Trust Grade	Vacant
York	295 (94.25%)	18 (5.75%)
Scarborough	141 (89.24%)	17 (10.76%)

Table 1: Training posts

	Filled	Vacant
York	80 (86.96%)	12 (13.04%)
Scarborough	48 (88.89%)	6 (11.11%)

Table 2: Non-training (non-consultant) posts

Vacancy rates appear relatively static although more detailed information on these figures is awaited. A further caution into interpretation of these numbers is that August is usually when the most noticeable change occurs. This is due to the large cohort of junior doctors that rotate to a new hospital. In addition, it is when doctors who hold non-training posts are likely to leave in order to re-join training. The Q2 Board report will therefore provide a better insight into what the rest of the year holds in terms of rota gaps.

Board of Directors
28 July 2021
Senior Information Risk Owner 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

This annual report presents assurances to the Board on the effectiveness of the Trust's information management and governance arrangements: that they are up to date; fit for purpose; effectively communicated and routinely complied with.

/ Executive Summary – Key Points

This year the Information Commissioner's Office (ICO) introduced the Accountability Framework. This is divided into 10 categories to aid demonstration of compliance with relevant legislation (including, but not limited to the Data Protection Act 2018, UK General Data Protection Regulations, Freedom of Information Act 2000), government standards, codes of conduct and best practice for the Trust.

This report includes assurances aligned as required by the ICO's Accountability Framework and the Data Security and Protection Toolkit.

The newly appointed Data Protection Officer has taken the first four months of their appointment to analyse the issues and risks facing the Trust, with regards to Information Governance and develop a strategy (Appendix 1) which will address these.

This report and the Information Governance Strategy has been presented, in advance of Board, to the Resources Committee who will seek assurance as to progress on the scoping, resourcing and delivery of the Information Governance Strategy throughout the year.

/ Recommendation

The Board are asked to note the SIRO report and support the work to deliver the Information Governance Strategy (Appendix 1)

Author: Rebecca Bradley (Head of IG and DPO) and Dylan Roberts (CDIO)

Director Sponsor: Dylan Roberts

Date: 14th July 2021

1. Background information

The Trust recognises the need to protect its information assets from both accidental and malicious loss and damage. Information Governance (IG) and this is evidenced by the on-going work to improve the management and security of our information. The Trust understands that information is a valuable asset and not only does Information Governance allow the Trust to comply with the law it also enables better use of the information held whilst supporting the digital agenda.

A Senior Information Risk Owner (SIRO) is an Executive Director or member of the Senior Management Board of an organisation with overall responsibility for an organisation's information risk policy. The SIRO is accountable and responsible for information risk across the organisation.

The purpose of the SIRO report is to update the Board on the work carried out by the IG Team on behalf of the IG Executive Group and to provide assurance on the controls in place relating to the IG standards and law.

The Main body of this report focuses on an assessment of the Trust's current position in relation to the Information Commissioners Office (ICO)'s Accountability Framework, the NHS Data Security and Protection Toolkit (DSPT) that are recognised best practice tools to measure compliance and identify gaps and the Information Governance strategy that articulates the roadmap to compliance.

2. Main Issues

2.1. Appointments

From September 2020, the Trust's newly appointed Chief Digital and Information Officer (CDIO) took over the role as the Senior Information Risk Officer (SIRO) with knowledge and experience of how to carry it out.

From March 2021, the Trust's newly appointed Head of Information Governance was also appointed as the statutory role of Data Protection Officer (DPO).

The Trust Medical Director continues as the Caldicott Guardian.

2.2. Audits

On the request of the CDIO the Audit team audited the Trust on its compliance with the UK GPDR and Data Protection Act. Both outcomes of this audit gave limited assurance to adhering to the legislation.

The following areas have been highlighted:

- Inconsistencies with the documentation of the lawful basis for processing;
- Relying upon consent as a lawful basis for processing in a healthcare organisation;
- Information available to individuals in both the Adult and the Children's Privacy Notices.

A Control Improvement Audit was undertaken with a focus on Information Asset Owners across the Trust. This resulted in red risk rating, with the following key risks:

- There is a lack of understanding in relation to what information is held in the Trust's information assets, what is added and what is removed, how information is moved, and who has access and why;
- The Trust is not able to fully understand and address risks to the information, and ensure that information is fully used within the law for the public good;
- A written judgement of the security and use of the Trust's information assets is not accurately completed on an annual basis, to support compliance with legal requirements, the GDPR and/or the Data Security and Protection Toolkit;
- Breaches of legislation and best practice guidance, resulting in financial penalties imposed by the ICO.

Further to this the Data Security and Protection Toolkit Audits resulted in unsatisfactory assurance and low confidence in submission. Highlighted are examples of high risks that have been found in both 2020 and 2021:

- All staff should be required to receive Data Security and Protection training test on an annual basis. Steps should be taken to ensure that levels of compliance across the Trust meet the 95% compliance target set;
- Root cause analysis of information security incidents;
- IT contracts should be reviewed for their compliance with the UK GDPR.

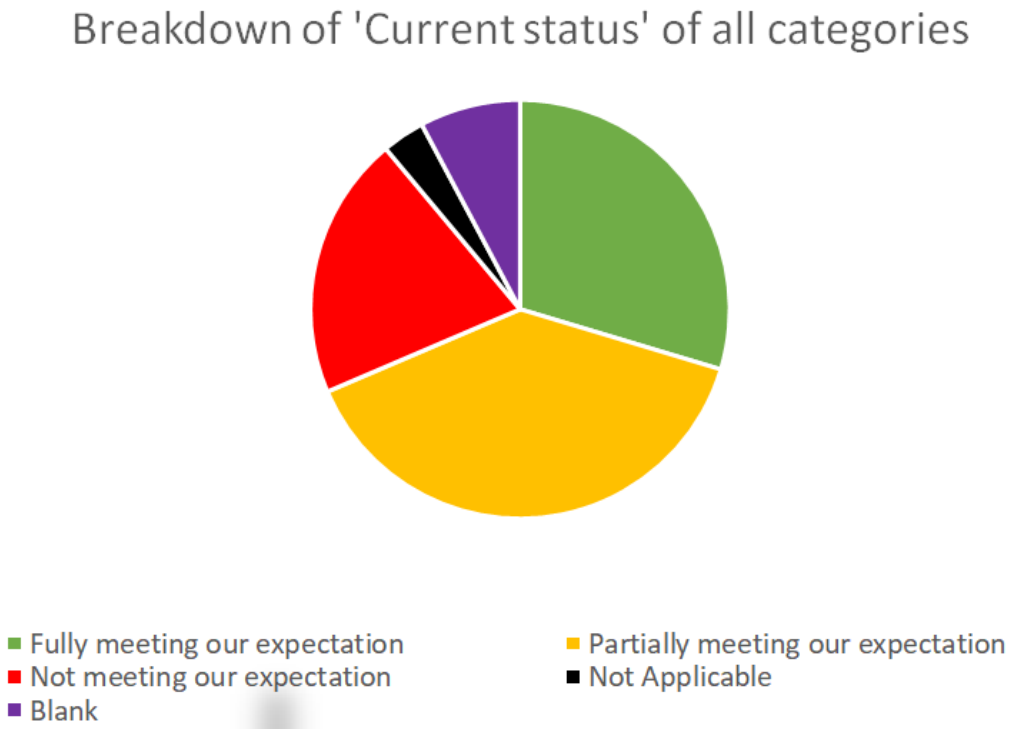
2.3. ICO Accountability Framework

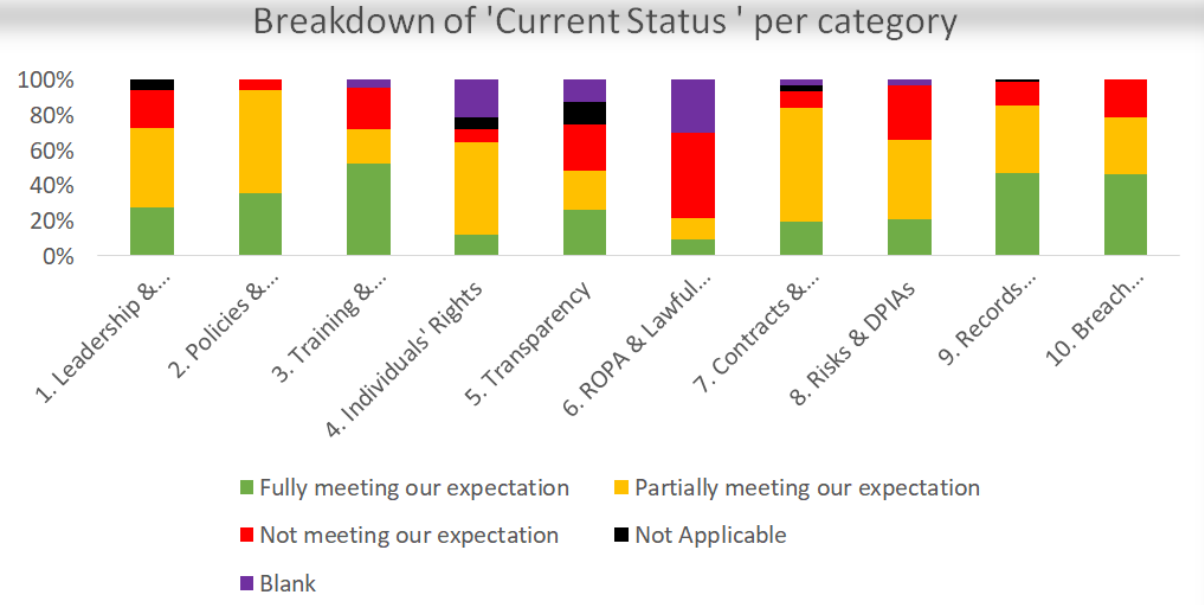
The Head of Information Governance has reviewed the audits and the Trust's current documentation, corroborating that significant improvement needs to be made for the Trust to achieve basic compliance. The framework has enabled the Trust to identify specific areas where it is unable to demonstrate compliance.

This Information Commissioner's Accountability Framework self-assessment is broken down into ten areas:

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individuals' Rights
- Transparency
- Record of Processing Activity and Lawful basis
- Contracts and Data Sharing
- Risks and Data Protection Impact Assessments
- Records Management and Security
- Breach Response and Monitoring

The outcome of this review:





Records of Processing Activity and Lawful basis are key areas of concern. The Trust has a legislative requirement to maintain a document which shows what personal information is being used and why that use is lawful under the Data Protection legislation. This will be the starting point for the Information Governance Strategy.

2.4. Data Security and Protection Toolkit

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. The standards were updated in 2017 with a significant focus on cyber security, and associated standards. More recently NHSx

have emphasised the need to address cyber security risks as the threat to NHS organisations rises. As the Trust moves to an increased digital way of working we must take steps to ensure we are adequately protecting the information we hold.

The Trust is addressing the recommendations from internal audit as well as completing further reviews in relation to the DSPT requirements.

2.5. Information Governance Strategy

The newly appointed Data Protection Officer has taken the first four months of their appointment to analyse the issues and risks facing the Trust, with regards to Information Governance and develop a strategy (Appendix 1) which will address these.

The Information Governance Strategy has been agreed at Executive Committee and a commitment made by all departments across the Trust to put resource into its delivery. The critical starting point to deliver the Strategy effectively and meet compliance obligations is to identify and assign responsibility to Information Asset Owners (IAO).

Their role is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why. As a result they are able to understand and address risks to the information, and ensure that information is fully used within the law for the public good, and provide written input to the SIRO annually on the security and use of their asset.

There are no IAOs in the Trust at this time and once identified they will need to be trained and understand their responsibilities. Until now the Trust has not realised there is a need for such roles which are a mandatory requirement of the DSP Toolkit.

The Strategy as it is highlights the minimum resource available to the IG team. The resource capacity has changed and the Information Governance Manager is likely to be unavailable for an extended period. The Strategy is necessary to achieve basic Data Protection Compliance; it is ambitious with a complete IG team, and it was developed with the framework in mind, which prioritises the Trust's compliance needs. This means it can be moved beyond 2023 if, due to resource constraints it is not completed. The Head of IG is completing a project scope for the Information asset register and IAO work which will document what needs to be delivered and assess the resource needed to deliver this.

Executive Committee have recently approved the appointment of a Cyber Security Manager, as part of the proposed DIS Restructure proposals. This is a vital role to provide expert input and assurance to achieve the DSPT toolkit requirements and keep the Trust safe. This is currently and interim appointment using non-recurrent funds but will be included as a necessary requirement for the 2022/23 budget as a recurrent requirement.

2.6. Risk

Current risks the Trust face which will be addressed and mitigated because of the IG strategy:

- Non-compliance with the law leading to monetary penalties and reputational damage
- Non-compliance with the DSPT leading to breach of contract and partner organisations ceasing to work with the Trust
- Risk of attach from malicious parties leading to loss of data availability and therefore provision of service and risk to patients

Information governance and cyber security risks have been added to the Digital and Information Service, corporate Risk Register and Board Assurance Framework.

The following risks have been identified and given risk ratings using the Trust matrix (Appendix 2)

- Cyber Security: 20
- Breach of Data Protection Principles: 12
- Confidentiality, Integrity and Availability of Data: 12

3. Information Security Incidents

From June 2020 - June 2021 the Trust reported 345 incidents which were an information governance incident or had an Information Governance element. Further details can be found in Appendix 3.

It should be noted the Trust reported two incidents to the Information Commissioner this year.

WEB142986 (Appendix 4)
Care Group 4: Breast Screening
Category: Disclosed in Error
ICO decision: Pending

WEB144643 (Appendix 4)
This has been reported under corporate services, but is primarily a Care Group 1: Elderly breach
Category: Insecure Document Disposal
ICO decision: Pending

4. Training

Staff must undertake Information Governance and Data Security training annually as part of mandatory training. It is also a DSPT requirement that at least 95% of all staff complete their annual Data Security Awareness Training.

As of June 2021 88% of staff have completed the IG training module.

Appendix 5 includes a breakdown of areas which are not achieving full compliance.

5. Data Protection Requests

2158 requests were logged by the Health Records team from June 2020 - June 2021 These requests include:

- Subject Access
- Police
- Requests from other health care professionals
- Access to Health records requests

We are unable to determine how many Subject Access Requests the Trust received as these are not logged centrally or systematically between teams.

We are unable to determine how many other rights requests were received as these are not logged centrally or systematically between teams.

It is part of the strategy to scope out how this can be rectified.

6. SIRO Comment

The Trust is now in a position where, using the ICO framework and toolkit, we can provide assurance that compliance gaps are being identified and the work to close these gaps is being scoped out. It is clear from the initial scoping exercise that commitment will be required by services and additional staffing will be required to complete the Information Governance Strategy and address the Data Security and Protection Toolkit audit recommendations. The extent of this resource is to be determined.

Appendix 1: Information Governance Strategy

Introduction
Information is a vital asset for any organisation. Our information assets at the Trust support both the day to day clinical operations and the effective management of our services and resources. The Trust is responsible for ensuring that any information is managed in line with legislative and regulatory requirements. There is also an expectation that as a healthcare provider the Trust is adequately equipped to handle members of the public's information effectively and securely. Information Governance provides a framework for the handling of all types of information in relation to personal information of staff and patients or business sensitive information. This strategy has been developed to recognise the importance of the Trust's information assets and the need to build an environment which means they can be exploited effectively and securely. It is critical that the information the Trust holds not only supports its values and is used in a way that improves the patient experience, but is also managed appropriately.

Purpose
The current data protection legislation has been in place since May 2018 and the Trust has received limited assurance for UK GDPR compliance audits in 2020 and 2021. This strategy has been developed to get the Trust to a basic level of compliance with the UK GDPR and Data Protection Act 2018 which in effect is basic compliance with the law. It sets out broad implementation plans to achieve this. It is acknowledged that work is required with regards to the Freedom of Information Act 2000; however this stage of the strategy will be addressed in 2023 due to their being a process in place for requests which lowers the Trust's risk of noncompliance.

By adhering to the requirements, standards and best practice, articulated in this strategy, for the processing of personal data, it will help the Trust to:-

- provide excellent care to our patients;
- comply with the law;
- implement the Department of Health guidelines and standards;
- meet CQC regulation 17 (Good Governance);
- fulfil the Data Security and Protection Toolkit (DSPT) requirements;

The Strategy also aims to support ongoing and future programmes within the Trust including:

- The Building Better Care programme and associated digital transformation
- Clinical Documentation Project
- Change in the Workplace
- N365
- The National Data Opt-out

Ensuring Information Governance is considered during these programmes lessens the likelihood of new systems or processes being implemented with unidentified information risks.

Monitoring progress
This Information Commissioners Accountability Framework self-assessment is broken down into ten areas:

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individuals' Rights

- Transparency
- Record of Processing Activity and Lawful basis
- Contracts and Data Sharing
- Risks and Data Protection Impact Assessments
- Records Management and Security
- Breach Response and Monitoring

By using these as a measure of compliance alongside the requirements of the Data Security and Protection Toolkit we are able to focus the actions the Trust needs to take, and monitor progression.

Annual internal audits agreed with the SIRO and DPO will be conducted to ensure previous audit actions have been completed and that any areas which are not being implemented effectively are identified.

Monitoring will be reported in detail to the Information Governance Executive Group, escalations to Executive Committee and reported at a high level to the Resources Committee and then Board.

Responsibilities

Trust Board

The Trust Board will define the requirements of the Information Governance Strategy, taking into account the regulatory environment. The Board will ensure sufficient resources are provided to support the requirements of the Strategy.

Chief Executive Officer (CEO)

The Chief Executive is required to provide assurance that all risks to the Trust (including information risks) are effectively identified, managed and mitigated.

Senior Information Risk Officer (SIRO)

The Senior Information Risk Owner (SIRO) is responsible for ensuring all information risks are correctly identified, managed and that appropriate assurance mechanisms exist.

Caldicott Guardian

The Caldicott Guardian is responsible for protecting the confidentiality of patient and service user information and enabling appropriate information-sharing. The Caldicott Guardian is responsible for providing advice within the Trust on the lawful and ethical processing of patient information. The Trust's Caldicott Guardian is the Chief Medical Director.

Data Protection Officer (DPO)

The Data Protection Officer is responsible for monitoring the Trust's adherence to data protection legislation, providing advice, devising training as necessary and being the point of contact for the Information Commissioner's Office.

Head of Information Governance

The Information Governance Lead will provide operational management of the Trust's Information Governance framework. The IG lead will:

- Provide strategic direction, planning and guidance to ensure compliance with information governance legislation and the national agenda;
- Ensure work practices are evaluated and supported through the development of appropriate policy and procedures across the organisation;
- Develop an appropriate IG training programme for all staff;

- Monitor all actual and near miss security incidents within the organisation;
- Ensure the DSPT submission.

Information Asset Owners (IAO)
Information Asset Owners are senior members of staff who are responsible for an information asset/s, and understand the value of that information, the risks associated with it and how it is being used. They should report risks to the SIRO.

All Trust Staff
Staff at all levels of the Trust must ensure that they are aware of their obligations with regards to Data protection and information Security.

Overview

Establishing ownership and accountability for information	Information is everyone's business and the Trust needs to foster a culture of ownership and responsibility for personal information it handles. Everyone is responsible for the Trust's compliance with the legislation. To support this, the Trust must establish and identify Information Asset Owners (IAO) from specialties, care groups and corporate departments. They should be senior members of staff who are responsible for an information asset/s, and understand the value of that information, the risks associated with it and how it is being used. The IAO must play a key part of the governance of information having due regard for: • Approving Data Protection Impact Assessments for their Assets; • Approving Information Sharing Agreements; • Enabling the investigation of information security incidents associated with their assets; • Ensuring staff they are responsible for having completed relevant Information Governance Training; • Reviewing the Information Asset Register on an annual basis; • Providing assurance to the Senior Information Risk Owner and the Data Protection Officer. The IAOs should attend the Information Governance Exec Group. Relevant sub-groups to IGEG should be considered so that information is fed up and down from the group. Records management, Rights Management and Data Quality should be included in this. This will also enable the Trust to develop an information risk management reporting structure to ensure all associated information risks are appropriately managed.
Training	Developing a culture of compliance means that staff must be adequately trained to understand data protection at a relevant level for them. At 87% the Trust is not compliant with the NHS Data Security and Protection Toolkit requirement to have at least 95% of staff trained. There must be a continued effort to achieve 95% training

	completion based on the mandatory e-learning module. IAOs should be made aware of staff members who have not completed training and have responsibility for ensuring this is done. The IG team needs to complete a training gap analysis to understand what levels of staff should receive Data Protection training that is relevant to their role, including IAOs. Training documentation and roll out plan will need to be developed. The IG team will review current guidance available to staff to assess its relevance and clarity. This will then be promoted to staff using a communication plan developed with the Communications team.
Lawful Basis	The Trust currently does not record its lawful basis for processing information in an effective way. It is not available on a record of processing activity, nor on privacy notices or Data Protection Impact Assessments. These should be reviewed alongside development of documentation and Ownership of information.
Data Protection documentation and process review	Documents to be reviewed and assessed for relevance and clarity by the IG team: • Data Protection Policy • Information Security Policy • Data Protection Impact Assessment (DPIA) template • Information Sharing Agreement (ISA) template • Information Asset Register (Record of Processing Activity) Documents to develop: • Appropriate Policy document for Special Category information Formal processes for completion and approval of DPIAs and ISAs must be developed and implemented (this should include data processor contract checks). A process for reviewing the Information Asset Register alongside IAO must be developed and implemented.
Enhance the Trust's transparency regarding how we process information	The Trust has a legal obligation to inform individuals how we use their information; this is usually done in a privacy notice. The Trust does provide some information in relation to this but it is currently not compliant with the UK GDPR. The IG team will review the current notices to ensure they meet the legislative standards and also that they are presented consistently. This will cover the basic set of notices for: • Patients • Staff and LLP Staff • CCTV • Complaints • Trust members • Volunteers • Children A layered approach to how we provide individuals with this

	information should be considered. Currently there is information on the Trust website and an IG leaflet. To ensure that transparency information is specific to the Trust, work must be completed with the IAO's on the current Information Asset Register to improve the visibility of what is happening to personal information in order for the Trust to be transparent. Alongside this the IG team will plan to bring awareness (via a communications plan) to the privacy notices and what to do if staff are asked what happens to patient's information. Front line staff should feel confident when addressing queries regarding information and know where to signpost individuals to.
Data Protection Rights	• The Trust must review its current processes with regards to Data Subject rights to ensure they are easy to exercise and the Trust has a suitable process for recording requests and concerns. • Currently there is only a central process for Subject Access Requests put in by patients via the requests team. • There is no oversight by the IG team of what requests are received elsewhere in the Trust. • There is no log for any other rights requests (rectification, erasure etc.) and no understanding of what should be considered a 'business as usual' request. • There are several references to the Trust using consent as a lawful basis but no indication of how this consent can be withdrawn. This must be reviewed and where necessary a process implemented. • Staff should be able to recognise a request and in the event of receiving one verbally or in writing know how to action this request.
Incident Management process	• The current process for dealing with information security incidents does not systematically or consistently assess incidents to understand the risks to the rights and freedoms of the individuals affected. • Where a serious incident occurs there is no internal approval mechanism for reporting to the Information Commissioner. • There is no set procedure for how incidents should be investigated (root cause analysis) and when the IG team should lead or where HR should be notified. • There is no report produced after an investigation which provides the cause of the incident, the impact of the incident and offers recommendations for future mitigations, with a management (IAO) response to recommendations. A new process must be implemented by the IG team working alongside the patient safety and governance team.
Information Security	There is a Security Focus Group in place coordinated by the Senior Server Analyst. The groups aim is to act as the expert group within the Trust that considers all aspects of IT Security; making strategic and technical security recommendations,

	ensuring adherence to standards and managing technical risks relating to IT Infrastructure and Software. This is reported to the Technical Steering Group. Due to this group there is assurance that security risks are considered and acted upon. The group does not currently feed into the Information Governance Exec Group to provide assurance to the SIRO and DPO. It is recommended that the SFG should be represented at this Group going forward and regularly report on current risks and progress on security certification. There is no specific security lead within the Trust to ensure this work is managed and prioritised appropriately. This is currently done between the team, however there needs to be a review of skills and knowledge with regards to security to ensure the Trust has adequate assurance that these matters are being appropriately addressed. A central lead should ensure the DSPT Toolkit submission is reviewed effectively, having received unsatisfactory risk assessment and low confidence in both the 2020 and 2021 audits. PCI compliance should be reviewed alongside finance as part of the Trust's information security requirement. When appropriate, Information Governance walks of staff areas should continue.
Freedom of Information	The current process for responding to requests must be reviewed. Information Asset Owners should be made aware of requests and ensure that they are answered appropriately and within statutory timescales. Resource for this service within the IG team should be reviewed. Currently there is only one member of staff coordinating requests whilst also fulfilling other responsibilities as an IG Officer.

Resource
The current IG team consists of:
Band 8 Head of IG and DPO
Band 7 IG Manager
Band 5 Information Governance Officer

The processes and documentation produced will rely heavily on interaction with the care groups and corporate services therefore the aim will be to make data protection as simple to apply as possible. This supports the DPO with resourcing and the IG team with providing assurance to the Trust with regards to compliance. There is no central lead for information security, or adequate assessment of skills and knowledge that are necessary to ensure security risks are appropriate reviewed and prioritised.

Review
This strategy will be reviewed in September 2023 and updated to reflect progress made and new strategic goals.

This should include plans to further:

- Records Management arrangements;
- Freedom of Information arrangements;
- Data Protection by Design and Default;
- Compliance as a driver for improvement.

Regulatory Environment

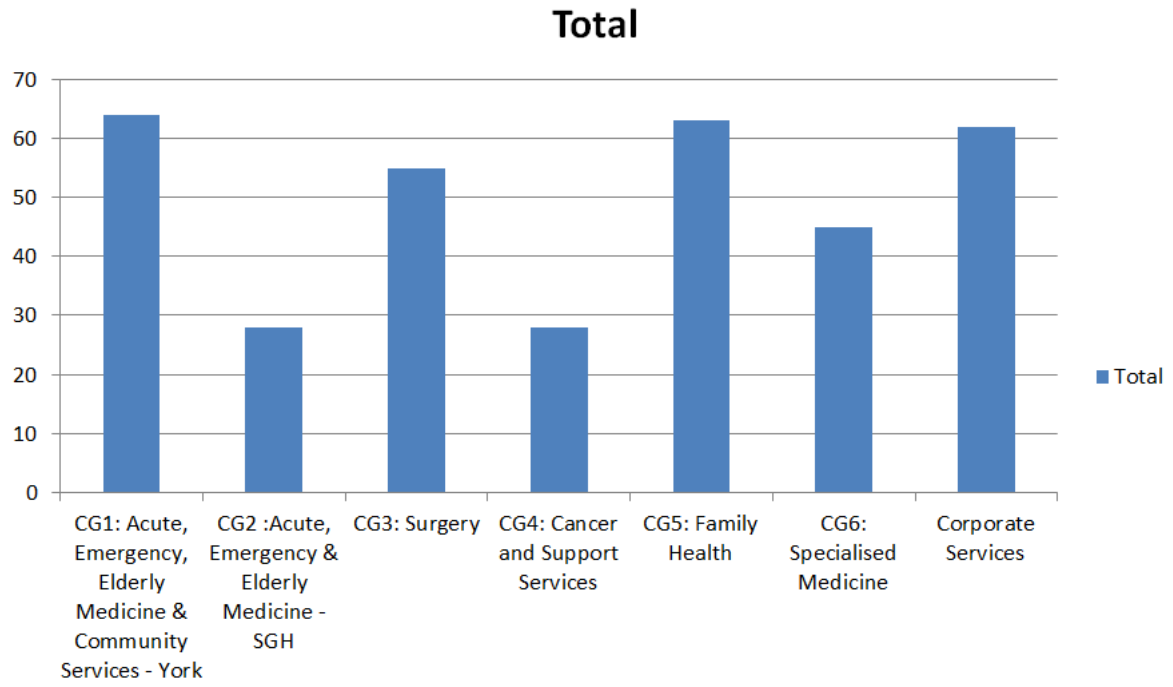
- The UK General Data Protection Act and the Data Protection Act 2018;
- The Freedom of Information Act 2000;
- The Environmental Information Regulations 2004;
- Access to Health Records Act 1990;
- The NHS Act 2006;
- The Health and Social Care Act 2012;
- The Human Rights Act 1998;
- Re-Use of Public Sector Information Regulations 2005
- The Misuse of Computers Act 1990;
- Privacy Electronic Communications Act 2003;
- Protection of Freedoms Act 2012;
- The NHS Confidentiality Code of Practice;
- The Caldicott Principles;
- NHS Records Management Code of Practice;
- Lord Chancellor's Code of Practice on Records Management under 46 of the Freedom of Information Act 2000;
- Data Security and Protection Toolkit;
- CQC regulation 17 (good governance)
- Regulator guidance

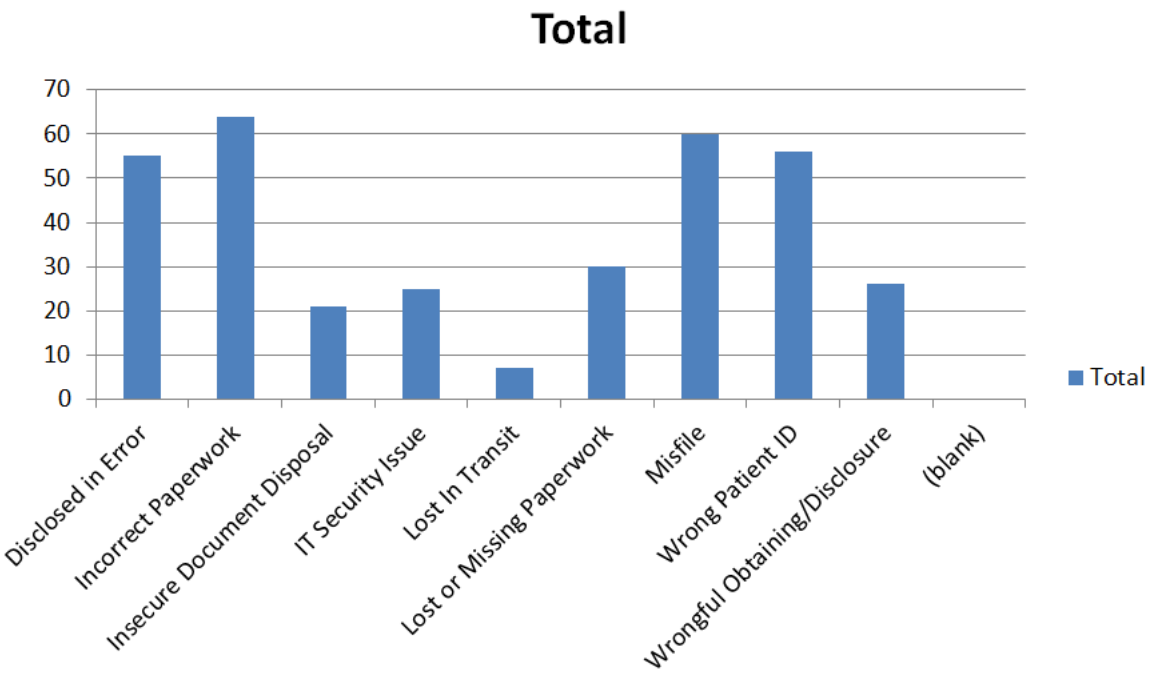
Appendix 2: Risk Assessment

IMPACT		LIKELIHOOD			
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely	No effective control; or ≥1 in 5 chance within 12 months	>20%
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Directorates; Extended service closure	4	Somewhat Likely	Weak control; or ≥1 in 10 chance within 12 months	≥10%
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Directorates; Service closure	3	Possible	Limited effective control; or ≥1 in 100 chance within 12 months	>1%
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥1 in 1000 chance within 12 months	≥0.1%
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely	Very good control; or < 1 in 1000 chance (or less) within 12 months	<0.1%

IMPACT						
	5 Catastrophic	5	10	15	20	25
	4 Severe	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 No Harm	1	2	3	4	5
		1 Extremely Likely	2 Unlikely	3 Possible	4 Somewhat Likely	5 Very Likely
		LIKELIHOOD				

Appendix 3: Information security incident breakdown by Care Group and category





Appendix 4: Detailed overview of ICO reportable incidents

WEB142986
Care Group 4: Breast Screening
Category: Disclosed in Error
ICO decision: Pending
Details: In May, a patient requested that the Breast Screening Unit (BSU) change their ethnicity and send confirmation of this change. To do this the member of staff took a screenshot of the information and cropped the image. The screenshot was a view of the BSU inbox used to manage screening appointments. This included 7 emails where names of attendees can be seen and 1 email confirming a rearranged appointment which included name and email address of the attendee (no appointment details such as date or time). The screenshot was cropped in Word so this information was not in view and confirmation of ethnicity was sent. The recipient contacted the BSU to inform them that when the image was opened on their phone they could see the cropped areas. When images are cropped the cropped areas are not deleted, just hidden, and can be restored in Word. It is unclear why this happened on the recipient's phone device and not their computer. The recipient was asked to delete the information and confirm this had been done.

The incident was reported to the Data Protection Officer and assessed as low risk to the data subjects. This was determined due to the low amount of data subjects and basic information 8 names and 1 email address, the overall likelihood that most women between 50 and 71 will be invited for an appointment and no specific care details were available making it hard to determine further information about the data subjects. The Data Subject whose email address was disclosed was contacted and informed of the breach.

In June, the recipient confirmed they had not deleted the information and explained they would be using this information to contact the data subjects to send them the screenshot. The recipient was informed that the Data Subject whose email address was available was contacted regarding the data breach.

All data subjects affected have been contacted and the recipient has again been asked to delete the information. Staff in the BSU have been told not to use screenshot as a method for sharing information.

WEB144643
This has been reported under corporate services, but is primarily a Care Group 1: Elderly breach
Category: Insecure Document Disposal
ICO decision: Pending
Details: A student nurse on their first placement left the hospital without correctly disposing of a ward handover list securely and left in in their pocket. The list included 18 patient's details. The student nurse then attended a Student Union in their uniform where the list was misplaced. The list was found by a member of staff at the union who returned it to the Trust.

The information has been contained. The Trust has set procedures in place to stop these incidents occurring. The individual concerned has been referred for a fitness to practice assessment by their University. They also undertook an exercise on reflection of practice and used the incident to educate their fellow students. Additionally they made posters for the ward as a reminder to check pockets before leaving site.

Appendix 5: Training completed breakdown by Care Group

Monthly Care Group Core Compliance by Staff Group	Information Governance and Data Security (CSTF) 1year
CG1 Acute Elderly Emergency General Medicine and Community Services York	
Add Prof Scientific and Technic	100%
Additional Clinical Services	89%
Administrative and Clerical	95%
Allied Health Professionals	97%
Healthcare Scientists	100%
Medical and Dental	92%
Nursing and Midwifery Registered	95%
Students	100%
CG2 Acute Emergency and Elderly Medicine-Scarborough	
Additional Clinical Services	91%
Administrative and Clerical	91%
Allied Health Professionals	98%
Estates and Ancillary	100%
Healthcare Scientists	71%
Medical and Dental	92%
Nursing and Midwifery Registered	97%
CG3 Surgery	
Add Prof Scientific and Technic	91%
Additional Clinical Services	90%
Administrative and Clerical	96%
Allied Health Professionals	100%
Estates and Ancillary	100%
Healthcare Scientists	94%
Medical and Dental	90%
Nursing and Midwifery Registered	92%
CG4 Cancer and Support Services	
Add Prof Scientific and Technic	98%
Additional Clinical Services	93%
Administrative and Clerical	93%

Allied Health Professionals	94%
Estates and Ancillary	100%
Healthcare Scientists	94%
Medical and Dental	86%
Nursing and Midwifery Registered	92%
CG5 Family Health & Sexual Health	
Add Prof Scientific and Technic	100%
Additional Clinical Services	91%
Administrative and Clerical	94%
Allied Health Professionals	93%
Estates and Ancillary	100%
Medical and Dental	88%
Nursing and Midwifery Registered	91%
CG6 Specialised Medicine & Outpatients Services	
Add Prof Scientific and Technic	96%
Additional Clinical Services	94%
Administrative and Clerical	96%
Allied Health Professionals	96%
Estates and Ancillary	100%
Healthcare Scientists	100%
Medical and Dental	83%
Nursing and Midwifery Registered	90%
CG Corporate Services	
Add Prof Scientific and Technic	54%
Additional Clinical Services	64%
Administrative and Clerical	89%
Allied Health Professionals	65%
Estates and Ancillary	82%
Healthcare Scientists	100%
Medical and Dental	55%
Nursing and Midwifery Registered	79%
CG Trust Estates and Facilities Management	

Administrative and Clerical	100%
Estates and Ancillary	100%
LLP CG Estates & Facilities	
Administrative and Clerical	92%
Estates and Ancillary	82%
Healthcare Scientists	100%

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021
Fire Safety Management Policy

/ 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

As part of NHS fire code and Trust fire safety arrangement it is required the Trust Board of Directors are sighted on the review and approval of the Trust current fire safety management policy.

/ Executive Summary – Key Points

The fire safety management policy has been developed and approved by the Trust Fire Safety Committee, reviewed by the Trust Health and Safety Committee and ratified by the Trust Health Safety and Non-Clinical Risk Group.

The policy was approved by the Quality Assurance Committee at its meeting on 20 July 2021 for onwards reporting to the Trust Board of Directors for information in compliance with NHS fire code and Trust governance arrangements.

/ Recommendation

The Board of Directors is required to receive and note the report and changes to the Fire Safety Policy.

Author: Colin Weatherill, Head of Safety and Security

Director Sponsor: Heather McNair, Chief Nurse

Date: 07 July 2021

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
28 July 2021
Risk Management Strategy 2021-2024

/ 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 paper is to provide the board with a draft of the 3-year Risk Management Strategy.

/ Executive Summary – Key Points

The Risk Management Strategy sets out the trust's vision and approach to risk management over the next three years. It describes how risk management activities will be undertaken centred around seven core risk objectives. The strategy provides clear direction and its successful deployment will embed risk management at all levels across the trust and transition it to a position of full risk maturity by the end of 2024.

/ Recommendation

The board is asked to approve the draft strategy.

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1. Introduction

Risk is an integral part of the services offered by the York & Scarborough Teaching Hospitals NHS Foundation Trust ('The Trust'). The management and mitigation of risks is essential to safeguard the trust's staff, assets, finances and reputation and is fundamental to the provision of high quality care for patients and staff by creating a control environment centred on continuous improvement.

Risk is defined within the trust as, 'the effect of uncertainty on objectives' (ISO 31000:2018). It is a future event that could, if it was to occur, adversely threaten the achievement of organisational objectives. Risk Management is defined by the Institute of Risk Management (IRM) as, 'a process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure'. A Risk management process is a methodical and systematic approach to addressing risks to an organisation's activities.

2. Purpose

The purpose of the Risk Management Strategy ('The Strategy') is to present an outlook of how risk will be managed within the trust over the next three years, 2021-2024, and provide a holistic approach to risk management from ward to board (and vice-versa). It is also to ensure compliance with relevant regulatory requirements (NHSI, CQC) and give assurance to the board that a sound system of internal control is in place across the trust to effectively manage the spectrum of risks it could be exposed to.

3. Risk Management Objectives

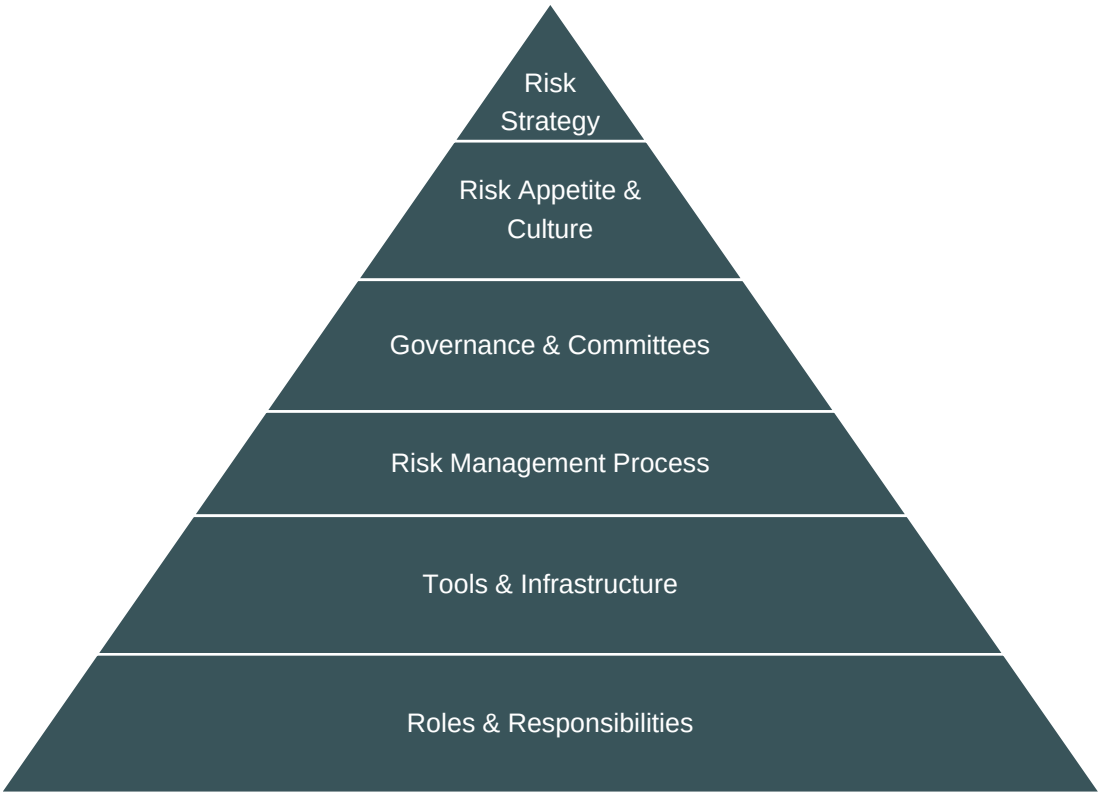
The strategy is underpinned by 7 core strategic objectives in relation to risk management:

1. To ensure there is a consistent understanding of risk management across the trust
2. To ensure all staff are aware of their responsibilities in relation to risk management in the context of their role;
3. To ensure a consistent and systematic approach to managing risks at all levels of the trust structure is in place;
4. To ensure governance structures are robust and operating effectively to provide adequate oversight of risk management;
5. To ensure risk management capability and knowledge gaps are identified and enhanced;
6. To ensure risk decisions are taken within board approved risk appetite and monitoring mechanisms are in place to identify, report and remediate risk appetite breaches;
7. To ensure the approach to risk management adopted remains proportionate and relevant to the trust.

(1) To ensure there is a consistent understanding of risk management across the trust

A comprehensive suite of risk management policies, guidance, systems and tools will be produced by the second line of defence to promote a consistent understanding of risk management across the trust. This will include a Risk Management Framework (RMF) which brings together all the individual components of the trust's approach to risk management within a single document. It will introduce a common risk language and processes for the management of risk. The same RMF will be applied for managing risks at every level within the trust from Care Group risk registers, to risks on the CRR and the BAF. A summary of the trust's RMF is illustrated below.

A risk management system will provide a central repository for capturing all risks and controls and will be supported by methodologies for the identification, assessment, monitoring and reporting of risks. Common templates for capturing risk information for example risk registers will also help to harmonise the approach and understanding of how risk information is captured and reported. Regular communication will keep all relevant stakeholders engaged throughout the risk management process and promote an environment of openness and transparency. It will also help to identify and address any misunderstandings around the risk management process providing the opportunity for the review and challenge of risk information.



Risk Management Framework

(2) To ensure all staff are aware of their responsibilities in relation to risk management in the context of their role

All members of staff will have a generic responsibility for managing risk within the context of their role; to exercise controls and identify and report when failures occur. Specific responsibilities for risk management will be assigned to individuals, committees and senior management to drive ownership and accountability for risk management processes, data and the decision-making process. The trust will operate a 'three lines of defence' model to risk management further drawing out the distinction between the management and accountability for risk data, the ownership and oversight of the risk management framework and its application and the independent assurance over the internal control environment. Specific responsibilities will be factored in to relevant role profiles to ensure there is a correlation between performance and risk management.

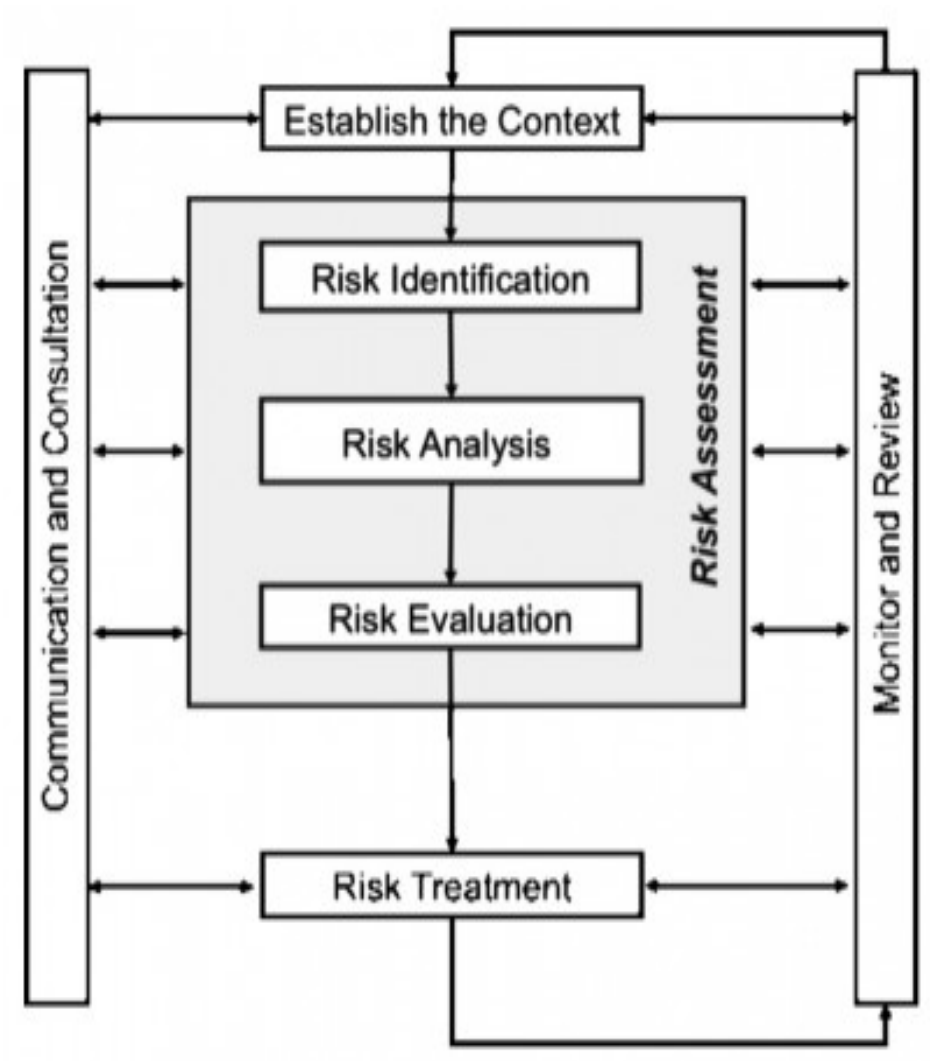
(3) To ensure a consistent and systematic approach to managing risks at all levels of the Trust structure is in place

(i) Risk Management Process

A Risk Management Process is a methodical approach to address risks to an organisation's activities. The figure below illustrates the stages of the Risk Management Process as defined by the ISO 31000 standard on Risk Management. This is a continuous and repeatable process which starts by establishing the context. Both a 'top-down' trust-wide approach and a 'bottom-up' approach to risk management will be

adopted. The top-down approach will set the strategic direction for risk management and establish the framework, architecture, systems and processes for the management of risk. It will provide a holistic view of risk through the governance structure relating to certain risk themes or trends or aggregated reports on particular types of risk. It will include the production and reporting of enterprise risk dashboards, risk heat maps and performance against agreed risk appetite through the trust board and sub-committees.

The 'bottom-up' approach will consist of the reporting and management of business-specific risks that are unique to a particular care group, specialty or corporate service function. Risks will be reported through local governance structures and escalated as necessary where emerging trends or systemic issues are identified that could have an adverse effect on the trust. The same risk management process will be adopted regardless of at what level of the trust structure, risks are being identified. This will promote a consistent approach to the identification, assessment, monitoring and reporting of risks and help to promote a positive risk culture.



Risk Management Process

(4) To ensure governance structures are robust and operating effectively to provide adequate oversight of risk management

(i) Governance structure

A sound governance structure provides transparency around the decision-making process and assurance that risks are being appropriately managed. The board and committee structure will set the 'tone from the top' and provide the necessary review, oversight and challenge of risks to protect the trust from adverse consequences and maximise opportunities that are in the best interests of the trust. The committees will act in

accordance with specific responsibilities which will be defined within terms of reference documentation. An annual review of the terms of reference of each committee will be undertaken to ensure they remain relevant and accurately reflect committee objectives.

(ii) Risk environment

A governance map will illustrate the inter-relationship and dependencies between the committees and how risk information flows through the trust. Committees will monitor and report on changes in the internal environment that could have an impact on the trust. This will include the effect of any transformation, project or programme activity, trust structural changes, new systems or processes, reporting of significant control failures, breaches of risk appetite and incidents requiring senior management attention, as a minimum. Reporting will also consider the external environment and how governmental, legislative or regulatory developments for example as well as socio-economic changes, technological advancements and changes in the broader health sector, could impact the trust.

(iii) Risk Committee

The trust risk committee will provide assurance and advice to the board and its group of sub-committees in respect of the risks facing the trust and plans to mitigate those risks. It will consider whether the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) are fit for purpose and whether they adequately reflect the strategic and operational risks that could impede the delivery of the trust's objectives. The risk committee will scrutinise, challenge, consider and moderate the description of risks, risk scores, risk mitigation and treatment plans provided by executive directors, corporate service functions, care groups and project leads to meet the trust's risk management standards and take account of the trust board's risk appetite (objective 5). Furthermore, the risk committee will oversee the trust's risk management systems and consider whether they are embedded across the trust and, where necessary, to clarify the responsibility for managing risks and the delivery of mitigation plans. The risk committee will also oversee the escalation and / or de-escalation of risks through the trust's organisational structure.

(iv) Board Assurance Framework (BAF)

The **Board Assurance Framework** (BAF) identifies risks in relation to each of the trust's strategic objectives along with the controls in place and assurances available on their operation. Board agendas will be structured to provide assurance that risks which may result in non-achievement of trust objectives are appropriately mitigated. The BAF will be reviewed by risk owners and quality assured by executive directors prior to presentation to board and its committees four times a year, and to every meeting of the Audit Committee. The BAF will be formally reviewed whenever strategic objectives change.

(v) Corporate Risk Register (CRR)

The **Corporate Risk Register (CRR)** is a high-level operational risk register which captures trust-wide risks and controls as well. Used correctly, it demonstrates that an effective risk management approach is in operation within the trust. Risks on the CRR are owned by executive directors. The CRR will be reviewed and quality assured monthly by the executive directors and/or their delegates prior to presentation at the Risk Committee, which includes risks escalated from care groups and corporate service functions to be considered for inclusion onto the CRR. Escalations to the Risk Committee will be considered by its members to determine whether a risk that is being proposed for escalation should feature on the CRR or should be de-escalated to its point of origin. For each risk that is escalated, rationale should be provided as to why the risk should be considered for inclusion on the CRR. The Risk Committee's decision to either approve or decline a request to add a new risk on the CRR will also be documented, including the justification for why a risk is de-escalated. The CRR will be presented quarterly to the board and its associated assurance committees.

Both the BAF and the CRR identify the most significant risks to the achievement of objectives. These reports provide the trust board with a means to satisfy itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the board where the delivery of objectives is at risk due to a gap in control and/or assurance. All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Annual Report brings together this evidence. It is the responsibility of the assurance committees to report to the trust board, on a quarterly basis any new corporate level risks identified, gaps in assurance/control, as well as positive assurance on an exception basis. The Deputy Director of Corporate Governance will work with the Trust Secretary, Head of Risk and Executive Directors to keep the document dynamic and integral to the Business Planning cycle. The trust Risk Management Framework and standard operating procedures will detail reporting requirements, including how frequently risks will be updated on the trust's risk management system, by whom and how these will be managed.

(5) To ensure risk management capability and knowledge gaps are identified and enhanced

Training is a key component to embedding risk management across the trust. This will be delivered on an ongoing basis as the risk culture and maturity of the trust evolves. A training strategy will be developed to identify training needs and determine the most appropriate channel, audience, content and mode of training at any given time. Training will be delivered through a combination of face-to-face, online and classroom based learning covering both generic risk management principles and targeted training on specific topics. As risk management is the responsibility of all staff, training will be provided to staff at all levels and tailored to audience needs. It will range from education and awareness through the trust intranet to the delivery of board developmental sessions on risk management.

A post implementation review will be undertaken following the delivery of any training to ensure key messages have been understood and consistently applied. This will also provide an opportunity to review how effectively training has been delivered and refine the overall approach where improvement areas are identified. An annual risk management effectiveness review will be carried out to gauge the level of risk maturity across the trust and target specific areas where gaps in knowledge are identified.

(6) To ensure risk decisions are taken within Board approved risk appetite and monitoring mechanisms are in place to identify, report and remediate risk appetite breaches

(i) Risk Appetite

Risk appetite is described as the level of risk that an organisation is willing to accept in pursuit of its strategic objectives before action is required to mitigate the risk. It provides a balance between the potential benefits of innovation and the threats that change inevitably brings. A documented risk appetite statement legitimises the level of risk the trust is prepared to take and is fundamental to make decisions that capitalise on opportunities when they arise. The absence of a fully documented and communicated risk appetite statement may stifle growth and development opportunities and could contribute to adverse patient outcomes if decisions are made outside limits set by the board.
The risk appetite of firms will vary depending on the sector within which they operate organisational culture and objectives. Different levels of appetite may be set for different types of risk which may also vary over time. Some common types of risk that may be considered when setting risk appetite are listed below:

- Patient experience
- Workforce
- Finance
- Regulatory
- Business Strategic
- Clinical
- Technology
- Innovation

Risk appetite is usually designed to:

a) clearly express the extent to which a firm's willingness to take risk in order to meet their strategic objectives i.e. define a firm's 'fight or flight' response to risk;
b) discharge the firm's corporate governance responsibilities more effectively; and
c) understand a firm's propensity to take risk compared to its propensity to exercise control

Risk Appetite will be developed around the key types of risk the trust is exposed to. Different levels of appetite will be determined depending on the type of risk and the trust board's willingness to take that particular risk. Risk appetite will be owned and approved by the board. Once approved, it will be built into the processes and culture of the trust. Actions will be proposed where risks are outside appetite to bring them back within agreed levels.

Monitoring adherence to risk appetite will be tracked and reported through the governance structure and principally the risk committee, assurance committees and the trust board. Risk appetite helps to inform and direct decision-making. Once determined, the risk appetite will be reviewed on an annual basis to ensure it remains relevant. Once risk appetite has been agreed, it will be used to determine the target risk scores within the risk registers of the trust.

(ii) Risk Tolerance

Whilst risk appetite is about the pursuit of risk to achieve objectives, risk tolerance is about what an organisation can cope with and thresholds at which it is willing to 'accept' a specific risk. Risk appetite and tolerance both need to be considered in the context of risk capacity. This is the amount of risk the trust can bear. The trust board may have a high risk appetite but not have enough capacity to handle a risk's potential volatility or impact. Conversely, the risk capacity may be high, but the trust may decide based on strategy and objectives to adopt a lower risk appetite. This is illustrated by the diagram below.

Risk Capacity	The maximum amount of risk the Trust can **support** within its available resources
Risk Appetite	How much and what type of risk the Trust is generally prepared to accept to achieve its strategic objectives.
Risk Tolerance	The maximum amount or type of risk the Trust is prepared to tolerate above risk appetite.

(7) – To ensure the approach to risk management adopted remains proportionate and relevant to the trust

One of the critical success factors to the implementation of any risk management approach is to tailor it to the size, scale and complexity of an organisation. As organisations evolve and objectives change, the risk management approach should mature and keep pace with it to ensure it continues to remain relevant. An annual review of the RMF will be undertaken to consider any material changes (internal or external) that could influence the risk management approach. This may include a change to roles and responsibilities, new governance forums, regulatory changes or evolution of risk methodology to reflect the risk maturity of the trust. As strategic objectives change so will the trust's risk appetite so an annual review of risk appetite will also be undertaken to ensure it remains relevant.

A risk management effectiveness review will also be conducted led by the Head of Risk and second line of defence to assess the extent to which risk management is embedded across the trust. This will consist of a combination of desk top reviews and interviews with relevant staff to gauge the level of risk management awareness and understanding across the trust.

Risk management is about continuous improvement and the approach adopted will evolve year on year to build a risk aware culture and develop the risk management maturity of the trust. The Risk Management Strategy will be formally reviewed in 2024, however, it is recognised that any fundamental changes to the strategic risk objectives detailed within the strategy may expedite any subsequent review.