York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Thursday 30th September 2021
Time: 9:00 – 12:05

Directors Lounge, York Community Stadium Leisure Complex, Kathryn Avenue, Monks Cross Dr, Huntington, York YO32 9AF

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Good Meeting Etiquette

KEY POINTS

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

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

ASK YOURSELF, *HAVE I...*

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

TELL YOURSELF, *I WILL...*

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

ENVIRONMENT

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: Thursday 30th September 2021

TIME	MEETING	ATTENDEES
09:00	**Board of Directors meeting held in public**	**Board of Directors**
12:05	Lunch	Board of Directors
13:00	Board of Directors – Private	Board of Directors
13:50	Close	Board of Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

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**	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 28 July 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	-	
6.	**Patient Story**	Chief Nurse	Verbal	-	09.10
7.	**Chief Executives Update** To receive an update from the Chief Executive.	Chief Executive	B	21	09.30

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ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
8.	**Board Assurance Framework** To note the report.	Chief Executive	C	25	
Strategic Goal: To deliver safe and high quality patient care					
9.	**Quality Committee Ecalation Report** Items for escalation to the Board:	Committee Chair			09.55
9.1	• To receive and note the minutes of the meeting held on 20 July 2021		D	37	
9.2	• To receive and discuss the committee escalation log from 21 September 2021		E (to follow)		
10.	**Safer Staffing Report**	Chief Nurse	F	45	10.00
11.	**Ockenden Report update:** To include Perinatal Clinical Quality Surveillance Report and Continuity of Carer Report	Chief Nurse	G	53	10.10
12.	**Care Quality Commission Update Report**	Chief Nurse	H	67	10.20
13.	**Winter Resilience Plan** To receive and discuss the plan.	Chief Operating Officer	I	85	10.25
Strategic Goal: To ensure financial sustainability					
	BREAK				10.40
14.	**Capital Programme Update**	Director of Finance	J	149	10.50

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ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
15.	**Resources Assurance Committee Escalation Report** Items for escalation to the Board: • To receive and note the minutes of the meeting held on 20 July 2021 • To receive and discuss the committee escalation log from 21 September 2021	Committee Chair	 K L	 161 175	11.00
16.	**Integrated Business Report** To receive and discuss the performance report	Chief Operating Officer/Chief Nurse/Diector of Workforce & OD/Director of Finance	M	179	11.05
16.1	• Integrated Business Report				
Strategic Goal: To support an engaged, healthy and resilient workforce					
17.	**Freedom to Speak-up Guardian Annual Report** To receive and discuss the report.	Freedom to Speak-up Guardian	N	189	11.25
Governance					
18.	**Audit Committee Escalation Report**	Committee Chair			11.40
18.1	• To receive the minutes of the meeting held on 10 June 2021		O	209	
18.2	• To receive and discuss the escalation report from the meeting held on 16 September 2021 (to include YTHFT Auditor's Annual Report)		P1 (to follow)		
18.3	• To receive the minutes of the meeting held on 11 May 2021		P2 (additional)		

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ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
19.	**Board Committee effectiveness Annual Reports** To receive the annual reports of the Board sub-committees: [Audit/Quality/Resources Committees]	Committee Chairs / Associate Director of Governance	Q1 Q2 Q3	217 223 239	11.45
20.	**Corporate Risk Register** To note and discuss the corporate risk register.	Associate Director of Governance / Head of Risk	R	247	11.55
21.	**Reflections of the meeting**	All	Verbal		12.00
22.	**Any other business**	Chair			
23.	**Items for information:**				
23.1	• Star Award Nomination Booklet – October				
24.	**Time and Date of next meeting** The next meeting held in public will be on 24 November 2021.				
25.	**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.				
26.	**Close**				12.05

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Minutes
Board of Directors Meeting (Public)
28 July 2021

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

Members present:

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

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

In Attendance:
Miss J Hall, Interim Trust Secretary
Prof V Jayagopal, Clinical Dean and Endocrinologist, Hull and York Medical School

The Chair welcomed everyone to the meeting, particularly Ruth Dunlop who was observing, and Prof V Jayagopal who attended each July to update on the Medical School. It was noted the Steve Holmberg, NED and Jill Hall, Interim Trust Secretary were both attending via Webex. It was also noted that the meeting was being livestreamed.

21/58 Apologies for absence

Apologies were received from Jenny McAleese, Non-Executive Director; Prof M Morgan, Non-Executive Director and Lucy Brown, Director of Communications

21/59 Declaration of Interests

There were none.

21/60 Minutes of the meeting held on 26 May 2021

The Board approved the minutes of the meeting held on the 26 May 2021 were agreed as an accurate record of the meeting.

RESOLVED
That the Board approved the minutes of the meeting held on the 26 May 2021

21/61 Matters arising from the minutes

No matters arising were discussed.

21/62 Patient Story

The Board welcomed Martin Smith to the meeting to tell his story of the end of life care received by his partner Glen and himself. He gave a background to his 30 year career in social care and managing residential care homes and Glen's cancer diagnosis, in particular, Glen's end of life plan and the decision for him to die at home. His story really began when Glen got pneumonia and had to be transferred to hospital, because of Covid, Martin was unable to go with him. He was put on lots of medication and when they spoke he sounded a lot better. Martin received a call from a Doctor at 1am to say that his health had deteriorated and that a decision had been made to withdraw active treatment and would be move him to 'comfort care'. At this point Martin was able to go and visit. Martin tried to arrange for Glen to be transferred home to die, however this was not possible due to his oxygen need. He reiterated how good staff were. When he arrived Glen was on his own, and it was obvious he was dying, he hadn't been told. He added that there were no quiet rooms for Glen to be transferred to and the ward was noisy. He left the hospital and when he got home he received a call to say that Glen had gone, the word die or died was not used. Martin wanted the Trust and Board to know that staff should and needed to use plain language and that people shouldn't have to fight for a single room for their loved ones end of life care and so the family can be on their own, he added it was as important as maternity and ED.

The Chair thanked Martin for his compelling and moving story.

The Director of Finance mentioned the Autumn Room and the need to find more rooms on both hospital sites. Martin confirmed that one room had been found at Scarborough and three needed to be found for York, adding that the rooms needed to be decorated and have comfortable seating with tea and coffee available.

21/63 HYMS Annual Update

The Board welcomed Prof Vijay Jayagopal to the meeting and congratulated him on becoming a Professor.

The Board received a presentation which provided an update on the Medical School for 2019/20 and particularly the impact of the pandemic and how it affected medical students, their learning and how the medical school adapted to ensure students learning experience was disrupted as little as possible. The Professor outlined 2021/22 with increases in the number of students, expanding to 120 per year for year one and two (previously 70). He added the disruption due to Covid-19 would continue to be a feature, but the school will continue to develop with the improved Teaching Fellow model, more Consultant involvement and continuing the SHaRP (Simulated Hospital achieving Readiness for Practice) model, set up in 2019/20, which give final year medical students experience of 'being on call'. It had been well received with 27 students taking part. A lot of learning and reflection had occurred at the debrief.

The Chair thanked him for the presentation expressing the Trusts continued support for the medical school.

LM welcomed the presentation, the great things the school was doing to support students and how the school and students had adapted to change, including their placements. She asked what had been learnt from other Trusts. In response it was noted that curriculum meetings were held for each phase which was where ideas were shared, the School

Council also looked at what others were doing; he described curriculum change as an evolution, but the last year had been a revolution. He further added that the school also shared what it was doing, for example, changes to workforce.

LB commented on the sense of belonging of students, SH commented on training and asked, on a national level, what was being done to monitor the effectiveness of training during the pandemic to train Doctors fit for the future. In response it was noted that it was a challenge to ensure graduates were trained. He added that grades were on par with other medical schools and that exams were the only marker.

The Director of Finance referred to the agreed capital programme regarding the HYMS build and gave assurance that the build was still on the capital programme. He explained the delay due to the pandemic and gave assurance there was Board approval to progress discussions. Professional advisors had been engaged to work on proposals to seek a partner(s) as the £30m proposal was far beyond the Trusts ability to fund and would be difficult for the ICS to fund. Work was expected to move forward with a workshop and then programme of work.

The Board thanked VJ for his annual update and invited him back in July 2022.

Action: Invitation to attend Board July 2022 (Trust Secretary)

21/64 Chief Executives Update

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

- The rise in the number of covid cases resulting in second Covid wards opening in both York and Scarborough. Covid numbers were still high in the North East. The COO reported that there were currently 36 Covid inpatients, 27 in York and 9 in Scarborough, with 4 in ICU. Since 1 July there had been 117 admissions with 18 Covid related deaths. From the 1-19 July there were on average 3-4 Covid admissions per day, this had doubled to 6-7 patients per day over the last week. The COO continued that Trusts were being asked to plan for a third wave surge to the end of August. She added that additional isolation beds were being opened in Scarborough and York. It was noted that patients being admitted with Covid were younger but had a shorter stay. LM asked if these patients had been vaccinated or received one vaccination, in response the Medical Director reported they were generally not vaccinated, they had less severe illness but there were deaths. JD asked if there was a new strain that was affecting younger people, it was noted it was the Delta variant but there were concerns over the Beta variant. The Chair referred to elective recovery and waiting lists coming down, recognising staff were under significant pressure. The COO added there was significant pressure on services and there may come a point when some procedures and out-patient appointments would be cancelled to help with staff gaps, risk assessments were being undertaken.
- Covid staff testing figures had been disappointing in the first eight weeks; staff were being encouraged to continue testing. There was now a requirement for NHS organisations to ensure staff comply with locally agreed testing regime, going forward the Trust will be sighted on organisational compliance as part of the Board Assurance Framework.
- Humber Coast and Vale and Care partnership objectives had now been agreed and published. The Board noted the six objectives.
- It was noted that the Trust had been accredited under the Good Business Charter (GBC), York had become the first city in the UK to sign up to the Charter. Nationally the Trust is the first to be recognised and accredited the GBC.

- The Board noted that the work on York ED was due to begin.
- The Board noted the joint project to fund the creation of a Scarborough Multimorbity Research Hub which was due to open in November 2021. It was an opportunity to attract significant research and investment.

RESOLVED
That the Board noted the report and noted the requirement for NHS Boards to be sighted on compliance with locally agreed Covid staff testing regime as part of the Board Assurance Framework.

21/65 Board Assurance Framework

The Board received the report noting that the August Board development session would be on risk appetite which would inform the scoring of risks on the BAF.

Resolved
That the Board received and noted the report.

21/66 Quality Committee Escalation Report

The Chair of the Committee presented his report which set out key topics discussed at the Quality Committee in July that the Committee agreed to be escalated to the Board, in particular:

- Deteriorating performance indicators at SGH ED
- Concerns around staffing levels especially at SGH
- The Committee approved the Fire Safety Policy, and
- Received the regular update on compliance with the Ockenden Report and recommendations.

21/67 Safer Staffing Report including Medical Staffing Report

Safe Staffing
The Chief Nurse provided an update on nurse staffing, it was noted that a number of initiatives were being deployed including a trial 'Getting back to work'. Staff were also being re-deployed to areas where there were shortages and specialist nurses were being released to work in wards.

It was reported that staffing in ED remained a challenge despite incentives being offered. She reiterated that staff were tired. She explained the challenges in Scarborough ED with patients being looked after in corridors, adding that there was good evidence that patients were safe and no harm was coming to them.

Nurse staffing remained good, a number were waiting for Pin numbers, international nurse recruitment was also good. It was noted that Coventry Students were now graduating.

Medical Staffing
The Medical Director gave an update on medical staffing noting there were two current work streams, 1. Urgent here and now so the Trust was safely staffed which included recruitment and job plans; and, 2. Longer term including the refresh and renew of strategies, particularly the Recruitment Strategy that would line up with the Clinical Strategy. He highlighted the need to establish Scarborough's identify and services it offers including the clinical workforce to deliver and the importance of being clear about expectations and what an integrated workforce looked like. He added that in terms of

recruitment and retention there had been discussions about HYMS, teaching, training, academic roles and research, all needed to be an attractive employer and a place where Doctors want to work.

The Chair agreed the importance of people's initial experience of the Trust and explained that generally at Consultant Panels they were people who had worked at the Trust in the past, highlighting that investment in the beginning was key to future recruitment.

The Medical Director referred to business cases for new consultants and the need to deliver quality and safety and whilst remaining within the financial envelope. In response the Director of Finance explained the changes in the financing regime going forward and conversations with the ICS and PLACE team would be about the particular needs for a service and arguing for a share of the money, but more importantly being able to demonstrate quality and safety going forward.

LM asked what more could be done to promote the organisation to potential candidates and how the Trust could be more assertive, JT added the importance of ensuring the organisations strategies were aligned.

JD referred to the Capital Investment in Scarborough describing how this was attractive to potential candidates and that it should be included in recruitment packs. The Chair agreed adding the importance of being professional about the way the Trust was promoted. LB referred to the cultural change work that was being done.

The Director of Workforce & OD reported on staffing issues over recent weeks highlighting that although the country was technically in a third wave, staffing was experiencing its most difficult time. She outlined that workforce absence was now higher than absence rates on 26/27 January during the peak of the second wave. She described the initiatives being put in place to mitigate the situation. She reported that the Newcastle model had been implemented on 16 July with a lot of work done with IPC and the Nursing Directorate to adapt and issue the guidance. Due to sporting event finals of the Euro football and Wimbledon, staffing over the weekend had been difficult with bank and agency staff not available.

It was noted that on 19 July Public Health England had published further guidance including the national test and trace team exemptions and individual risk assessments. It was noted that testing across the region had dropped off, daily monitoring of the absentee rate was being reported to the centre. She described the incentives brought in to the nurse bank, and due to the lack of uptake after implementing a10% uplift, it had been decided to increase this to 20% up to and including 15 August, there had been a bigger uptake which was being monitored closely. She added that they were trying not to ask an already exhausted staff to cancel leave or to do overtime as this could impact on staff wellbeing and have a negative long term effect.

SH reported that the Quality Assurance Committee had discussed staffing, he reiterated the need for a co-hearant recruitment strategy and be an employer of choice. LB felt assured that staffing issues were being managed and patients were being kept safe. HM referred back to the trolley waits in SGH ED and she would bring a paper to the next Quality Assurance Committee.

Action: HM to bring report on 12 hour trolley waits in SGH ED to Quality Committee

The Chief Operating Officer added that Silver and Gold Command had been stepped up to daily, SM added that the same pressures were being felt in every hospital and social care sector where there was a severe shortage of care. It was noted there were 42 patients in

Scarborough waiting for packages of care, adding that external pressures were compounding the situation, Primary Care was overwhelmed and there were issues with Vocare.

RESOLVED
That the Board noted and discussed the verbal update on staffing.

21/68 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. She highlighted that non-compliance would be declared to NHS Resolution this month.

The Chief Nurse reminded the board of the non-compliant areas as set out in the report adding that training was a challenge at Scarborough. It was further noted that one new Serious Incident had been reported jointly with Care Group 6, regarding a medication reaction on an outpatient ward at Scarborough.

Lorraine Boyd, NED, and Maternity Champion reported she had attended the first HCV LMS meeting on health and safety which provided an opportunity to bench mark against other Trusts. She added that the Trust had applied for an £80k grant to support non-compliance. In response to a question it was noted that the Trust was required to be compliant with the standards by the end of 2021, the grant would go some way to achieving this.

RESOLVED
That the Board received and discussed the report acknowledging the data required.

21/69 Implementing Continuity of Carer in Midwifery Services

The Chief Nurse introduced the report which provided the Board with a detailed plan to implement and ensure compliance with the continuity of carer national principles and standards by March 2023. The Board noted that an early aim was to improve the experience of high risk women to place them on a continuity of carer pathway by March 2022. It was noted that the role out would require funding, following the submission of a bid for £1.2m, the Trust received £500k.

RESOLVED
That the Board received and reviewed the Maternity Services plan.

21/70 Infection Prevention and Control (IPC) Annual Report 2020/21

The Board received and noted the IPC Annual Report for 2020/21, noting this pulled together information the Board received on a regular basis throughout the year. Highlights raised included that no patients with flu required critical care during the year, she added that a prevalence of flu was expected this year. It was further noted that C-Diff remained a challenge.

The Chair welcomed the comprehensive report and the amount of work the IPC team do.

RESOLVED
That the Board received and noted the IPC Annual Report 2020/21.

21/71 Care Quality Commission (CQC) Update

The Board received the report which provided an update and progress against the action plan for regulatory requirements and next steps. The Board were reminded that five of the seven conditions associated with registration had been removed. It was noted that the two remaining conditions, relating to mental health pathways, would be reviewed following consistent audit results being demonstrated over the next three months, notifications would be submitted in September 2021 to request removal of the remaining section 31 conditions of registration, the Trust expected to hear later in the year if it was successful. The Board noted that the deep dives being carried out across all Care Groups on the safe domain were almost complete, this would be followed by Well-led deep dives.

The Board welcomed the report and progress being made across the 'should do' and 'must do' action plans.

RESOLVED
That the Board noted the updated position for the Trust in relation to CQC action plans.

21/72 Resources Assurance Committee Escalation Report

LM introduced the report which set out a number of matters the Committee had discussed at its meeting on 22 June and 20 July 2021, and sought to escalate to the Board, in particular LM referred to the deep dive with IT and the Cyber report which the Committee had asked for further assurance.

RESOLVED
That the Committee received and noted the escalation reports.

21/73 Integrated Business Report

The Board received the IBR, in particular the following was highlighted:

- 1488 patients were waiting longer that 72 weeks
- 75% of P2 patients had been seen in 4 weeks, the Trust was on trajectory to achieve the target of 90% by the end of September
- Good progress was being made to reduce the 62 day cancer target backlog, in response to a question from the Chair, it was noted that the good progress being made could be jeopardised by current staffing issues particularly in August
- Overachieved the plan in outpatients for first and follow up appointments
- Underachieved the plan in ordinary electives, this was related to issues in theatres, staffing and bed capacity
- It was noted that generally the Trust was making good progress against the plans submitted in Q1, however performance in July, particularly ED standards slipped, noting other Trusts were also struggling. She added that there were concerns as during July there had been 41 12 hour trolley breaches, 40 of these were in Scarborough.
- HMcN updated on IPC noting that the Trust was significantly off trajectory for C-Difficile in Scarborough. The Board noted that the Trust was working with the regional teams at Public Health and NSSE/I for support and had requested an external review.

- AB reported on the M3 finance noting a £10.6m surplus. The Elective Recovery Fund (ERF) had confirmed payment of M1 plus 90% of M2, he added this gave assurance that the mechanism was working and that the value was linked to performance. AB added that it was important for the Board to be aware that although this was encouraging caution should remain as it was expected there would be a reduction in expenditure during the second half of the year. LM asked if there was an update on the efficiency programme, in response it was noted that there were conversations ongoing with a suggestion of 3% of spend, however this was not confirmed. AB reminded the Board of the plan agreed in the first half of the year for some savings which would be carried on to the second half, he described the work with the operational teams on the Building Better Care Programme.

RESOLVED
That the Board noted and discussed key elements of the Integrated Business Report.

21/74 Guardian of Safe Working Hours Q1 report

The Medical Director introduced the report which provided the Board with oversight into compliance with safe working hours and assurance that issues raised in exception reports were escalated appropriately. It was noted exception reporting was low which was good evidence of safety culture.

He reported on recruitment and retention and those doctors on fixed term contracts that had come to an end. The Director of Workforce explained that many of the posts were on Health Education England (HEE) training contracts, and described the work underway to understand the proportion of those posts that Health Education England routinely send trainees for and the risk to recruit substantively into the posts. Work with HR, Finance and operation teams was ongoing to present a proposal.

Junior doctor awards were highlighted and supported.

The Chair referred to paragraph 2.1.3 in relation to junior doctor placements in psychiatry. The Director of Workforce explained the arrangement between the Trust, HEE and GP practices, in particular line management responsibilities and the effect the arrangement had on the Trusts training figures. It was noted there were conversations with HEE regarding the Trust continuing to support the arrangement beyond the end of the contract in early 2022.

The Board noted the report.

RESOLVED
That the Board received and noted the report.

21/75 SIRO Annual Report

The Board received the report which provided assurance on the effectiveness of the Trust's information governance arrangements, noting that the Resources Committee had looked in detail at the report at its meeting the previous week. The Chief Digital Information Officer described the work and progress made since Rebecca Bradley, Head of Information Governance had joined the organisation in May around applying national frameworks and an accountability framework to measure compliance. It was further noted the plan would be tracked through the Resources Committee to close the gaps. He added

that by law the Trust should have an information asset register, work to comply with the requirement is ongoing to identify the information asset owners and provide training.

The Chair stressed that the Board supported the work being undertaken.

RESOLVED
That the Board noted the SIRO report and supported the work to deliver the information governance strategy.

21/76 Fire Safety Policy

The Chief Nurse reported that this was a mandated policy through the NHS Fire Code that should be reviewed every three years. It was noted it had gone through the Trust's governance processes to approve the changes and was presented to Board for formal ratification. The Board noted there were no material changes to the policy.

RESOLVED
That the Board ratified the policy noting the changes to the Fire Safety Policy.

21/77 Risk Management Strategy

The Board welcomed Bobby Anwar, Head of Risk, to the meeting who presented the new Risk Management Strategy which set out the trust's vision and approach to risk management over the next three years. In response to a question on implementation it was noted that the 2021 plan to deliver risk across the Trust, developed earlier in the year, was part of the implementation. He added that the plan was on track and well underway. In terms of 2022, this would be discussed with the Associate Director of Governance when he joined the Trust in September.

The Director of Finance complemented BA on the work he had achieved; this was echoed by the Chief Digital Information Officer. It was noted that the Board would have a session on risk appetite in August.

The Chair thanked BA for the work he had achieved and particularly the Risk Management Strategy.

RESOLVED
That the Board approved the Risk Management Strategy.

21/78 Reflections of the Meeting

The Board reflected on the meeting:

- LM felt the patient story was powerful and set the meeting. She asked for assurance that the right training was in place for dealing with death. In response the Chief Nurse explained that feedback received on end of life reflected that staff mainly got the conversation right and communication was not a theme coming from PALs and Complaints. She added that there was a suite of end of life training available to staff. In relation to side rooms, there were enough but this sometimes meant displacing other patients. JT felt a language the public understood should be used as often terminology was confusing. HMcN added that dying at home is often traumatic for loved ones and more could be done to prepare family and carers.

SM asked if there were any lessons for PALs as they tried to encouraged Martin to complain which he didn't want too. The Chair added that she would write to Martin and thank him for sharing his story.

21/79 Any Other Business

The Chair reminded the board of that at the last meeting there had been discussion on violence and aggression towards staff. The Board had requested an update. The Director of Workforce reported that she had added this to the IBR and provided detailed information on the number of Datix reported over the past three years noting there had been a fall in reported incidents in 2020/21 compared to the previous year. She explained the processes being implemented and that the security team were doing a gap analysis which would be reported through the Health and Safety Committee. The Chief Nurse added that staff felt that Datix was not enabling and work to improve the system would help. There was work ongoing with the LLP Security Team to enable staff to access violence and agression training.

AB reported that whilst on a walk round at AMU I York with LM they had discussed this with staff, one thing heard was their acceptance of the aggressive incident with the patient, and particularly relating to patients struggling with alcohol and substance abuse and that the incorrect acceptance that often the patients' medical condition contributed to the violent incident is accepted. LM added that this had been discussed at the Resources Committee and a lot is cultural issues. The Chair felt that the Board should keep this on its agenda for time to come.

21/80 Time and Date of next meeting

The next meeting will be held on 29 September 2021, at the Community Stadium, York

Board of Directors – Public

Action Log

September 2021

Agenda Item:	Action	By whom	By when	Progress / Comments
21/50 Integrated Business Report	Winter plan to be submitted to Board	Chief Operating Officer	September 2021	Included in Board forward planner CLOSE – on agenda
21/42 Board Assurance Framework	In preparation for a CQC visit the briefing documents to be updated.	Chief Nurse	TBC	

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Chief Executive's Overview

/ Trust Strategic Goals

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

/ Recommendation

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

/ Purpose of the Report

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

/ Executive Summary – Key Points

The report provides updates on the following key areas:

- Covid-19 update and current operational pressures
- Funding announcements for health and social care
- Health in Coastal Communities report
- Healthy Bridlington
- Humber, Coast and Vale ICS appointments

/ Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: 30 September 2021

1. Covid-19 update and current operational pressures

Following a period of low numbers of admissions of patients with COvid-19, the number of Covid-19 positive patients began to increase again at the end of June. At the time of writing we have 54 patients in our hospitals, with two Covid-19 wards in York and one in Scarborough, which has been the case for a number of weeks. Our Covid-19 surge plan remains in place and we can create additional capacity if needed.

Although current Covid-19 admissions are significantly lower than the last peak in January, our hospital services remain under significant pressure, as do those across all areas of health and social care.

This is being influenced by several factors. Firstly, our emergency departments are extremely busy. The lockdown restrictions in 2020 resulted in a significant reduction in A&E demand, however both emergency departments have seen activity returning to pre-pandemic levels.

Workforce pressures are also having an impact, and this is our most pressing challenge. Although there was a steep drop in Covid-19 related absences during May and June, this increased significantly again from the start of July. Staff absence has been impacted by test and trace/covid-19 isolation requirements and August/school holiday annual leave. Many staff are fatigued due to the prolonged period of time they have spent working under COVID-19 restrictions, and there is lower pick-up of bank and agency shifts. Our pre-pandemic recruitment challenges also remain, which inevitably affects our resilience.

Finally, we are working hard to tackle the backlog of patients needing planned treatment whilst continuing to treat urgent and acute patients and those with Covid-19. However, our ability to carry out pre-pandemic levels of non-covid activity is restricted by the ongoing need for covid-related infection prevention measures such as social distancing.

Given the current pressures, and with winter not far away, we are exploring all possible options for improving staffing and creating additional capacity whilst finalising our resilience plans for the coming winter months. We are also responding to staff suggestions for how we can support staff while they are at work.

2. Funding announcements for Health and Social Care

Earlier this month the government made a series of announcements on NHS funding for the second half of 2021/22 (H2) and the next three financial years.

The NHS will receive an extra £5.4bn over the next six months to support its ongoing response to the COVID-19 pandemic. This can be broken down into:

- £2.8bn for COVID-19 costs
- £600m for day-to-day costs
- £478m for enhanced hospital discharge
- £1.5bn for elective recovery, including £500m capital funding.

At the time of writing we are still to receive the planning guidance however the Finance Director and I expect to be able to provide an update in the Board meeting as to how this funding is being allocated at a local level.
A new Health and Social Care Levy was also announced, to be spent exclusively on health and social care. To fund this, UK National Insurance payments will be increased by 1.25% from April 2022 for both employers and employees. Then, from April 2023, National Insurance will return to its current rate, and the extra tax will be collected as a new Health

and Social Care Levy. This is expected to raise around £36bn over three years, which initially will mostly be used to tackle NHS backlogs, but from October 2023 it will pay for new caps on individual contributions to social care.

3. Health in Coastal Communities report

Since I wrote my last report the Chief Medcal Officer Professor Chris Whitty's annual report has been published. The report, titled Health in Coastal Communities, is of course of interest to us and provides an analysis of the common problems facing coastal communities with regard to health and wellbeing, from demographic and economic issues to the difficulties in recruiting health and care staff. As the Board is well aware, this is an issue that we have been highlighting for a number of years and I was pleased to see the very challenges we have been talking about described in the report. By making this the subject of his annual report, and in calling for a national strategy to tackle these longstanding problems, Professor Whitty is pushing this up the agenda which, if action is taken, will be beneficial for our local population.
The report makes several detailed recommendations and calls for a national strategy to support the work being done at a local level in each of these communities. It is well timed alongside the formation of the ICS, who will have ill health prevention and addressing health inequalities as a key priority, and I anticipate that this will become central to the work that will be done at Place level in the coastal areas of our ICS.

The full report and summary document are available by searching on www.gov.uk

4. Healthy Bridlington

As covered in my previous report, and a timely follow up to the previous item, public service organisations across East Riding of Yorkshire, the East Riding Place Partnership, are working together to create opportunities for change to improve the health and wellbeing of people living in and around Bridlington. Plans have been drawn up that focus on six specific areas:

- Education, schools and workforce
- Transport
- Digital opportunities
- Diagnostics
- Communities
- Estates and assets

These plans were shared and views were sought from a wide range of local stakeholders with a critical role to play in how we shape and improve Bridlington.
A survey ran from 27 May to 18 July and some really good insight was received.

In terms of the Ambition, 39.5% agreed it was excellent, 20.5% about right, 15.5% partly right, 24.5% not right. Some comments left about the ambition included that it sounds good but might be challenging to achieve and that the plans would benefit from further explanation.

Of the six plans, there was most support for diagnostics (59%), followed by transport (58%), then community resilience and prevention (57%). Of the remaining comments 44% related specifically to Bridlington Hospital, predominantly wanting to retain the current services, protect the services at the hospital or requesting more services be provided from the hospital.

There were a number of comments made around travel and transport to and from other hospitals. Respondents who accept the need to travel for more specialised treatment worry about the time, inconvenience and costs incurred when travelling to other hospitals such as Scarborough, York or Hull for treatment or to access A&E. A number of other health services were mentioned that people would like to see improved in Bridlington including dentistry, mental health and falls.

There were some comments relating to improving public transport as well as developing cycling and walking infrastructure. There were other comments relating to issues in Bridlington such as addiction, environmental issues and homelessness. There is worry that these issues have a detrimental effect on the town which will deter tourists and ultimately the economy and wellbeing within Bridlington. People want to see Bridlington thriving. Comments suggest that if the right investment was in place, Bridlington would have a stronger economy, more job opportunities and be a better place to live.

A summary of the feedback from these early conversations is being produced which will be made publicly available and used to inform the next steps.

5. Humber, Coast and Vale ICS appointments

Interviews took place at the start of September to appoint a Chair for the ICS. At the time of writing we await an official announcement as to the outcome of the process. Once the Chair is in place a Chief Executive will be recruited, which is expected to result in an appointment towards the end of the year.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 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 progress on the BAF.

Executive Summary – Key Points

During quarter 1 a great deal of work has been done with Executive Leads to not only populate the BAF but to understand the principal risks to delivering the Trusts strategy and focus on ensuring the controls and assurances identified are correct and effective. Monthly meetings continue to be held with Executives, during the last review round the focus was on populating the risk ratings with a gross and net score. As discussions with the Executive continue the template will evolve to ensure it meets the needs and purposes of the Board and will include risk appetite and how this is reported.

In August the Head of Risk ran a workshop session with the Board looking at risk appetite, the follow up work to this will inform the work on drafting and agreeing a risk appetite based on four categories of quality, people, finance and IT. As previously reported the risk target scores will be populated following the completion of this work together with actions to bring those risks outside of appetite back within agreed appetite levels or to manage risks.

Next Steps

The BAF has been reported to the Board's sub-committees in September. The Audit Committee received the report and noted that work to agree the risk appetite statements had begun and would be reported to the Board in November for formal Board approval.

The Board will be asked to agree:

1. the quantitative – to agree the risk appetite thresholds for each risk category This is the range of values for the green (appetite) and amber (tolerance) bands.

2. the qualitative – a risk appetite statement for each risk category. This will describe our level of appetite e.g. cautious, minimal etc.

Recommendation

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

Author: Jill Hall, Interim Trust Secretary

Director Sponsor: Simon Morritt, Chief Executive

Date: 30 September 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, Constitutional targets 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 cash flow 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	**Gross**	**Net**	**Target**	**Initial date of assessment:**	**Lead Committee: Quality**	
Impact	4	4		**Last reviewed:**		
Likelihood	4	3		**Target date: Month / Year**	**Risk Owner:**	**Heather McNair/Jim Taylor/Wendy Scott**
Overall risk rating	16	12			**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	4	4		**Last reviewed:**		
Likelihood	5	4		**Target date: Month / Year**	**Risk Owner:**	**Dylan Roberts**
Overall risk rating	20	16			**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
IT Service management standards / processes	Low maturity due to lack of training			

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

Action description	Progress to date / Status	Lead action owner	Due Date
Implement IT Service Management industry standards (i.e. ITIL v4)			
Secure funding for plan A of ESP			

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	4	3		**Last reviewed:**		
Likelihood	4	3		**Target date: Month / Year**	**Risk Owner:**	**Wendy Scott**
Overall risk rating	16	9			**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		3		**Last reviewed:**		
Likelihood		4		**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin / Jim Taylor**
Overall risk rating		12			**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		2		**Last reviewed:**		
Likelihood		3		**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin**
Overall risk rating		6			**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		2		**Last reviewed:**		
Likelihood		2		**Target date: Month / Year**	**Risk Owner:**	**Polly McMeekin**
Overall risk rating		4			**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**

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Quality Assurance Committee Minutes - 20 July 2021

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

Attendees: Mike Taylor (MT)

Apologies for Absence: Marco Baroni (MB)

Declaration of Interests

There were no declarations of interest.

Minutes of the meeting held on 22 June 2021

P7 – Duty of Candour section was updated to 'JM asked if the reason for delay was known'.

P5 – the wording for the action 88 update was updated to '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 than this, the minutes of the last meeting held on 22 June 2021 were agreed as a true and accurate record.

Matters arising from the minutes

Action 99 – the Committee agreed to close this action and revisit in September when Mike Taylor joins the Trust.

Escalated Items

WS shared slides (disseminated to all Committee members) re the challenges around demand being faced in both ED departments, particularly on the East Coast (mainly due to staycations and easing of lockdown), for escalation as appropriate.

The Committee noted that this is a local, national and regional issue. Unprecedented demand and significant workforce pressures are impacting our elective programme and our ability to manage urgent care demand. WS said we need to provide assurance that we are keeping our patients safe and our priority is to ensure we can demonstrate and

triangulate evidence that we are doing this. The Committee noted that the CQC will also want assurance on this and may make reactive visits to both sites.

There was a group discussion about medical staffing as a main concern, especially on the SGH site. The Committee agreed that an effective clinical strategy is dependent on the right strategic focus for the SGH site and discussed the potential obstacles, including the quality of its workforce. Whilst the YH site also has gaps, staff feedback about the medical workforce is better compared to SGH.

The Committee discussed site integration and noted the success of this in surgery (5 new surgeons were quickly recruited onto an integrated YH/SGH rota), albeit with significant cost. JT confirmed that York-based physician Dr Gerry Robins (GR) has been appointed as Care Group Director for Care Group 2 to assess the SGH site and push the integration agenda. The Committee raised concern about timescales as medical staffing has been a consistent issue and agreed to escalate this to the Board as a question of how to spread risk across our two main operational sites. JT said there are opportunities to improve the service at SGH with the current workforce and that we are looking at bringing GR into position sooner than the current date of 1st September 2021.

HM said that bays are being shut due to Covid, norovirus and C. Diff outbreaks on SGH site and WS added that a programme of decanting is required to support cleaning but that this is extremely difficult due to the pressures on urgent care. WS said there is an issue with implementing and driving SAFER from a medical perspective and that there is little traction around ownership of this. Ideally SGH would recruit 3 ED consultants and the Committee discussed whether we could recruit to YH on an integrated rota basis as consultants seem to be reluctant to be permanently based on SGH site.

The Committee also noted the risk to the elective programme on YH site due to staff isolating due to track and trace (colloquially known as the ‘ping-demic’). The Committee agreed that an understanding of oversight and assurance around clinical strategy at Board level would be useful, as would oversight of current workforce pressures.

WS gave assurance on the work being done by HM, JT and CJ around triangulating patient safety and evidence of this, as well as any issues, risks and assurance around understanding risk and reporting risk mitigation. JM asked if the Executive Directors need any more support and WS confirmed there are conversations being held within the system and ICS around public communication to discourage unnecessary visits to ED. Primary care are also seeing unprecedented demand and have suggested they have no further capacity. There is a feeling that the pressure on ED is due to primary care changes to appointment systems but this is being investigated by the ICS.

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

JT said there has been a modest improvement in post-take reviews. There is a record of improvement work in insulin prescribing on YH site. There has been a single point downward variation on Duty of Candour so this is being monitored.

The Committee noted that we have met overall ERF targets for elective care and restoration of services.

LS gave an update on cancer and noted improved performance from April but that June has been a challenging month. Approximately 40% of breaches were due to patients delaying treatment but the remaining 60% was due to Trust capacity, primarily diagnostics within the patient pathway. Lung and Upper GI have been flagged as key areas of concern by the Cancer Delivery Group re correlation between waits and potential patient harm. The Committee noted the ongoing work in cancer. Each tumour site has been asked to run a full pathway analyser, which assesses every point of a patient journey per tumour site. Once the data is received, the tumour site will refresh recovery plans accordingly.

The Committee noted the area most under pressure as inpatient elective care. LS confirmed orthopaedic surgery was reinstated on the YH site from the beginning of July but said that it is at risk of being paused again if there is a significant surge in Covid cases.

Patient Safety

Medical Director's Report

JT gave an overview of the report and highlighted the following points:

The #NOF pathway is being reviewed as there is scope for improving safety and effectiveness.

The Committee was asked to note the work on Patient Safety Specialists and compliance with national guidance.

The Committee was asked to note the work around radiology safety incidents and SIs declared, which JT confirmed were spread across the department and agreed to report back on once investigations are complete. The Committee was assured of the robustness of the radiology governance process. LB asked for assurance that high volumes of low level issues are being reported. CJ gave assurance that radiology are sharing their learning and are also monitoring low level issues through the REALM process, which can then be analysed through Datix.

The Committee clarified that SIs should be discussed both at Quality Assurance Committee and Board of Directors, and JT gave an overview of the completed SI investigations (Appendix B).

SI 2021/6371 – JT said diagnostic error was a better title for this and noted a failure to consider a differential diagnosis in time. CJ confirmed evidence of reflection upon investigation and said the clinician retrospectively added a D-Dimer test. JT added that the patient was admitted in a timely manner and was only on the ward for an hour before they arrested.

SI 2021/7201 – the Committee noted a more holistic approach would have been helpful as well as the lack of a proper senior input re escalation. CJ gave assurance that the QI team are looking at more robust actions for sepsis and deteriorating patients. LB queried why a

holistic approach was not considered and CJ said it was due to a combination of staffing, resource and process issues.

SI 2021/5796 – CJ confirmed this was an agency nurse and that the care group has fed back to the agency, and that our use of agency nurses is being considered. Care groups have been asked to share their processes for how they share learning downward to frontline staff.

SI 2021/5198 – this was a complex patient for whom all possibilities were not considered and was a case of failure to escalate.

There was a group discussion about the value of discussing SIs in isolation compared to quarterly reviews to identify themes and trends. It was agreed that the report needs to focus more on trends in order to provide both the Committee and Board of Directors with assurance but that SIs should still be discussed at the Committee.

Action: JT to check that patients declined #NOF surgery on grounds of medically unfit for surgery are assessed appropriately

Action: JT to lead discussion on the most appropriate way to summarise SIs and identify themes and trends for future reports

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.

Infection Prevention and Control Annual Report (DIPC)

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

Infection Prevention and Control Monthly Report (June 2021)

HM highlighted the following key points:

C. Diff remains an issue at SGH but we are working with operations to deliver actions. We have also asked the national team to come and check if there are any further interventions that may help.

There have been some early outbreaks of D&V, which are being managed.

There have been 5 cases of VRE, all on the ICU and Ward 16 on YH site.

Water safety at the Community Stadium remains an unresolved issue – it is being safely managed in terms of testing and flushing but at an ongoing cost.

HM gave assurance that the failure of the HPV machine on YH site is down to a communication breakdown, which has now been resolved.

To note, the deputy DIPC Paul Rafferty (Deputy Chief Nurse, SGH) is leaving the Trust at the end of September and this is a risk until he is replaced.

Staff survey results – redeployment as a result of Covid

HM said this was a useful exercise and felt cathartic for staff. The main challenge is clinical supervision, which staff are requesting. The Committee noted the improvement plan on P110 and that Emma George (Associate Chief Nurse) is leading on delivery.

There was a discussion about senior staff visibility and that whilst sometimes difficult, it is important. HM said this has been discussed at Executive Committee and that patient safety walkarounds are helping senior visibility but added that non-clinical visits to clinical areas are not always well received. However small changes such as changing a route into work via clinical areas could be helpful.

Ockenden Update (Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report)

LB highlighted the following key points:

The Committee is well cited on CNST non-compliance and the action plans is to be signed off by the Chief Executive this week.

Staffing issues continue to be a significant concern and have been worsened by the track and trace proximity app. HM said that this week the home birth service was suspended, two wards were amalgamated, community midwives were brought in to ensure the labour ward was safe and we have had to transfer women between YH and SGH, which is very unusual. Despite this, no adverse outcomes have come to light but it will be a challenge to meet Ockenden recommendations at the moment.

Medical workforce training compliance requires improvement.

LB asked the Committee to note the significant amount of scrutiny that maternity is under at the present time from all quarters and the impact this is having on staff.

HM confirmed that we can bid for a small amount of capital back from CNST and we have made two. The CNST report format is being reviewed for next month. We now know how much revenue we are receiving from the Ockenden bid and there will be a staffing shortfall of approx. £1m. Andrew Bertram is in talks with the ICS re our increased run rate and HM asked the Committee to note that this is an ongoing revenue requirement.

Maternity Incentive Scheme – Board Declaration Form (for approval)

The Committee approved this declaration form for sign-off by the Chief Executive.

HM asked the Committee to note that staff training compliance in SGH obstetrics is a particular issue. This is being investigated by JT and senior care group leads as there are behavioural concerns around individual consultants, which is an ongoing issue and was initially raised as a concern by HEE. There is work ongoing to try and resolve this.

Learning from Deaths Report

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

We are currently tracking 3 mortality indices; Trust crude mortality, internal SHMI based on HES and NHS digital SHMI, which allows us to be proactive if a particular issue arises.

The funnel graphs give us insight into when we have outlier status for individual coding sub-groups, which leads to further investigation. We have found that our CuSum trigger point is over-sensitive so there is work needed to triangulate with other information streams such as SI's as we still have to respond to national triggers. The Committee saw this as a reflection of increasing maturity within the Trust.

The Committee noted typos on P167 – there are 6 top themes rather than 5 and there is no correlation between the mortality action plan and the themes action plan point 6.

The Committee was assured that Donald Richardson is pursuing the organisational aim of trying to learn from deaths, as well as the robustness of the Learning from Deaths Group. The report is a first iteration and the Committee said that a stronger emphasis on actions and review of actions would be helpful. JT agreed to try and get more feedback on the outcomes of actions and include this in the report, as well as highlighting learning and rationale behind it.

Action: JT to look at including more feedback on outcome and actions to include in Learning from Deaths report as well as highlighting learning and rationale behind actions

Fire Safety Policy

The Committee received and approved the report and noted that it has been through Health & Safety Committee, reviewed by Trust Health & Safety and ratified by Health & Safety and Non-Clinical Risk Group. No further discussion was required.

Effectiveness

Care Quality Commission Report

Quality & Regulations Group are still meeting monthly and have good care group engagement. A current risk is the PEM consultant recruitment issue, which could potentially lead to a Section 31 condition notice. JT confirmed there is a plan in place to tackle this and Gary Kitching (Emergency Medicine Consultant) is escalating this with JT's involvement.

The CQC provides all organisations with bi-monthly insight reports that include a range of indicators but the data used can sometimes be out of date, which we are working on. One of our indicators is around whistleblowing, which has been logged by the CQC as a potential concern as it suggests we do not have the ability for staff to speak up within the organisation. This has been investigated and the CQC are content with our responses, but further work is still being done.

Work on deep dives is continuing with a current focus on safe domain. The care groups are using specialty frameworks to identify strengths and areas for improvement.

Performance and Risk

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

The Committee discussed urgent care, the pressure on our inpatient elective work, cancer and recovery under Escalated Items.

The Committee received the report and acknowledged their formal thanks to the elective recovery teams for their hard work, particularly outpatients and day cases where 19/20 activity levels have been exceeded.

Quality Committee Effectiveness Annual Report

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

Integrated Business Report

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

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)
- Fire Safety Policy (for approval)

- Deteriorating performance indicators at SGH ED and concerns around staffing levels, especially at SGH (for discussion)

Any other business

JM raised concerns over seeing the same maternity reports each month and said it is a potential risk. The Committee agreed but as the reports are mandated they have to be seen on a regular basis. However HM said the format can be changed to be more user-friendly.

The Committee welcomed Mike Taylor, Associate Director of Corporate Governance, who will join the Trust on 06 September. As part of his induction, he has been observing various Committee meetings to understand governance.

Time and Date of next meeting

The next meeting will be held on 17 August 2021 at 1pm via WebEx.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Nurse Staffing 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

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

This report covers the requirement to submit the safer staffing metrics using Care Hours Per Patient Day (CHPPD). The August 2021 data is presented in Appendix 1 of the report. The Quality Committee should note that the collation and validation of the data remains a challenge in August due to a number of wards changing function, a reduction in bed occupancy and staff deployed per shift, compared to the actual staffing levels for these wards. An example of this is Ward 39; this was previously an elderly care ward but recently opened as the elective orthopaedic ward for joint replacement and therefore had reduced bed occupancy and staffing model.

The average day fill rate for Registered Nurses was 82% and Non – Registered 93%, the average night fill rate for Registered Nurses was 92% and Non – Registered 102%.

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

- International recruitment
- Healthcare support worker recruitment
- tNA and RNDA provision
- Development of a recruitment and retention improvement plan

A high level summary of registered nurse staff vacancy levels is provided for assurance, alongside recruitment activities. Additionally, information is provided to indicate the projected staffing levels and the impact of both recruitment activities and the investment achieved through Establishment Review paper which will be effective from October 2021.

Executive Summary – Key Points

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

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

- Trainee Nursing Associate Apprenticeship (tNA)
- International Registered Nurse Recruitment
- Registered Nurse Degree Apprenticeships
- HCSW recruitment to achieve 0% vacancy and a sustainability and retention plan

Planning is in place to:

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

Colleagues in Human Resources and Finance are briefed and a schedule of work will be established to deliver both the realignment of budgets and health rosters and the associated required recruitment activity.

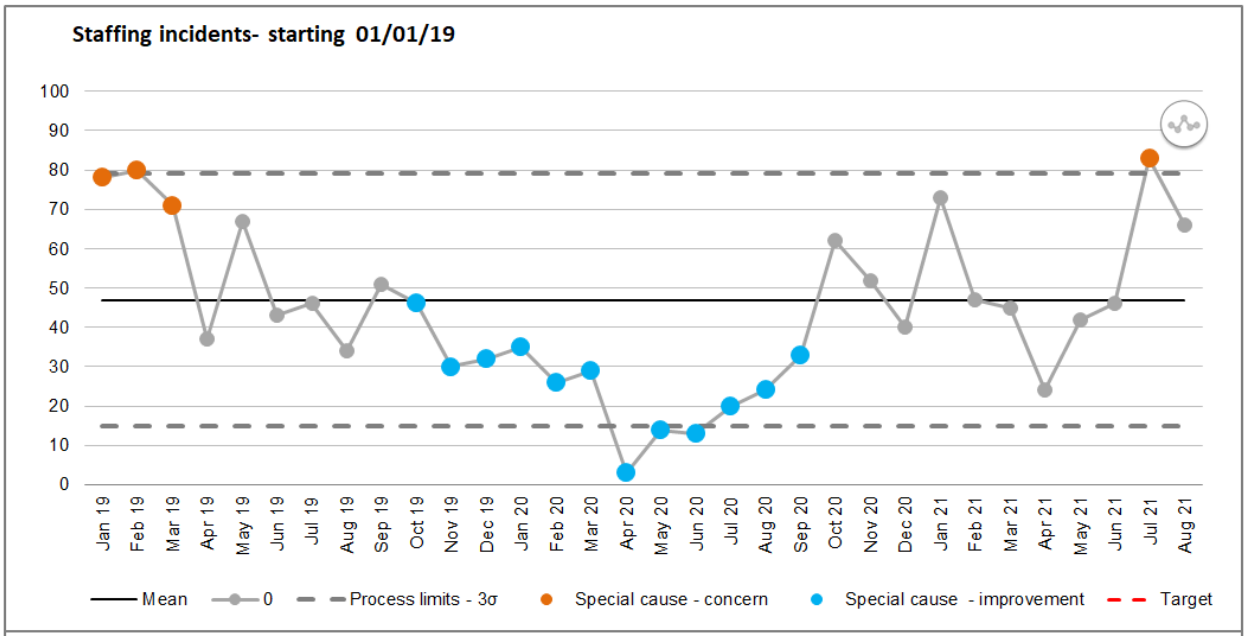
In terms of strategic planning the next step will be to review and develop a proposal to support the second year investment aligned to the establishment review to ensure all the identified requirement is met in year 2 or minimally by year 3. However, it will be prudent to also plan to revisit the establishment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

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

The Quality Committee should be assured that whilst the wards / units undertook delivery of elective work, continued to respond to Covid-19 infection fluctuations and responded to an increase in acute care with demand across the Emergency Departments exceeding demand every month compared to 2019 – 20, nurse staffing levels have been flexed and reviewed daily. Additionally the impact of maximum annual leave in August (17.9%), an increase in sickness in comparison to the last year 2 years (July 2020 4.20% , July 2021 5.18%) and the impact of test and trace August has been a challenging month in regard to deployment of staff. The Matron of the Day for both acute sites oversees delivery with escalation to Associate Chief Nurses and Chief Nurse Team as required. The delivery of safe nurse staffing remains dynamic and challenging.

The table below displays the incidents recorded that state 'staffing shortages' as an indication and there is clear spike from June 2021 which indicates a concern. The impact on patient care and safety will be reviewed to assess whether there has been an increase in harm and complaints. There is a clear correlation between the increase in falls in August and this is aligned to the lack of enhanced supervision availability and RCAs are suggested increasingly that nurse staffing levels have impacted the patient fall.

Pressure ulcers have also increased in August across the older adults' wards indicating that due to staffing pressures intentional rounding of patients has not been undertaken accordingly.



We will continue to monitor the incidents and report any correlation between quality of care and nurse staffing levels and ensure targeted support is given to the areas where there is a higher incident rate reviewing other quality data available over a period of time.

Recommendation

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

Author: Emma George, Associate Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: August 2021

1. Introduction and Background

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

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

During August, the Trust continues to be as agile as possible in response to the requirements for a program of work commenced to restore / re-provide services, a continued demand for COVID 19 beds, provision of elective care recovery programme and a sustained monthly increase in Emergency Care attendances.

2. Detail of Report and Assurance

2.1 Management of Nurse Staffing Levels in August 2021

Nursing teams, led by the Matrons, continue to adapt and respond to the requirements of patients and services. COVID-19 continues to impact the operational organisation of wards and units throughout August 2021 with the requirement to open a second ward in July on the York Site and maintaining Aspen Ward in Scarborough. Ward changes in capacity and function have continued.

As noted in the June report, the associated impact of Covid-19 should not be underestimated and the Chief Nurse Team has continued to meet with and support teams who have been affected by the ongoing pressures associated with work, changing wards , teams and working in challenging circumstances. The impact of staff well-being and a feeling of exhaustion cannot be under estimated during this time, where there may have been a willingness to work additional hours, there is a sense that staff feel they are unable to do this. The Chief Nurse team have been working with ODIL to offer support and develop a robust plan to address the areas of concern collaboratively. Ongoing incentives are being considered and the Director of HR is working with a senior team of clinicians and operational teams to consider what is effective to offer further support.

The requirement to continually flex and increase the bed base for the senior nurses presents a daily challenge and the work of the Matrons and Associate Chief Nurses should continue to be noted.

2.2 Nurse Staffing levels, Associated Risk and Establishment Reviews

The Trust has submitted the planned versus actual (CHPPD) return to NHSE/I on time in August 2021 (Appendix 1). The Quality Committee should note that the data collection and submission remained complex due to the wards changing function and bed base within the month, sometimes on more than one occasion. The data has been reviewed and there are no specific risks to report associated with CHPPD.

In respect of the fill rates in August 2021, whilst a number of the wards fell slightly below 80% on the York site the risk level was managed by using Safecare, assessing acuity and dependency and deploying staff when required. The data indicates that these wards

worked by a reduction of one registered nurse and can be aligned to the changing bed base on some wards. The fill rates on the Scarborough site indicate that Anne Wright ward had a low percentage but this is due to the ward opening and closing throughout July and August. Care Group 2 continues to work through their budgets and staffing models and realign in accordance with their permanently amended bed base, this work needs to be progressed to ensure accurate data submission.

The Chief Nurse team has gained approval for £2.6M investment as a result of the establishment review paper with ½ year effect (£1.3M) in 2021/22. A program of work to ensure the plans are fully enacted from 1 October 2021 has taken place to ensure the budgets and rosters are aligned accordingly and to ensure the associated required recruitment is underway. The impact of this welcome investment will require additional registered nurses and HCAs, this is being finalised with the finance teams due to a few changes in wards allocated the funds due to previous investment on the elderly and medical wards in Scarborough. A further review has been undertaken with the Chief Nurse, Assistant Chief Nurse and Deputy Chief Nurse to re allocate funding for first phase to also include wards in Care Group 1 and 3.

The associated risks, specifically temporarily increasing the registered nurse and HCA vacancy rates will be reflected in revised risk registers and has been communicated externally to the Chief Nurse of the CCG. Progress against recruitment requirements will be monitored.

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

Table 2 – Nurse Vacancy Levels Trust wide and per site August 2021

Trust wide

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Trust wide	2,214.38	121.69	1,077.78	2,017.89	134.48	999.07	23.11	1.00	19.32	96.20		31.36	123.40	-11.79	66.67	5.57%	-9.69%	6.19%

York

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
York	1,561.31	89.90	694.93	1,454.22	86.51	671.95	20		16.6	66.6		16.6	60.49	3.39	22.98	3.87%	3.77%	3.31%

Scarborough and Bridlington

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Scarborough & Bridlington	653.07	31.79	382.85	563.67	47.97	327.12	3.11	1	2.72	29.6		14.76	62.91	-15.18	43.69	9.63%	-47.75%	11.41%

Table 2 details the August 2021 vacancy position for the Trust and for York and Scarborough / Bridlington sites. The Trust registered nurse vacancy position is stable at 5.57%, which is a slight increase on July 2021 which was 5.11%. Turnover for both RN and HCA remains below 8%.

Table 3 – Nurse Vacancy Levels Trust wide and per site – projections with establishment review investment and projected newly qualified recruitment

Trust wide

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Trust wide	2,214.38	121.69	1,077.78	2,017.89	134.48	999.07	23.11	1.00	19.32	96.20		31.36	123.40	-11.79	66.67	5.57%	-9.69%	6.19%

Table 3 provides a projected forecast for nurse staffing levels in August 2021, capturing the planned international recruitment activity and the newly qualified nurse recruitment activity and the ongoing HCSW recruitment activity.

Confirmed leavers is a projected estimate based on current leaver rates. A significant regional work stream has been established to examine retention of HCSWs and the new lead for workforce has been linked into this work.

2.3 Development work

NHSE / I North East and Yorkshire Regional continue with the work to deliver the expansion program for nurses, midwives and allied health professions. This is in response to the Governments pledge to increase the number of nurses by 50 thousand by 2024.

The Trust are undertaking a review of recruitment and retention work programs aligned to most of the activity and are engaging with the regional work to ensure the Trust is best placed to benefit from any regional program or support.

International Recruitment

The Trust continues to provide its well-established international nurse recruitment program. The Trust continues to welcome Internationally Recruited nurses with a further 90 expected in the next calendar year.

The Trust has recently experienced a decline in international nurses passing their OSCE examinations and a piece of work has commenced which will ensure the current arrivals and pipeline achieves their examinations. The pace and the impact of on line learning and quarantine is possibly impacting the Trusts ability to achieve a high first time pass rate. This is impacting the international nurses' experience and is inefficient; plans are in place to rectify the position as soon as possible.

Health Care Support Worker Recruitment

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

The Recruitment Team and nursing teams continue to strive to achieve this target but currently sit with a 68 WTE vacancy. It is projected we require 200 HCAs in the next year and need to consider new ways to attract HCAs who have an increased choice in work availability as the leisure and retail industry has opened and this work has commenced. It is now vitally important that the Trust embraces the output of this work as the attrition rate has increased recently. All new recruits are enrolled on a comprehensive induction

package which incorporates the Care Certificate. The induction is under review to ensure it matches the needs of the HCA in a more practical manner following on from a Healthcare Support Worker survey run by NHSE/I in June. In addition, the Work Based Learning team is working to facilitate individual's access to further education and highlighting apprenticeship routes to develop careers in healthcare and how we advertise this when recruiting to attract HCAs into a career in healthcare. The Trust has also been allocated funding to appoint a Band 4 Pastoral Role for HCAs and job descriptions are being reviewed to be able to recruit to this post soon.

Undergraduate Education and work with schools and colleges

There are three key developments to report.

The Trust has commissioned places with University of York and Coventry University at Scarborough for the Trainee Nursing Associate Program and has a plan for 40 places to commence between January and March 2022.

A new t-Level qualification will be introduced from September 2021 and a high number of local colleges are embracing the new format for young people to undertake a technical level qualification with associated work based experience. Currently the understanding is that there will be a qualification in health / social care and this will be supported by 45 days experiential learning on placements. The team will work closely with schools and colleges to examine the opportunity this will bring to help young people explore careers in health and social care.

The Trust has supported Scarborough UTC for the last year in their development of a Health Pathway for 16-17 years olds. A small multi-professional non-medical team is attending the college for a visit in June to link Scarborough Hospital with the team and examine how we can support their exposure to the hospital environment and support them on their career and leadership sessions.

3. Detailed Recommendation

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

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021 (July 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 (Dec 2020) and the supporting 'Implementing a revised perinatal quality surveillance model' document has led to immediate changes in the reporting and escalation of Maternity Safety information to Trust Board. This report will provide monthly oversight of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to Maternity safety across York & Scarborough Teaching Hospitals NHSFT.

Executive Summary – Key Points

Data reporting for July 2021:

- 2 PMRT notified and 2 completed
- 1HSIB cases 0 HSIB reviews received
- 0 SI report received 0 SI declared
- 4 Incidents logged as 'moderate harm' or above
- Training detail for midwives and medical staff
- Staffing levels information
- 0 HSIB/NHSR/CQC concerns or requests made directly to the Trust
- 0 Coroner Regulation 28 made directly to the Trust in relation to Maternity Services
- CNST non-compliance detail
- Ockenden evidence submitted – awaiting RAG response from national team
- 43.6% of women booked onto a Continuity of Carer pathway

Recommendation

The Trust Board are asked to review the detail of this report monthly and have oversight of any recommendations made.

Author: Care Group 5 Quality and Governance Team

Director Sponsor: Heather McNair, Chief Nurse

Date: September 2021

1. Detail of Report and Assurance

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

1.1 York & Scarborough Teaching Hospitals NHSFT data measures table

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

	2021											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Number of PMRT notified Number of PMRT completed				1 3	1 2	1 2	2 2					
Cases referred to HSIB Finalised HSIB reports				1 0	0 0	0 0	1 0					
Number of incidents logged as 'moderate harm' or above				1	0	0	4					
Training compliance of all staff groups in maternity related to the core competency framework and stat/mand training				See below	See below	See below	See below					
Minimum safe staffing Midwifery Obstetricians Unit closures:				See below 0	See below 2	See below 0	See below 4					
Service User Feedback				See below	See below	See below	See below					
Staff feedback provided to safety champions at walk around				See below	See below	See below	See below					
HSIB/NHSR/CQC etc contacting the Trust directly with a concern or request for action				0	0	0	0					
Coroner Reg 28 made directly to the Trust				0	0	0	0					
CNST compliance (number of safety actions compliant with /10)				8	8	8	8					
Ockenden update (number of IEA complaint with /7)				0	0	0	0					

Continuity of Carer bookings				38%	39.5%	37%	43.6%					

York & Scarborough Teaching Hospitals NHSFT	Scarborough	York
Proportion of midwives responding to the 2020 staff survey with 'agree or strongly agree' on whether they would recommend their Trust as a place to work	**58.97%** (from 41.82% last year)	**47.42%** (from 58.49% last year)
Proportion of midwives responding to the 2020 staff survey with 'agree or strongly agree' on whether they would recommend their Trust as a place for a friend or relative to receive treatment	**69.23%** (from 54.55% last year)	**62.89%** (from 74.53% last year)
Proportion of Speciality Trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours	Awaiting data	Awaiting data

The 2020 staff survey results indicate that Midwifery staff at Scarborough feel generally happier than those at York. 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. Boards have been ordered for all maternity areas to highlight safety concerns/themes, learning from incidents and investigations, training compliance and to highlight areas of good practice. 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 expressions of interest to join were re-circulated in July.

2. Context

2.1 PMRT

2 cases notified and we anticipate review of these within 4 months, they will then be discussed at PMM and detailed in this report
2 PMRT reports completed, as below.

1 case was reviewed at Perinatal Mortality Meeting (PMM) in July. The report will be provided in the next report.

Summary of case	Findings	Recommendations
Notified:		

Antenatal stillbirth at 24 weeks Late miscarriage at 22+6 weeks.	Awaiting PMM Awaiting PMM	
Completed: Late fetal loss at 23weeks and 4 days.	Attended for her routine anomaly USS and the baby was found to have died some time before the scan was carried out.	Staff to be reminded of booking timely ultrasound scans. Scan capacity remains challenging. Bereavement midwife to remind staff about the guidance on offering parents the opportunity to take the baby home if they wish and documenting the conversation. Bereavement training to be updated.
Twin pregnancy at 23 weeks and 1 day. Twin 1 was a late miscarriage and Twin 2 had a resuscitation attempt and was a neonatal death at 1 hour and 42 minutes of age	The mother was given a PCA for analgesia when an epidural may have been appropriate in view of the plan for resuscitation	Report written not yet published. Bereavement and clinical skills midwives to update staff on guidance. Bereavement training to be updated

2.2.1 HSIB cases referred and/or received

Summary of case	Findings	Actions
Attended in labour with an undiagnosed breech prior to labour. Progressed rapidly. Baby born following a difficult delivery. Transferred out to a tertiary unit for therapeutic cooling	Ongoing investigation	

2.2.2 SI declared and/or reports received

Summary of case	Findings	Actions
None		

2.3 Number of incidents graded 'moderate' harm or above and actions taken

The Q&G team are reviewing the grading of what constitutes moderate harm.

Summary of case	Findings/ 72 hour report	Actions
Postnatal readmission of patient with infection requiring IV antibiotics and symptomatic of anaemia. Delay in commencing prescribed blood transfusion >24 hours. Delay in antibiotic dose	The 'anaemia in pregnancy and the puerperium' guideline wasn't followed - Monofer should have been prescribed, rather than blood. The blood sample results weren't followed up. Cannula not sited at time of prescribing IV antibiotics and blood. Delay in senior review	Guidance re postnatal anaemia sent out and discussed at handovers Learning from to be added to weekly messages on labour ward. Staff emailed re follow up of results. Discussed in labour ward handovers All doctors emailed (including new starters) re importance of siting a cannula at the time of prescribing medication or escalating if unable to do so. Staff emailed re timing of senior review. Audit of postnatal readmissions to be carried out by 30/09/21
Patient with known breech presentation was offered and declined LSCS on one occasion. Offered again and accepted - Attended in labour on the date booked for LSCS. Unable to auscultate the fetal heart and an intra uterine death was confirmed on USS.	A bedside USS had been performed by the fetal medicine lead. The estimated fetal weight was documented. There was no documentation of the margin of error with regard to fetal weight. After the birth the actual weight of the baby was 730 g less and the baby was on the 6.7 centile. The patient had had an unsuccessful	To investigate acceptable margin of error in fetal growth scans. To update Trust Breech guideline ensuring it is in line with National Guidance.

	ECV and had been advised that the Trust could not facilitate an elective vaginal breech delivery due to insufficient vaginal breech deliveries to maintain skills. The patient was referred to Leeds Hospitals and they were also unable to facilitate an elective breech delivery due to the low numbers of skilled practitioners at their maternity unit. The patient was not offered a vaginal examination as she should have been when laboring. A partogram was not commenced. This does not affect the outcome as we had already identified that the baby had sadly died.	Remind staff of the guidance around vaginal examinations in the Care in Labour guideline, even in the event of fetal death
Patient had an elective Caesarean section for a breech presentation. Bladder injury not identified until postnatal day 4 .	Delay in diagnosis. Index of suspicion should have been higher for bladder injury in the context of raised creatinine, pain when not catheterised, and haematuria. Speciality doctors unable to find operation notes when reviewing patient. ?did not seek support with this	Teaching session on bladder injuries at caesarean section being planned, including when to have a higher index of suspicion Ward manager to ensure availability of support for colleagues reviewing our patients. Escalated to Matron to action.
Attended in labour with an undiagnosed breech prior to labour. Progressed rapidly. Baby born following a difficult delivery. Transferred out to a tertiary unit for therapeutic cooling	Not all documentation completed contemporaneously. Not all people present documented in birth notes. HSIB referral made	Email sent to staff re documentation. Discussed at labour ward handovers. To be added to Q and G highlight report

2.4 Training Compliance

Training compliance will be monitored monthly via the Quality & Governance Team. The MDT Training Needs Analysis (TNA) meeting will be held in August to ensure training is compliant against the Core Competency framework and in line with the Trust statutory/mandatory training programme for the next three years. Consideration will be given to ensure incident action planning, service user and staff feedback and any investigation themes are incorporated into training contemporaneously. Medical staffing compliance has been escalated and action planning is in progress.

Midwife/HCA York

	Frequency	January	February	March	April	May	June	July
Neonatal Life Support	Annual	91	93	96	96	99	96	93
Infant Feeding	Annual	88	93	95	96	99	93	87
Professional Midwifery Advocate	Annual	88	92	98	94	96	92	90
Perinatal Mental Health	2 yrly	98	99	93	96	96	95	92
PROMPT - Midwives	Annual	78	86	90	91	93	92	86
PROMPT - MSW/HCA	Annual	88	92	88	86	96	93	76
COVID in pregnancy - Midwives	Annual	45	63	76	86	90	90	89
COVID in pregnancy - MSW/HCA	Annual	13	25	44	57	79	93	93
Antenatal and Newborn screening	Annual	91	91	90	92	92	89	86
Maternal Obesity	3 yrly	94	94	93	94	95	94	93
Learning from Incidents, Complaints & Claims	Annual	32	30	25	26	29	28	29
Substance Misuse	3 yrly	94	94	93	93	93	93	91
Mentorship	Annual	26	29	24	24	25	27	28
Customised Growth Chart	Annual	31	35	26	26	29	31	31
Bereavement update	Annual	88	88	88	90	90	86	81
e-IfH National Bereavement Care Pathway	One off	2	3	5	8	11	11	10
K2 - New Starter pathway	One off	27	0	0	0	0	29	20
K2 - Intrapartum CTG Chapter	Annual	88	83	76	76	85	77	78
K2 - Intrapartum CTG Assessment	Annual	82	84	81	82	83	81	79
K2 - Intrapartum Intermittent Auscultation chapter	Annual	86	83	81	81	85	86	87
K2 - Intrapartum Intermittent Auscultation Assessment	Annual	89	84	81	81	83	85	84
K2 - Full Midwife pathway	Annual	43	38	37	37	43	44	44
SBLCB - Supporting a smoke free pregnancy	Annual	79	81	78	83	82	79	74
SBLCB - Detection and surveillance of growth restrictions	Annual	11	47	66	74	84	83	83
SBLCB - Reduced Fetal Movements	Annual	16	52	69	79	87	88	88
SBLCB - Effective continuous fetal monitoring	Annual	11	49	68	74	82	84	85
SBLCB - Reducing Pre-term birth	Annual	10	49	67	76	86	86	87
Bereavement Workshop - HCAs	One off	75	75	64	64	82	82	83
2 day BFI - Midwives/MSWs/HCAs	One off	88	87	91	86	85	89	85
SBLCB - Fetal Monitoring (with Becky Galloway)	Annual	7	14	22	26	36	41	49
BLS - Midwives	3yrly	94	96	95	95	95	96	93

Midwife/HCA Scarborough

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

York medical Staff

Course	Frequency	January	February	March	April	May	June	July
PROMPT	Annual	65	73	74	74	77	84	83
COVID in pregnancy	Annual	55	63	65	68	80	87	87
Antenatal Screening	One off exl F2 & GP	20	20	16	16	17	19	22
Customised Growth Chart	One off exl F2 & GP	16	16	13	13	13	15	17
Fetal Monitoring (with Becky Galloway)	Annual	19	20	35	42	63	68	65
SBLCB - Supporting a smoke free pregnancy	Annual	19	40	48	48	73	74	83
SBLCB - Detection and surveillance of growth restrictions	Annual	16	43	42	39	63	71	78
SBLCB - Reduced Fetal Movements	Annual	16	37	42	42	70	71	78
SBLCB - Effective continuous fetal monitoring	Annual	13	40	39	39	63	68	78
SBLCB - Reducing Pre-term birth	Annual	13	33	39	42	63	68	74
K2 - Intrapartum CTG Chapter	Annual	68	63	48	58	62	67	61
K2 - Intrapartum CTG Assessment	Annual	62	67	58	71	79	70	65
K2 - Intrapartum Intermittent Auscultation chapter	Annual	35	33	29	42	59	63	65
K2 - Intrapartum Intermittent Auscultation Assessment	Annual	38	40	39	52	66	67	65
K2 - Full Medical Staff pathway	Annual	23	17	19	31	33	33	17

Scarborough medical staff

Course	Frequency	January	February	March	April	May	June	July
PROMPT	Annual	55	55	53	53	56	47	43
COVID in pregnancy	Annual	38	50	42	53	50	53	52
Antenatal Screening	One off exl F2 & GP	10	10	11	11	11	13	
Customised Growth Chart	One off exl F2 & GP	15	0	0	0	0	0	0
Fetal Monitoring (with Becky Galloway)	Annual	0	5	47	11	11	11	20
SBLCB - Supporting a smoke free pregnancy	Annual	90	35	16	22	22	37	45
SBLCB - Detection and surveillance of growth restrictions	Annual	95	35	21	22	22	37	55
SBLCB - Reduced Fetal Movements	Annual	95	30	21	22	22	32	55
SBLCB - Effective continuous fetal monitoring	Annual	95	35	26	22	22	37	50
SBLCB - Reducing Pre-term birth	Annual	95	35	21	22	22	32	45
K2 - Intrapartum CTG Chapter	Annual	85	73	53	68	78	58	50
K2 - Intrapartum CTG Assessment	Annual	80	73	42	63	72	53	44
K2 - Intrapartum Intermittent Auscultation chapter	Annual	35	33	26	58	78	74	61
K2 - Intrapartum Intermittent Auscultation Assessment	Annual	30	33	26	63	78	74	61
K2 - Full Medical Staff pathway	Annual	25	27	47	50	61	53	44

2.5 Safe maternity staffing levels

2.5.1 Midwifery

A full Birthrate+ review was undertaken in April 2021 which identified a midwifery shortfall of 21.5wte across York and Scarborough, including projections for the implementation of Continuity of Carer. Acuity tools, capturing real time activity against staffing levels have been introduced into the labour ward, antenatal and postnatal areas. A twice-daily cross-site safety huddle, led by a senior Midwifery leader to monitor acuity and action plan for any shortfall is working well. The Maternity Escalation Policy is under review. There is a monthly staffing establishment meeting between the Head of Midwifery and the Matrons and vacancies are monitored, with regular recruitment when vacancy is identified.

Themes from Acuity Tool:

1:1 Care in Labour: All women should receive 1:1 care in labour. This is not currently being achieved. Workforce plans are being developed by the Head of Midwifery to address this.
Supernumerary Labour Ward Coordinator: This should be 100% of the time and we are not meeting this target. Workforce planning is underway and how this information is being recorded has been updated to include how long the Supernumerary period was interrupted for and why.
There were 4 unit closures in July.

Midwife: Birth Ratio York 1:32 and Scarborough 1:22 against a national target of 1:28

2.5.2 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 identified

SGH
Scarborough had a challenging month in terms of medical staffing. The reasons for this were as follows;

- A number of consultants on annual leave, this compounded with the sickness levels (detail below) made for a challenging period in terms of providing acute cover and planned activity.
- Currently, 2 consultants are not undertaking on call duties due to occupational health recommendations.
- 3 substantive consultants were off sick
    - 1 x long term sick since May 2021
    - 2 x short term sick throughout July

Locum consultants were used to help fill the gaps on the rota as well as York colleagues offering support throughout this period where able.

YH
Although not as challenging as Scarborough, York experienced some rota gaps throughout July. This was mainly due to annual leave and short term sickness gaps. These gaps were managed by colleagues picking up ECP activity as well as utilising locum agency staff.

2.6 Service user Feedback – If what, so what, what now?

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 are addressed directly and resolved.

Positive feedback received from service user on our Facebook page:

First of all I want to say how grateful I am to the gestational diabetes team and midwives on the ante natal clinic at York hospital for my care throughout my pregnancy it was a big shock to be diagnosed with my diabetes and also to be put on fragmin injections on my third baby when the other pregnancies were so smooth! My care was fantastic so thank you. Although the initial stages of my induction were not smooth I want to say special thanks to my first midwife who cared for me when I arrived who was just lovely (I am sorry I can't remember your name but you may remember me and the after care once I had my little or not so little man was fantastic, special mentions to Blair, Scarlet and Phoebie who were so so good with me when my little chunk was taken away to SCBU the first day I had him as you know how emotional I was ! I think it might Ann Marie over in SCBU who was just fantastic so thank you. The midwives were so good and kept checking on me constantly and also I had to stay in on my Birthday and Blair and Phoebie got me a cake and birthday card and made me feel so special !! We didn't have a name for him but we do now he is a month old now, I won't forget the special attentive midwives that helped make a traumatic birth a little easier. Love to all the team.

There is a delay to receiving July Friends and Family (FFT) so we will update in the next report.

2.7 Safety Champions walk around feedback

MATNEO Safety forum feedback action plan			
Date/Site	**Safety Champion**	**Safety concern**	**Action**
July/ both sites	Heather McNair, Simon Morritt	lack of basic equipment - thermometers etc Ageing beds /incubators	Staff are aware to escalate any issues when trying to order equipment to management Maternity beds business case approved Business case agreed for two new cots on SCBU

2.8 CNST year 3 progress - awaiting standards for year 4

Safety Action	Compliance	Detail of each standard position
1	COMPLIANT	All cases eligible for PMRT have been appropriately reported. Quarterly reports to board are submitted
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. Action: To recommence MDT transitional care meetings to track progress and support further development
4	COMPLIANT	Action planning around neonatal workforce developed. Action: To commence working group to track progress
5	PARTIAL COMPLIANCE	Final Birthrate+ report received. Action: Maternity workforce paper to Board in August. Embed Acuity tools. Action plan to achieve 100% 1:1 care in labour and supernumerary LW coordinator status
6	PARTIAL COMPLIANCE	The Trust is not compliant with Saving Babies Lives v2. Action: MDT working group with CG4 to progress USS planning. Business case submission. Progress midwifery sonographer training
7	COMPLIANT	MVP hub and spoke model in place. Action: Ongoing attendance at local and regional MVP meetings. Ongoing engagement and collaborative working with MVP and LMS
8	COMPLIANT	Training action plan for agreement at board July
9	COMPLIANT	Safety Champions Meetings ongoing. Action: To update current agenda
10	PARTIAL COMPLIANCE	One case from HSIB not reported from April 2020 – will be reported by the end of the first week in August.

2.9 Ockenden action planning

All evidence collated towards the 7 Immediate, essential actions (IEA) has been submitted via the portal in June 2021. We are awaiting a RAG rated response from the national team. MDT meetings will continue in order to address any immediate shortfalls identified and work towards full compliance. The need for full compliance with SBL v2 adds further challenge. The second part of the Ockenden report is due October 2021 and more actions are anticipated from this.

IEA	Compliance	Detail of each IEA position
1	PARTIAL COMPLIANCE	**Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.** Actions: Evidence submitted around strengthened processes within the organisation and the LMS. SI sharing process in place. X3 midwives trained in undertaking investigations
2	PARTIAL COMPLIANCE	**Maternity services must ensure that women and their families are listened to with their voices heard.** Actions: Evidence around co- production with the MVP and LMS submitted, however awaiting national guidance around advocate for women during Trust processes
3	PARTIAL COMPLIANCE	**Staff who work together must train together.** Actions: action planning in place around training compliance, TNA and training planning underway in line with core competency frameworks. Ongoing audit of consultant led MDT ward rounds on labour ward
4	PARTIAL COMPLIANCE	**There must be robust pathways in place for managing women with complex pregnancies.** Update: Awaiting formation of maternal medicine networks.
5	PARTIAL COMPLIANCE	**Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.** Actions: Ongoing audit of risk assessment compliance
6	PARTIAL COMPLIANCE	**All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.** Actions: Obstetric and midwifery fetal monitoring leads in place, awaiting JD for medical staff.

7	PARTIAL COMPLIANCE	**All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.** Actions: Evidence of co production with MVP and LMS submitted, formation of SOPS around personalised care planning required (currently piloting these)

2.10 Continuity of Carer

We continue to work towards offering all women continuity of carer by 2023, with a focus towards women from our BAME communities and those living in the higher centile areas for deprivation. This will require investment in midwifery staffing, particularly at our York site where we currently offer continuity from one team in a geographical area. Action planning for wholescale continuity will be submitted to the LMS, with an expected assurance visit from the regional continuity leads in the Autumn.

July 2021

Booked for CoC	Intrapartum CoC received
43.6% Black, Asian and mixed ethnicity backgrounds = 70% Postcode for top decile for deprivation = 88%	18.6% Scarborough = 54.8% York = 4.5% Black, Asian and mixed ethnicity backgrounds = 15.4% Postcode for top decile for deprivation = 35.3%

3. Next Steps

To continue to provide this report monthly.

4. Detailed Recommendation

For the board to acknowledge and discuss the data required.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 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

No notifications submitted have been submitted to the CQC since the last report. Mental Health Risk Assessment audit data (table 1) is not displaying consistent results above 85% and as such the Trust will not be in a position to request the removal of the final outstanding Section 31 conditions of registration. Work is being undertaken to address any improvement requirements.

Four actions are behind delivery-ongoing, all of which have a plan in place to address compliance. One of the four overdue actions presents a high risk for the Trust – this relates to the recruitment of a PEM consultant for Scarborough Emergency Department. Non-compliance with this recommendation could result in a Section 31 condition notice. Mitigations are in place to reduce the risk but further mitigations need to be explored.

The bimonthly CQC insight report demonstrates 6 much worse indicators (increase) and 23 worse indicators (decreased) when compared nationally. The “Much Worse” indicators have been summarised in this paper, 3 of which have been resolved, whilst the remaining 3 have worsened in recent months. The results and data will be shared with the CQC for the 3 metrics which have been resolved.

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. There may be associated delays

with submissions due to current operational pressures. The responsive tool which was due to be shared at the beginning of September has been deferred for a 4 week period to enable effective operational delivery.

Recommendations

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

Author: Shaun McKenna – Head of Compliance & Effectiveness

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

Date: 15-09-2021

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

1. 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

1. 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

Two engagement meetings have taken place since the last summary report to Trust Board. The most recent engagement meeting had representation from the Head of Midwifery and CG5 Associate Chief Nurse, discussing Maternity care and Ockenden. In addition the Associate Chief Operating Officer and Chief Operating Officer attended the meeting to discuss a CQC whistleblowing in relation to Scarborough Emergency Department. The next engagement meetings will include a presentation on mental health progression. Engagement meetings have not required any escalation. The Trust will receive a new inspection manager in the next few weeks, as our current inspection manager has secured employment elsewhere within the CQC. In addition the community inspector has changed portfolio due to pregnancy and as such the Trust will have an Interim community inspector. This should not impact on the Trust.

2.2 Notifications

No notifications submitted have been submitted to the CQC since the last report. Mental Health Risk Assessment audit data (table 1) is not displaying consistent results above 85% and as such the Trust will not be in a position to request the removal of the final outstanding Section 31 conditions of registration. A new audit tool has been developed and the Patient Safety & Quality Governance Team will work with the Emergency Department. Following implementation, the Patient Safety & Quality Governance team will work with both emergency departments to understand the reasons for reduced compliance and work on an improvement plan to create an embedded solution.

Results	**Scarborough Emergency Department**	**York Emergency Department**
May 2021	81%	58%
June 2021	70%	90%
July 2021	72%	88%

Table 1: Mental Health Risk Assessment Compliance

2.3 General Updates

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

- **Infection Prevention and Control NHS Trusts**

The CQC have released a 'Well-Led' framework for IPC practices, this has been used to carry out a benchmarking by the Trusts IPC team and has been presented at Quality & Regulations Group. A full summary will be included in October 2021. Since the release of the framework, CQC have carried out several unannounced inspections of NHS Trusts and have now shared some positive learning from their findings. The link has been shared with the IPC team for them to identify any learning our Trust can take.

- **Identifying and Responding to Closed Cultures**

This month's insight report includes a narrative in relation to identifying and responding to closed cultures with examples of concerns received. CQC are actively reviewing notifications and whistleblowing alerts to determine if any providers may have a closed culture. The abuse at Whorlton Hall, Winterbourne View, Mid Staffordshire Hospital and other services highlighted breaches of human rights that resulted from closed cultures, and the impact that these had on people using services. The information will be used within the "well-led" benchmarking exercise which is scheduled for Q3.

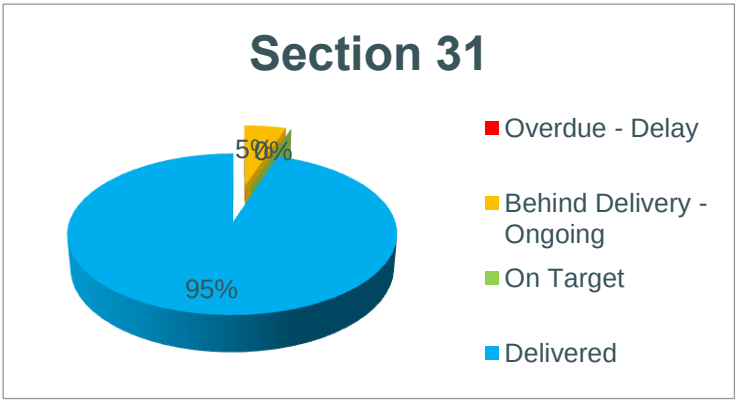
- **Mandatory Vaccination Requirements**

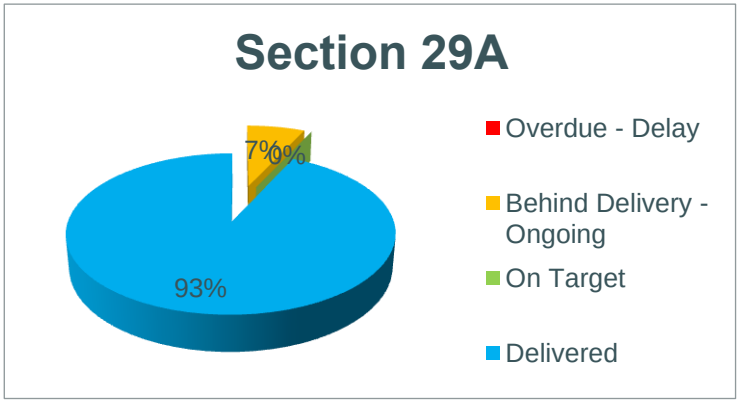
New regulations were created in July 2021, and will be in force from November 2021 which requires all persons working or deployed into care home to be fully vaccinated against COVID19 unless an exemption applies. CQC have released a statement with their monitoring requirements including robust processes for monitoring vaccination status of staff. This has been shared with community services to ensure a robust process is in place and can be demonstrated ready for November 2021.

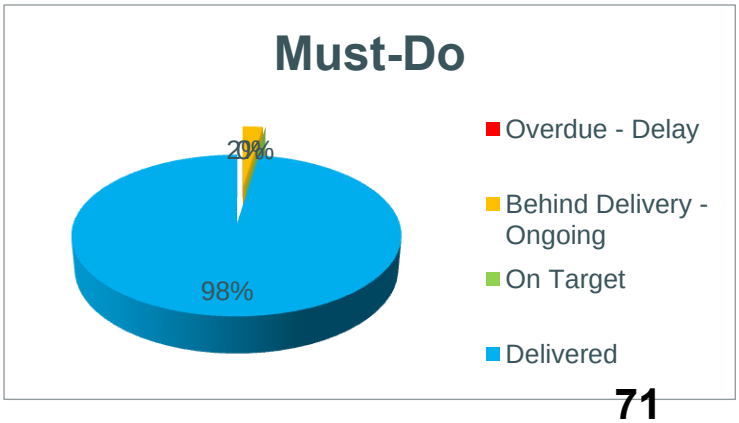
3. Regulatory Action Plan Update (Appendix A)

3.1 Overview

	Overdue - Delay	Behind Delivery - Ongoing	On Target	Delivered
Section 31	**0**	**1**	**0**	**19**
Section 29A	**0**	**2**	**0**	**27**
Must-Do	**0**	**1**	**0**	**40**







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. 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. Through the next engagement meeting CQC will be asked if there are any other mitigating actions that could be considered through learning from other Trusts.

- 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. Further information is required from an external stakeholder which is currently being progressed. The final document is going to Mental Health Steering Group in October before submission to QPAS for final ratification in November 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 Assistant Chief Nurse for workforce to review and consider. The risk associated with this action being delayed / not completed is moderate.

- 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 October 2021. The team leading on this work feel are engaging with the national teams and are on track with all actions that are currently allocated. The work stream timescale is determined externally and is outside of the Trusts control.

4. CQC Insight Report

4.1 Overview (CQC National Comparison)

Classification of Indicators	Number of Indicators – May 2021	Number of Indicators – July 2021
Much Worse	**5**	**6**
Worse	**25**	**23**

About the Same	**174**	**175**
Better	**7**	**5**
Much Better	**2**	**3**

CQC Insight reports are released bimonthly and benchmark Trusts against previous internal performance and against national performance / quality indicators. The 6 “much worse” indicators have been reviewed by the Trust and determined that 3 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. In addition there are 175 indicators which demonstrate the Trust are either comparable nationally or have remained the same in terms of previous performance. Finally, there are 8 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 has been reviewed by Care Groups. Summary Sheets have been completed and presented to Quality & Regulations Group. The overall summary paper will be presented to Quality Committee in October 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 in October 2021.

Well-Led deep dives were initiated at the end of July 2021, with the intention of a summary paper to Executive Committee in November 2021. This is in line with the schedule submitted to the last committee. There may be associated delays with this submission due to current operational pressures. The responsive tool which was due to be shared at the beginning of September has been deferred for a 4 week period to enable effective operational delivery.

6. Recommendations

Board of Directors are requested to consider the following recommendations:

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

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

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

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Jan20/R29A-3.1	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Re-establish a Joint Operational Delivery Group between the Emergency Department and Paediatric Department in both of the Trusts Emergency Departments.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered
Jan20/R29A-3.2	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Establish a Paediatric Strategic Oversight Group.	CG5 Quadrumvirate	Feb-20		Feb-20	Delivered
Jan20/R29A-3.3	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Audit against 'Royal College of Paediatrics and Child Health: Facing the Future Standards' and develop an action plan subsequently.	CG5 Quadrumvirate	Jun-20	As a result fast track pathways were reviewed and refreshed.	Jun-20	Delivered
Jan20/R29A-3.4	Section 29A	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Add the lack of Paediatric Emergency Medicine (PEM) Consultant at Scarborough Hospital Emergency Department to the risk register and identify mitigations.	CG5 Quadrumvirate	Aug-20	The initial risk rating was 'High' with a score of 16. Mitigations were implemented.	Aug-20	Delivered
Jan20/R29A-3.5	Section 29A	Medical Director	Care Group 2	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Recruit a Paediatric Emergency Medicine (PEM) Consultant for Scarborough Hospital Emergency Department	Paediatric Strategic Oversight Group	Nov-20	Discussions taking place with an individual who is interested in the post. Call to take place on 20/08/2021 to firm up the plan with the candidate.		Behind Delivery - Ongoing
Jan20/R29A-4.1	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Implement standardised paper documentation across the Trust including care plans and risk assessments.	Deputy Chief Nurse (H.H)	Mar-20		Mar-20	Delivered
Jan20/R29A-4.2	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Recruit a Documentation Lead Nurse to lead the docmentation standards within the Trust.	Deputy Chief Nurse (H.H)	Nov-20	Lead Nurse for documentation is in place and leading a steering group.	Dec-20	Delivered
Jan20/R29A-4.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Produce a long term plan for introudcing standarised electronic documentation across the Trust.	Deputy Chief Nurse (H.H)	Dec-20	Paper to Exec Committee with approval for a 2 year digital docuemntation project.	Dec-20	Delivered
Jan20/R29A-4.4	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department or across medical wards at Scarborough hospital to ensure safe care and treatment for patients.	Safe Well-Led	Purchase and implement the "perfect ward" app for use across the Trust	Deputy Chief Nurse (H.H)	Sep-20	Perfect-Ward now in use and providing assurance reports including documentation standards.	Oct-20	Delivered
Jan20/R29A-5.1	Section 29A	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	Staff did not always report incidents and where they did there were often significant delays in reporting	Safe Well-Led	To ensure that staff are appropriately reporting incidents as per trust policy	Deputy Director of Governance (F.J)	Jan-20	CQC response received in January 2020 advising no further information reqired.	Jan-20	Delivered

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Jan20/R29A-6.2	Section 29A	Chief Nurse	Trust-Wide	Trust-Wide	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Well-Led	Undertake ward establishment reviews to ensure staffing establishment refelects the requirements.	Deputy Chief Nurse (H.H)	Nov-20	Proposal has been submitted to Exec Committee and further work is required before a decision can be reached.	Dec-20	Delivered
Jan20/S31-2.3	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of Scarborough Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Emergency Department Matron (S.F)	Jun-21	This tool is being used as a "live" working document, updated on a minimum monthly basis. Document owned by ED Tri Team.		Delivered
Jan20/S31-1.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	Senior Operational Manager (A.W)	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/S31-1.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & York Emergency Department	Senior Operational Manager (A.W)	Mar-20	Established in April-2020. Action log maintained on a monthly basis.	Apr-20	Delivered
Jan20/S31-1.3	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within York Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered
Jan20/S31-1.4	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered
Jan20/S31-1.5	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Senior Operational Manager (A.W)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered
Jan20/S31-2.1	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Effective	Carry out a PLAN / RCEM compliance benchmarking assessment within the Emergency Department	Senior Operational Manager (A.W)	Mar-20	Monitored twice monthly through Governance Meetings.	Mar-20	Delivered
Jan20/S31-2.2	Section 31	Medical Director	Care Group 1	Emergency Department	York	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Jan-21	Delivered
Jan20/S31-1.10	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a risk assessment tool to assess the level of risk a patient presents to themselves and others.	York Mental Health Operational Steering Group	Mar-20	Risk Assessment implemented from beginning of May 2020 in line with RCEM standards. Several adaptions since initial version. Latest version signed off at QPAS in December-2020 and is now a trust-wide document with version control.	May-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jan20/S31-1.11	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Responsive	Implement a rolling programme of education for Emergency Department staff	Emergency Department Matron (S.F)	Mar-20	2 day course delivered by MIND to Senior Medics and Senior Nurses. 1 day course delivered by MIND to Junior Medics and Junior Nurses. X Drive CG1 - Emergency and Acute - Emergency Dept Steering Group - Mental Health in ED Operational Steering Group - MH First Aid Training Trust attendance.	Aug-20	Delivered
Jan20/S31-1.7	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Include Mental Health care to the care group risk register covering the lack of suitable environment, lack of risk assessment, and delays in referral and assessment.	CG2 Quadrumvirate	Mar-20	Added to Risk Register 27-04-2020. Reviewed in May, June, August 2020. Risk rating reduced from 12 to 6 in August 2020.	Apr-20	Delivered
Jan20/S31-1.8	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Operational Steering Group' between TEWV & Scarborough Emergency Department	Emergency Department Matron (S.F)	Apr-21	Informal meetings are held with TEWV on a regular basis. Formalised meeting to be established. New Action	Jan-21	Delivered
Jan20/S31-1.9	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Effective	Create and implement a Mental Health Referral Pathway which is used for all Mental Health presentations within Scarborough Emergency Department.	Mental Health Strategic Oversight Group	Jun-21		Apr-21	Delivered
Jan20/S31-2.5	Section 31	Medical Director	Care Group 1	Emergency Department	Trust-Wide	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Well-Led	Develop a SOP for the use of the PLAN compliant Mental Health Assessment Suite	Mental Health Strategic Oversight Group	Jun-21	This will be incorporated into "Mental Health Care within the ED" SOP. Draft SOP has been shared. For final comments followed by approval at Mental Health Steering Group and QPAS in September 2021.		Behind Delivery - Ongoing
Jan20/S31-2.4	Section 31	Medical Director	Care Group 2	Emergency Department	Scarborough	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Responsive	Establish a PLAN compliant Mental Health Assessment Suite within the Emergency Department.	YTHFM	Jun-20	Delayed during COVID	Nov-20	Delivered
Jan20/S31-4.1	Section 31	Chief Nurse	Care Group 2	Medical Wards	Scarborough	The registered provider must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff at all times to meet the needs of patients within all medical wards at Scarborough hospital.	Safe Responsive Well-Led	Introdcue a daily staffing huddle for CG2, utilising a daily staffing template which feeds into a monitoring database.	CG2 Quadrumvirate	Mar-20	Staffing database monitored monthly.	Mar-20	Delivered
Jan20/S31-3.1	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Utilisie Nurse Agencies to ensure adequate Registered Childrens Nurses on each clinical shift across both Emergency Departments	Head of Childrens Nursing (S.K)	Jan-20		Jan-20	Delivered
Jan20/S31-3.2	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Establish a Paediatric 'In-Reach' Service to enable consistent support for times where RCN cover is less than optimal.	Head of Childrens Nursing (S.K)	Jan-20	Audit undertaken in July 2020 to demonstrate effectiveness of the service being used.	Jan-20	Delivered
Jan20/S31-3.3	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Recruit substantive RCN's for York and Scarborough Emergency Department	Head of Childrens Nursing (S.K)	Jun-20	Due to the very low numbers of paediatric attendance in the Scarborough ED and the support which can be offered from the acute Paediatric ward a proposal was made for Scarborough to have one RCN on shift at all times, rather than the guidance of 2.	Oct-20	Delivered
Jan20/S31-3.4	Section 31	Chief Nurse	Care Group 5	Emergency Department	Trust-Wide	The registered provider must by 20 January 2020, there must be a minimum of two registered sick children's nurses (RSCN) in the emergency departments at York Hospital, twenty-four hours a day, seven days a week.	Safe	Add the lack of substative Registered Childrens Nurses within the Emergency Deparments to the Risk Register.	Head of Childrens Nursing (S.K)	Jan-20	Risk added to Care Group 5 Risk register with a risk rating of 12. Reviewed in November 2020 and risk rating now 1.	Feb-20	Delivered
Jan20/S31-1.6	Section 31	Medical Director	Trust-Wide	Emergency Department	Trust-Wide	The registered provider must with immediate effect implement an effective system to identify, mitigate and manage risks to patients at York Hospital who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Establish a 'Mental Health Strategic Oversight Group' which governs the Operational Steering Groups for the Emergency Departments.	Deputy Director of Patient Safety & Governance (C.J)	Jan-21	First meeting took place in January 2021, second meeting scheduled for February 2021. TOR and agenda required.	Jan-21	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jan20/R29A-6.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Re-launch and utilise Safe-Care as a tool for measuring CHPPD across the organisation	Deputy Chief Nurse (H.H)	Jun-21	Trust-wide improvement plan to be created with realistic timescales. Assistant Chief Nurse will lead this workplan. Current winter planning in progress.		Behind Delivery - Ongoing
Jan20/MD1	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD2	Must Do	Chief Nurse, Medical Director	Care Group 2	Emergency Department	Scarborough	The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD3	Must Do	Chief Nurse	Care Group 5	Emergency Department	Scarborough	The service must ensure that care is provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed	Safe Responsive	Create and implement a Paediatric risk assessment tool to assess the level of risk a patient presents to themselves and others.	CAMHS Nurse	Mar-20	Implemted across the Trust	Apr-20	Delivered
Jan20/MD4	Must Do	Chief Nurse	Care Group 2	Emergency Department	Scarborough	The service must ensure that there is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD5	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed.	Safe Well-Led	Covered in Section 29A & 31 Actions	Care Group Quadrumvirate	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD6	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure staff are maintaining securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of thecare and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD7	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure systems for recording clinical information, risk assessments and care plans are used in a consistent way across the medical wards. This should include ensuring staff are aware of how to effectively use systems to identify, assess and monitor patients at risk of deterioration.	Safe Well-Led	Covered in Section 29A & 31 Actions	Deputy Chief Nurse (H.H)	Mar-20	Covered in Section 29A & 31 Actions	Dec-20	Delivered
Jan20/MD8.1	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Uttilise the Staff magazine to educate staff of the value of incident reporting.	Associate Director of Patient Safety & Governance	Nov-20	November 2020 Edition of 'Safety Spotlight'	Nov-20	Delivered
Jan20/MD8.2	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Update dashboards on Datix to enable senior leaders to monitor and understand their incident reporting data.	Associate Director of Patient Safety & Governance	Oct-20		Oct-20	Delivered
Jan20/MD8.3	Must Do	Chief Nurse / Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure systems and processes for staff to report incidents are capable of giving senior staff objective assurance that reporting of incidents can be effectively monitored and audited so that actions can be taken if there is evidence that there may be under reporting of incidents.	Safe Well-Led	Develop a monthly Patient Safety assurance report regarding incidents and present this at QPAS.	Patient Safety & Governance Team	Jan-21		Jan-21	Delivered
Jul19/MD1.1	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake promotion exercise to ensure ALL staff understand the current processes for identifying learning from deaths and Sis	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered
Jul19/MD1.2	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Develop a policy for the identification of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	In Jan 2020 Staff Matters Policy to Feb Quality Committee Presentation of Policy to EB March 2020	Mar-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD1.3	Must Do	Medical Director	Trust-Wide	Trust-Wide	Trust-Wide	The trust must ensure it has a robust process for identifying learning from deaths and serious incidents and ensure this is systematically shared across the organisation	Safe	Undertake a multi-professional engagement exercise and in response review and revise the processes for the dissemination of learning from deaths and serious incidents	Deputy Director of Healthcare Governance (F.J)	Feb-20	Review document Revised processes and publications	Mar-20	Delivered
Jul19/MD10	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure the processes for the management of risks, issues and performance, and the governance and oversight of these processes are fully embedded within its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Review, revise and deliver a Governance Management structure that meets the needs of the new Care Group	Care Group Quadrumvirate	Apr-21	Draft structure created. Next steps to feature at Quality Committee for approval and sharing with wider team.	May-21	Delivered
Jul19/MD11	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered
Jul19/MD12.1	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	Chief Executive to examine recruiting to a director position with a specific focus on digital part of whose remit will be to review how IT can support record keeping.	Chief Executive	Apr-20	Digital Director is in post	Sep-20	Delivered
Jul19/MD12.2	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that the quality of medical record keeping improves and that medical staff maintain accurate and contemporaneous records for all patients, in accordance with professional standards and trust policy.	Safe	The Medical Director will write to ALL medical colleagues detailing their responsibility to comply with the Record Keeping Standards Medical Staff – Records Management Policy. In addition, the screensaver will be refreshed during September 2019 and a feature in Staff Matters article October 2019.	Medical Director	Oct-19		Oct-19	Delivered
Jul19/MD13	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered
Jul19/MD14	Must Do	Medical Director	Care Group 3	Surgery	Trust-Wide	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered
Jul19/MD22	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy.	Safe Well-Led	Medical staff in surgery will be issued with their individual compliance data and set a target date for full compliance, specifically safeguarding training modules	Care Group Director (A.V)	Mar-20	Letters have been issued. Learning Hub compliance discussed and monitored through CG3 Quality Assurance Committee monthly Mandatory Training compliance presented to Trust Board by Director of Workforce and Organisational Development monthly	Nov-20	Delivered
Jul19/MD15	Must Do	Medical Director	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed overnight for medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Where the Trust has unfilled shifts bank, agency and locums will be utilised.	Care Group Director	Mar-20	Daily monitoring is in place to ensure the safety of the ward	Mar-20	Delivered
Jul19/MD16	Must Do	Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing staff are deployed across the medicine wards on the Scarborough Hospital site to promote safe care and treatment of patients.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Dec-20	Delivered
Jul19/MD17	Must Do	Medical Director / Chief Nurse	Care Group 2	Medicine	Scarborough	The service must ensure that all staff on medicine wards at the Scarborough Hospital site are maintaining securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.	Safe Effective Well-Led	Replaced with Section 29A Actions	N/A	N/A	Replaced with Section 29A Actions	Dec-20	Delivered
Jul19/MD18.1	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	A review of all substances hazardous to health to be undertaken to ensure only appropriate substances are stored correctly and that COSHH risk assessments are in place	Head of Health, Safety & Security	Mar-20	All Wards have files in place, but need to provide assurance. Evidence of compliance has been provided	Apr-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD15.1	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Aug-21	August 2021: National project - Trust up to date with requirements. Starting testing phase this month, due for completion in October 2021. Timescales out of control of Organsiation - National NHSBA project. Project Board presentation details stored in evidence folder. Jun-21: Following QRG completion date extended in line with national work-stream.		Behind Delivery - Ongoing
Jul19/MD18.2	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	Up to date list of COSHH Appropriate training or training updates to be delivered to COSHH Leads for all areas to be provided and reported through CG2 Quality Assurance Meeting	Head of Health, Safety & Security	Mar-20	List held by CLAD Evidence requested 50-60 staff have been trained. Staff were trained in 2018 and will require refresher training. Business case has been approved to appoint a Health and Safety Traner which is currently (June 2020) going out to advertisement	Apr-20	Delivered
Jul19/MD18.3	Must Do	Director of LLP	Care Group 2	Medicine	Scarborough	The service must ensure that substances hazardous to health are stored securely and used in a safe way to avoid potential or actual harm to patients.	Safe	COSHH Leads to provide local training and ensure staff in each department understand their roles and responsibilities associated with the management of hazardous substances	Head of Health, Safety & Security	Mar-20	Evidence has been provided, there is a need to provide refresher training that will be a priority for the H&S Trainer when appointed. Interviews July 2020	Apr-20	Delivered
Jul19/MD23	Must Do	Director of Workforce & Organisational Development	Care Group 3	Surgery	Bridlington	The service must ensure that all medical and nursing staff receive annual performance appraisals, in accordance with professional standards and trust policy.	Safe Well-Led	Review current appraisal rate for medical & nursing staff in surgery and set a trajectory for appraisals to be undertaken to achieve 85%	Care Group Quadrumvirate	Sep-20		Nov-20	Delivered
Jul19/MD19	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered
Jul19/MD2.1	Must Do	Director of Workforce & Organisational Development	Trust-Wide	Trust-Wide	Trust-Wide	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Apr-21	Duplicate action - See Action Jul19/MD15.1	N/A	Delivered
Jul19/MD2.2	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical staff in its urgent and emergency care service at Scarborough hospital are compliant with all aspects of mandatory training.	Safe Well-Led	Ensure that there is adequate and accessible mandatory training sessions for staff to access. Medical staff in urgent and emergency care will be issued with their individual compliance data and set a target date for full compliance	Care Group Quadrumvirate	Feb-20	Mandatory Training monitored through Care Group Structure and IBR.	Mar-20	Delivered
Jul19/MD20	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered
Jul19/MD21	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Scarborough	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Update the RTT Recovery Plan to clearly state the projections for service delivery and backlog reduction	Care Group Manager	Mar-20	Enhanced management of Follow up partial booking currently being rolled out in Diabetes and will follow in cancer and gastroenterology. Two way text reminder service for all OP appointment and follow up. The specific action could be closed as completed. Recommend a new action to meet the national standards for Clinical Validation of the Waiting List and ongoing Risk Stratification.	Dec-20	Delivered
Jul19/MD25	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure the backlogs and overdue appointments in the trust is addressed and improved	Safe Effective Responsive Well-Led	Deliver the Outpatient Transformation Programme	Care Group Manager	Jun-20	Superseded by COVID-19. Phase 3 plan submitted and in delivery. The focus for the national ask is on restoring activity levels which will not address backlogs in 2020/21. The Outpatients Dashboard provides increased oversight of the outpatients and Follow Up position. The Trust has implemented Clinical Risk Stratification for overdue FU as part of the risk management processes following the pandemic.	Jun-20	Delivered

Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating
Jul19/MD26	Must Do	Chief Operating Officer	Care Group 6	Outpatients	Bridlington	The service must ensure improvements are made where the service is not meeting the 18-week referral to treatment time target and cancer waiting times so that patients have access to timely care and treatment	Responsive Well-Led	Monitor progress against the Performance Delivery Plan at Trust Board	Chief Operating Officer	Mar-20	Action is complete. The Trust Board receives the performance each month and position against the plan.	Dec-20	Delivered
Jul19/MD3.1	Must Do	Director of Workforce & Organisational Development	Care Group 2	Emergency Department	Scarborough	The service must ensure all medical and nursing staff in urgent and emergency care services at Scarborough hospital complete the required specialist paediatric life support training to enable them to safely care for children in the department.	Safe	Ensure that there is adequate and accessible paediatric life support training sessions for staff to access and that this is monitored by the care group	D.T (Care Group Manager)	Feb-20	Rolling programme in place, monitored by the Clinical Educator.	Nov-20	Delivered
Jul19/MD4.1	Must Do	Executive Committee	Care Group 2	Emergency Department	Scarborough	The service must ensure it has enough, suitably qualified, competent and experienced medical and nursing staff in its urgent and emergency care service at Scarborough hospital, to meet the RCEM recommendations, including enough staff who are able to treat children in an emergency care setting.	Safe Responsive Well-Led	Replaced with Section 29A & Section 31 Actions.	N/A	N/A	Replaced with Section 29A & Section 31 Actions.	Mar-20	Delivered
Jul19/MD5.1	Must Do	Chief Nurse	Care Group 1	Emergency Department	Scarborough	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Update the Trusts Medicines Management policy with 7 key messagesand display in the clean utility / drug storage areas.	Lead Nurse Medicines Management	Oct-19	Policy updated and key message circulated.	Jun-20	Delivered
Jul19/MD5.2	Must Do	Chief Nurse	Trust-Wide	Pharmacy	Trust-Wide	The service must ensure medicines are managed safely in its urgent and emergency care service at Scarborough hospital.	Safe	Chief Pharmacist has commissioned Internal Audit to undertake: Safe and Secure Handling of Medicines Audit	Chief pharmacist	Mar-20	Internal Audit Completed in June 2020 - This showed an increasing risk with a Red/Amber rating. An action plan has been developed and this is monitored through Medicines Management Group on a monthly basis.	Jun-20	Delivered
Jul19/MD6.1	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered
Jul19/MD6.2	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Consider privacy screens for monitors in Acute Admission areas such as Emergency Department, SDEC, SAU, AMU to reduce the risk of unintentional viewing of patient identifiable information during situations whereby locking the computer has not been possible.	Care Group Quadrumvirate	Jun-21	Privacy screens ordered. Confirmation from Deputy Care Group Manager on 19/08/2021	Aug-21	Delivered
Jul19/MD6.3	Must Do	Chief Digital Information Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure that computer screens showing patient identifiable information are not left unlocked when not in use, in its urgent and emergency care service at Scarborough hospital.	Safe Well-Led	Agree with IT a suitable time for implementing an automatic locking function for computers which are inactive for a period of time.	Service Desk	Jun-21	Auto-lock functionality currently at 15 minutes across the Trust.	Jul-21	Delivered
Jul19/MD7	Must Do	Chief Operating Officer	Care Group 2	Emergency Department	Scarborough	The service must ensure it takes action to improve its performance in the RCEM standards in its urgent and emergency care service at Scarborough hospital.	Safe Effective Well-Led	Undertake a gap analysis against previous RCEM audit standards and as necessary develop and action plan that delivers improved performance against the standards	Care Group Director	Jun-20	Clinical Director has provided a response to the RCEM audit findings on the latest audits • QA2018-002 Feverish Children (Care in Emergency Departments) 2018/19 • QA2018-003 Vital Signs in Adults (Care in Emergency Departments) 2018/19	Mar-20	Delivered
Jul19/MD8	Must Do	Chief Nurse	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure all nursing staff have an up to date appraisal each year in its urgent and emergency care service at Scarborough hospital.	Well-Led	Review current compliance rates within the Care Group and dedicate time to achieve required compliance	Head of Nursing (J.B)	Mar-20	Compliance rates monitored within the Care Group and at Trust Board.	Dec-20	Delivered
Jul19/MD9.1	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. • the median time from arrival to treatment. • the percentage of patients admitted, transferred or discharged within four hours. • the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Develop a recovery plan relating to performance	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Acute Pathway Programme Board overseeing a programme of work with ECIST, to strengthen site management at York, and improve flow and performance in Emergency Departments in York and Scarborough. Opened Home First Unit SGH. Restoration of Services Plan post COVID submitted to board.	Mar-20	Delivered
Jul19/MD9.2	Must Do	Chief Operating Officer	Care Group 2	Urgent and Emergency Care	Scarborough	The service must ensure they continue to work to improve the following performance standards for its urgent and emergency care service at Scarborough hospital. • the median time from arrival to treatment. • the percentage of patients admitted, transferred or discharged within four hours. • the monthly percentage of patients that left before being seen.	Safe Effective Responsive Well-Led	Engage with the offer of support from ECIST to further develop approaches to improve the Trusts' performance as identified during the CQC visit.	Deputy Chief Operating Officer (M.L) / Care Group Manager (D.T)	Jan-20	Action closed following discussions at March QRG - superseded by Quality & Performance Summit and the subsequent improvement plan created. Evidence to be held in CQC folder.	Mar-21	Delivered
Jul19/MD24	Must Do	Medical Director	Care Group 3	Surgery	Bridlington	The service must ensure that all records are secure when unattended.	Safe Well-Led	Roll out a programme of Information Governance Team peer reviews which would provide an opportunity for immediate rectification and for staff feedback on any information governance concerns	Deputy Director Healthcare Governance (FJ)	Feb-20	Programme in place - though put on hold during pandemic. To be recommenced.	Feb-20	Delivered

CQC Regulatory Action - Trust-Wide Action Plan														
Reference	Section	Executive Lead/ Assurance Committee	Care Group	Area	Site	Area of Regulatory Breach / Reccomendation	CQC KLOE	Actions (SMART)	Responsible Person / Group	Target Completion Date	Narrative Update	Actual Completion Date	Rag Rating	Evidence Check
Jan20/R29A-3.5	Section 29A	Medical Director	Care Group 2	Emergency Department	Trust-Wide	Neither emergency departments were meeting the standards from the Facing the future: standards for children in emergency settings.	Safe Effective Responsive	Recruit a Paediatric Emergency Medicine (PEM) Consultant for Scarborough Hospital Emergency Department	Paediatric Strategic Oversight Group	Nov-20	Discussions taking place with an individual who is interested in the post. Call to take place on 20/08/2021 to firm up the plan with the candidate.		Behind Delivery - Ongoing	
Jan20/S31-2.5	Section 31	Medical Director	Care Group 1	Emergency Department	Trust-Wide	The registered provider must by 24 January 2020 ensure that risk assessments are carried out and reviewed to ensure that the environment in the emergency departments of York Hospital is safe for their intended purpose, specifically in relation to patients with mental health condition.	Safe Well-Led	Develop a SOP for the use of the PLAN compliant Mental Health Assessment Suite	Mental Health Strategic Oversight Group	Jun-21	This will be incorporated into "Mental Health Care within the ED" SOP. Draft SOP has been shared. For final comments followed by approval at Mental Health Steering Group and QPAS in September 2021.		Behind Delivery - Ongoing	
Jan20/R29A-6.3	Section 29A	Chief Nurse	Trust-Wide	Chief Nurse Team	Trust-Wide	We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the medical wards at Scarborough and emergency departments at both sites.	Safe Responsive Well-Led	Re-launch and utilise Safe-Care as a tool for measuring CHPPD across the organisation	Deputy Chief Nurse (H.H)	Jun-21	Trust-wide improvement plan to be created with realistic timescales. Assistant Chief Nurse will lead this workplan. Current winter planning in progress.		Behind Delivery - Ongoing	
Jul19/MD15.1	Must Do	Director of Workforce & Organisational Development	Care Group 5	Maternity	Scarborough	The service must ensure that all medical staff complete mandatory training and safeguarding training modules in accordance with trust policy	Safe Well-Led	Implement the 'Training Passport' for staff employed from other NHS organisations – National Streamlining Programme	Director of Workforce and Organisational Development	Aug-21	August 2021: National project - Trust up to date with requirements. Starting testing phase this month, due for completion in October 2021. Timescales out of control of Organsiation - National NHSBA project. Project Board presentation details stored in evidence folder. Jun-21: Following QRG completion date extended in line with national work-stream.		Behind Delivery - Ongoing	

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Board of Directors
30 September 2021
Winter Resilience Plan 2021-2022

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

The purpose of this report is to inform the Board how the Trust will respond to the various operational pressures that may arise over the winter period 2021-2022. The report will describe the plans, initiatives and schemes that will be implemented to mitigate winter operational pressures and has been compiled within regional direction and guidance, issued by the Scarborough and York Health and Care Resilience Board (A&E Delivery Board).

Executive Summary – Key Points

The lessons learned from the implementation and review of the Winter Resilience Plan 2020-2021 have provided the basis for this year's plan, which has been endorsed by Executive Committee (September 2021).

The complexity and interaction of pressures that are experienced during the winter period have necessitated the development of a series of plans, initiatives and schemes in order to create the capacity and capability for the Trust to maintain appropriate service delivery. This Winter Resilience Plan provides the holistic awareness required for the Trust Command and Control structure to coordinate the numerous work strands that will be required over the winter.

The plan this year comprises of:

- Schemes and initiatives to mitigate operational pressures by reinforcing patient pathways to meet demand, by maximising inpatient bed availability and maximising patient discharges in a timely manner;
- Schemes and initiatives to maximise the capacity, capability and availability of the workforce by increasing workforce and reducing staff absences and sickness.
- Implementing robust surge plans to escalate and de-escalate wards in response to COVID-19 inpatient demand.
- Monitoring and maintaining reset and recovery activity whilst simultaneously responding to operational pressures.
- Maintaining robust Business Continuity plans to respond to seasonal incidents whilst responding to high levels of operational pressure.

Recommendations

The Board is requested to:

- Note the significant and comprehensive planning that has been conducted to mitigate the multiple work strands that will be implemented this winter.
- Note the £1.153M expenditure identified to deliver specific Winter Schemes (see Appendix 1).

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Director Sponsor: Wendy Scott, Chief Operating Officer

Date: 17th September 2021

1. Introduction and Background

The Winter Plan in previous years has comprised of a number of schemes and initiatives that are implemented to mitigate operational pressures from December to March. The requirement to coordinate the Trust response to the COVID-19 Pandemic in addition to mitigating winter operational pressures and risks such as EU Exit have necessitated a more holistic approach to winter resilience; this year is no different.

Clear direction from HCV ICS has been received for the preparation of winter plans. Incorporating the guidance from HCV ICS and building on the holistic approach to responding to operational pressures the Winter Resilience Plan 2021-2022 will describe the plans and initiatives that will be implemented to mitigate risks. The plan will also describe the command and control arrangements to implement the response, will describe the specific winter schemes and provide links to any supporting documentation.

The plan has been endorsed by Executive Committee in September 2021.

2. Humber Coast and Vale ICS Direction

HCV ICS has directed that Winter Resilience Plans should adopt the following principles:

- **Surge and Escalation**. Ensure Command and Control arrangements, resilience plans and Operational Pressures Escalation Levels (OPEL) frameworks meet organisational needs and contribute to system and ICS plans. Escalate early in anticipation of surges in demand; ensuring critical care capacity is in place to deal with routine winter pressures, potential surge in COVID-19 cases and align plans with recovery and restoration of planned care; collaborating with local authorities, ambulance services, primary care and community services to monitor illness patterns in the local community and weather changes that may affect specific patient cohorts, ensuring that health inequalities is integral to all plans.
- **Paediatric Respiratory Infections.** Be able to respond to the increase and expected surge in RSV/Childhood respiratory infections.
- **IPCC Management**. Systems should plan for COVID-19 as part of Business As Usual (BAU) arrangements and ensure the impact of outbreaks is minimised and managed.
- **Robust testing.** Including routine testing for staff and inpatients, and sufficient rapid point of care testing within ED.
- **Vaccination** – Build upon success of the flu campaign and COVID-19 vaccination roll out, including plans for any future COVID booster requirements.
- **Staff Support and Wellbeing**. Arrangements should be in place to support a resilient workforce.
- **Clinical engagement and leadership.** System wide engagement in the ongoing development of plans and oversight.
- **Communication plans.** Development of plans with system partners and the public to influence behaviour.

The full HCV ICS planning guidance can be accessed here: 

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2. Risks and Mitigation Summary

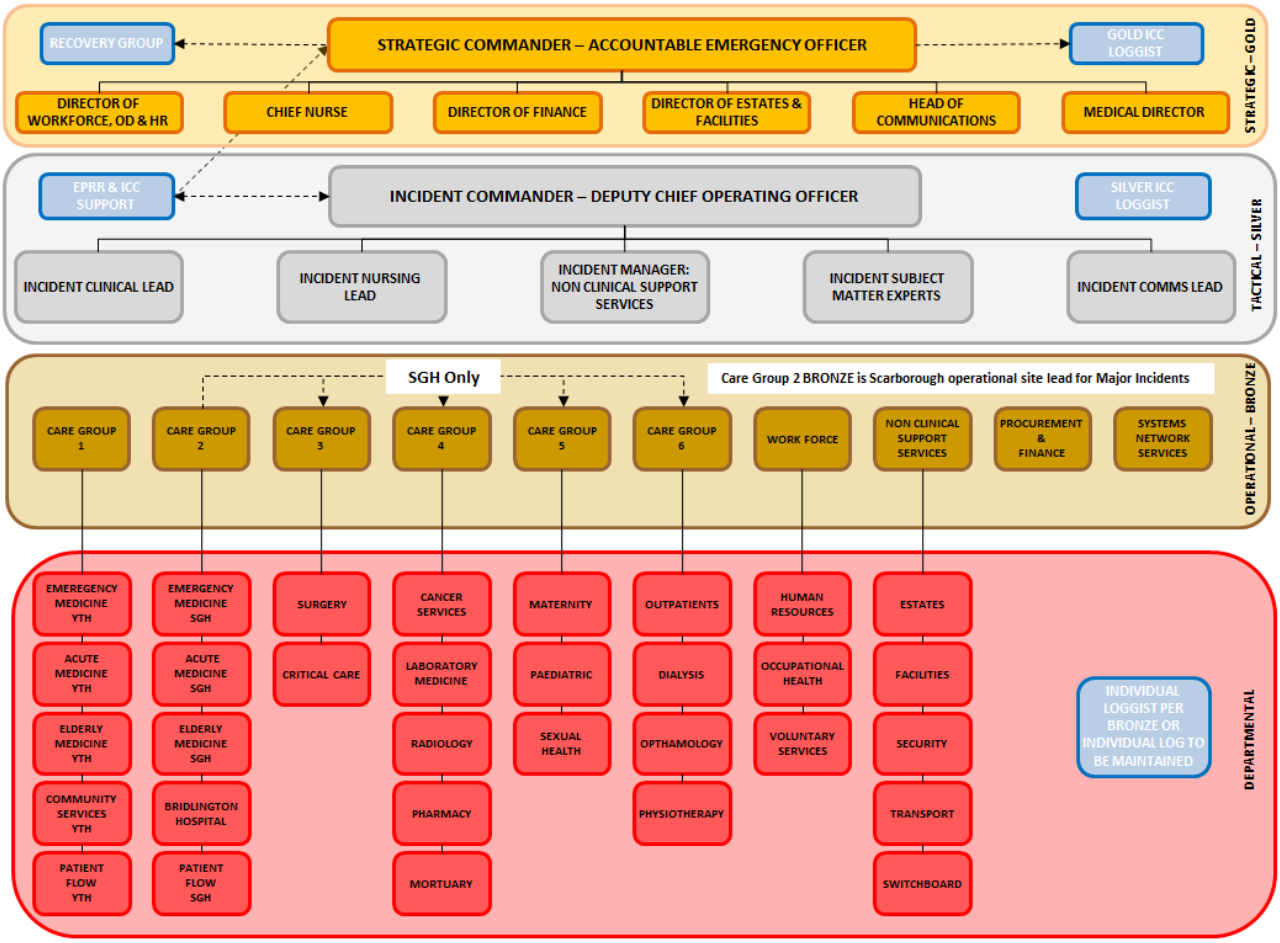
A summary of the risks to service delivery over the winter period are articulated below. The measures identified to mitigate those risks are listed in column (d) and are linked to the appropriate paragraph in this plan.

Ser	Risk Title	Risk Description	Winter Resilience Plan Mitigation Measure

(a)	(b)	(c)	(d)
1	Operational Pressure – Demand and overcrowding	The volume of ED presentations overmatch the capacity of ED increasing the time patients are seen in ED and the waiting times for an inpatient bed.	• Reinforce patient pathways – Winter Schemes • Trust OPEL Framework
2	Operational Pressure – Bed Availability	The volume of patients requiring inpatient beds overmatches the Trust bed stock. An increased closure of beds to infectious disease reduces the availability of Trust bed stock.	• Command and Control – Battle Rhythm • Hospital Outbreak Management
3	Operational Pressure - Discharges	Inpatients are not discharged into packages of care and local authority care homes in a timely manner. The availability of the Trust bed stock is reduced.	• Discharge Command Centres • System Collaboration
4	Workforce Availability	The availability of the workforce is reduced due to sickness, annual leave and the requirement to self-isolate thereby reducing the staff levels on patient pathways. This will result in a reduction of patient flow through patient pathways.	• Trust Vaccination Plans • Hospital Outbreak Management • Communications Plan
5	COVID - 19	The level of hospitalisations for COVID-19 increase resulting in the requirement to further enact the surge plan by opening more COVID wards and more COVID ICU beds.	• Ward Escalation Plan • ICU Escalation Plan
6	Recovery	The escalation measures required to respond to COVID-19 hospitalisations result in a reduced number of beds available for elective work to continue as per the recovery and restoration plans.	• Managing the Elective Programme
7	Business Continuity	Severe cold weather events increase the levels of attendance of patients to ED and restrict the ability of staff to travel to work and for work purposes.	• BC Plan • Adverse Weather Plan

3. Command and Control

The Winter Resilience Plan 2021-22 will integrate the incident management command and control structure with the routine operational management processes to improve Trust situational awareness across all sites, to facilitate internal mutual aid and to initiate any requests for / offer of external mutual aid. The structure will operate as follows:



3.1 System Collaboration

System winter preparations began in the Spring with a HCV Urgent and Emergency Care workshop to review the Winter Resilience Plans and to identify individual and collective learning. The Scarborough and York Health and Care Resilience Board coordinates the plans of health and social care partner and the system plan was sumbitted by 16 September 2021.

Collaboration with system partners will be achieved through the submission of Organisation Exception Reports to report operational pressures, implementation of business continuity plans and elective activity cancellations from the Incident Coordination Centre to the HCV Locality Team when required; weekly meetings with system partners to escalate discharge delays to the System Discharge Coordinator; weekly System SILVER Leadership Executive meetings to maintain situational awareness, explore possible mutual aid and adjust Winter Resilience Plans as required.

3.2 Winter Battle Rhythm

The Trust weekly routine meetings will coordinate activity over the winter period and will take place as follows:

- **SILVER Briefings.** A full briefing by the SILVER Commander to all BRONZE Commands will take place at 1000hrs every Monday and Thursday. The focus will be to reflect on issues / escalations from the weekend, for BRONZE Commands to brief on their activity and issues and to plan for the weekend ahead. Additional daily SILVER briefings will be scheduled according to operational activity and levels of escalation.
- **Operational Meetings.** Operational meetings will take place on both sites as usual at 0900hrs and 1500hrs, with additional meetings scheduled according to the site pressures and OPEL level.
- **Handover to Weekend On Call Management Team.** A WEBEX handover to the Weekend On Call Management Team will be held at 1600hrs every Friday. It will be chaired by the SILVER Commander and will be attended by 1st and 2nd On Call Mangers for both sites for Friday, Saturday and Sunday (and Bank Holidays), IPC representatives and the duty Procurement manager for the weekend.
- **Additional Managerial Support at Weekends.** An Operational Manager will be rostered on each site between 0800-1430hrs on each weekend and bank holiday. This will provide continuity and operational oversight until the 1st On Call Manager arrives on site circa 1400hrs when a handover is conducted.
- **Trust Operational Performance Escalation Levels (OPEL) Framework.** The Trust OPEL Framework is part of the system escalation processes with partners, contributing to the system Resilience Plan for 2021-22. The framework supports BAU arrangements at OPEL 1, with a series of actions to be taken as the escalation levels rise, supported by corporate actions internally and equivalent plans in partner organisations. The response is led by the Care Groups and coordinated by the Corporate Operations Team.
- **Local Authority Outbreak Control Plans.** The City of York and the North Yorkshire COVID-19 Outbreak Control Plans aim to provide central frameworks to preventing and controlling outbreaks of COVID-19 and reducing the spread of the virus. The Local Authorities lead the Outbreak Control meetings (the Trust is a member), ensuring that the

Winter Plan 2020-21 coordinates with the plans, especially regarding the impact of the national and local Test and Trace services.

4. Patient Pathways

The main winter operational pressures are: high levels of non-elective attendance / admission, availability to stream patients to alternative services and appropriate specialities, availability of inpatient beds and levels of discharges. The impact of COVID-19 will further complicate the winter

operational pressures. The Trust has prioritised a number of schemes which reinforce plans to manage these issues during the winter period by creating additional capacity and capability. The focuses of these schemes are:

4.1 Managing Acute Demand - Streaming and Ambulatory Care

The Trust has now embedded Same Day Emergency Care (SDEC) services and embraced the 'assess to admit' approach, integrating them into BAU models. The Trust continues to expand the availability of alternative services to admission and continues to work with the Urgent & Emergency Care Network to accelerate further developments. This includes the ICS implementation of the national Talk Before You Walk (TBYW) / NHS 111 First programme, a local CAS provision and direct booking by NHS111 to ED and UTC. We continue to stream at the front door of the EDs and further work will enable direct referral and booking by primary care and the ambulance service to SDEC services. Additional plans to develop community SDEC models are emerging to enable the provision of a 2 hour community crisis response to respond to patients who are at risk of deterioration leading to admission to a hospital or a care home. All of these ambulatory pathways allow patients to receive treatment without the need to stay in hospital overnight.

4.2 Managing Discharges - Discharge Command Centre

The establishment of the Discharge Command Centres on both sites during the COVID-19 response has been successful and is now well established as BAU. The Centres are multi-disciplinary and supported by the system health and social care partners. The Centres now operate a coherent approach for discharging patients seven days a week. A System Discharge Coordinator is now embedded in the process and is in daily/weekly dialogue with Trust colleagues; in addition the post provides a focus for the escalation of discharge issues to the System Executive Leads.

The Trust continues to support a Home First approach. Several schemes are now established as BAU but still benefit from further development and / or extension (eg. SAFER, the community based intravenous antibiotic service and the community sub-cutaneous fluids service).

4.3 Managing Paediatric Demand - Paediatric Escalation

The child health team have worked with local and regional partners since the beginning of June to share intelligence in relation to any potential paediatric respiratory surge as a consequence of COVID-19 and the impact of the COVID response on non-COVID respiratory illness in children and young people, particularly those under 5 years old, based on the experience of the southern hemisphere earlier in the year.

The headlines from resilience planning to date are:

- The Yorkshire and Humber Paediatric Critical Care ODN has worked with the Trust to confirm the arrangements for paediatrics critical care beds across the region and the requirements for each acute provider to be as resilient as possible in relation to managing higher acuity within their services. The Trust is investigating the resourcing of extra critical care equipment to provide further resilience in Scarborough.
- The Care Group has confirmed the resilience schemes for child health which support additional capacity across both sites, July – March, supported by COVID funding rather than winter funding as the surge period has already started as a direct consequence of COVID.
- The Trust escalation and surge plans have been refreshed to incorporate the paediatric respiratory surge plans and confirms trigger points.
- The team are also joining and contributing to the HCV ICS Paediatric Respiratory Syncytial Virus primary care group meetings weekly, including supporting some initials ideas for a proposal for a pilot for managing early RSV / Respiratory illness in young children with a specialist children's nurse led community based intermediate / ambulatory care service for acute respiratory disease in children. The service aims to provide safe supported care and management of young children with respiratory viral

disease at home / in their local community setting, preventing unnecessary attendance at ED and supporting primary care in the care and management of children with respiratory viral disease.

4.4 Winter Schemes

The winter schemes have been developed over the summer through the SILVER Command forum. Care Groups and services have submitted schemes, prioritisation has taken place and the schemes have been rationalised to achieve a scheme total of £1.153M; evidence from past planning rounds indicates that this will deliver an actual spend to the control total of £1M. Details of the schemes for 2021/22 include a description of the scheme and expected impact, as well as measures of success; the summary can be found at Appendix 1.

5. Operational Pressure Escalation

Operational pressure escalation is manged regionally in the North Yorkshire and York System Escalation and De-escalation Response Plan; this can be found here: NYY System Surge Escalation_2021_22....

The Trust manages operational pressure escalation through the daily patient flow operational meetings in hours and the On Call Manager system out of hours articulated in the Trust OPEL Framework. Plans to mitigate operational pressures at all levels are set out in the form of action cards for the use by wards, clinical staff and On Call Managers; they can be found here: OPEL Action Cards and Quick Links v4 3....

6. Management of Hospital Outbreaks

A COVID-19 hospital 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.

COVID-19 results are sent twice daily from the labs directly to the IPC team. These results are tracked back to areas where they are linked to; if the cases in a given area meet the definition of an outbreak an outbreak meeting is convened. The outbreaks are highlighted to BRONZE and SILVER Commands via routine meetings. Outbreaks are also notified Trust-wide through the outbreak notification emails sent out twice daily. Outbreak meetings are convened and involve the IPC team, a microbiologist, clinical teams, Occupational Health, Facilities and Care Group leads to ensure all actions involving patients and staff are managed and coordinated through the outbreak control group. All outbreaks are reported electronically on the NHSE/I outbreak portal; and updated weekly up to 28 days when PHE NHSE/I stipulates as the end of an outbreak if no further cases are identified.

Other initiatives to continue throughout winter include:

- Mitigations at Trust level involve maximised testing of both patients and staff to identify any asymptomatic cases.
- Social distancing of beds in clinical areas has been challenging due to rising admission numbers and other services restarting at full capacity. To mitigate this, Quality Impact Assessments (QIA) have been developed by Care Groups and agreed at Quality Committee so that patients are protected whilst meeting increasing operational demands.
- Visiting is restricted where outbreaks have been identified in order to reduce footfall and reduce on-going transmission.
- Staff are restricted from working between RED wards and AMBER wards within the same day to prevent any potential transmission.
- The Trust has dedicated COVID-19 wards and any patients identified to be positive are transferred to the COVID wards.
- Ventilation in clinical areas is mostly reliant on natural ventilation with Air Handling Units only provided in rooms used for high risk procedures such as Aerosol Generating Procedures (AGPs) and patients who are positive for COVID-19.

7. COVID Escalation Plans

The Trust is well into the 3rd wave of responding to the COVID-19 pandemic. The response has been refined through the lessons learned process and with a clear, robust and well understood Command and Control structure the Trust has the agility to escalate and de-escalate in response to COVID-19 admissions in the following ways:

7.1 Ward Escalation

COVID-19 inpatient numbers are monitored on a daily basis at the SILVER Command meeting. Care Groups escalate concerns and SILVER make recommendations to escalate or de-escalate the number of COVID wards on each site to GOLD Command. Escalation and de-escalation actions are best conducted during the week negating the requirement for weekend On Call teams to reorganise the hospital bed base. Weekend On Call briefings include details of how to implement the next stage of the Trust Surge Plan; this can be found here .

7.2 ICU Escalation

ICU capacity is monitored on a daily basis at the SILVER Command meetings and the escalation measures are articulated in the Trust Surge Plan. The requirement to escalate ICU beds as the COVID19 admissions increase and decrease will operate on the following principles:

- Utilisation of CPAP & NIV including daily monitoring of capacity.
- Initial COVID escalation is managed in side rooms and mutual support across sites.
- ICU floorplans will then be reorganised to provide COVID and non COVID areas.
- Extreme COVID pressure escalation will be achieved by moving into PACU and utilising appropriately trained staff from areas out with of ICU.
- York Hospital is the primary site for ICU COVID capacity and will conduct liaison with Scarborough Hospital to maximise ICU COVID capacity.

7.3 Workforce Escalation

The Trust Surge Plan sets out its staffing requirements to operate an increased number of COVID beds in line with demand. The sequence for redeployment of staff from other services is set out therein, along with the implication for the services they support. Through the Trust Command Structure, staffing levels are monitored via local BRONZE Commands and Trust-wide surveillance mechanisms (Matron of the Day and Associate Chief Nurse of the Day). Any issues which cannot be addressed either locally or in line with existing plans are reported to SILVER Command (which includes a SILVER Nurse and SILVER Medic) so that appropriate action can be considered (e.g. incentive payments for Bank shift pick-up, reduction in service to support redeployment). Where there are implications for the provision of services due to staff shortages, the SILVER Staff Officer will ensure regional/national reporting is submitted as required.

The workforce challenges have been significant in the months of August and September as annual leave, school holidays and the requirement to self-isolate has seen unprecedented levels of staffing in the Trust services. The SILVER coordinated surveillance of staffing levels has worked well and the early establishment of working groups chaired by the SILVER Nurse and supported by the Associate Chief Nurses has delivered mitigation options for SILVER to escalate to GOLD as required. Daily review of incentives and the standing down of services to redeploy staff has been possible in a timely manner and with full impact awareness. The command and control system, supported closely by the Workforce BRONZE Command and coupled with a comprehensive communications plan has allowed mitigations to be employed and amended swiftly.

It is envisaged that workforce challenges will endure through the winter and there will be a continued requirement for SILVER to coordinate the development of innovative strategies to maintain safe levels of care across the Trust.

7.4 Managing the Impact on Elective Services

The Trust Plan for elective work is seasonally planned to support urgent care pressures over the Winter Period, with a planned reduction in ordinary electives January-March to support a winter ward and reduction in day case activity through December-March to reflect increased Non-Elective surgery pressures. Additional cancellations may occur due to staff shortages or bed shortages. This is managed through the site daily operational meetings and OPEL framework.

At all times the Trust will apply the Trust Access Policy, with patients treated in order of priority for life saving and urgent cases; and then in chronological order by speciality for 'routine' patients. There must be a clinical review and decision of which patients to suspend or cancel where lists have been booked.

The Trust has an approved Elective Stand-down Standard Operating Procedure where the Trust exceeds control limits in relation to COVID or workforce pressures requiring pro-active cancellation of elective work to support urgent care pressures. This is enacted through the COVID Command and Control structure. The SOP may also be enacted through the Executive Committee or Chief Operating Officer on behalf of the Executive Committee through OPEL escalation in the event that the COVID Command and Control structure is stood down.

8. Co-ordinating Instructions

8.1 Trust Vaccination Plans

The Trust is making plans to conduct seasonal flu vaccinations, to continue COVID19 vaccinations and to respond to any national direction on COVID-19 booster vaccinations that maybe required. The vaccination programmes will run from 09 September 2021 to 14 December 2021. The intent is to take learning from previous years in relation to "flu" but to apply the same model as last year (i.e. peer vaccinator model). Lessons from previous seasonal flu campaigns have been identified, high risk areas have been nominated and staff incentive schemes have been developed.

National guidance is still awaited regarding COVID-19 booster vaccinations and options have been identified for the delivery of the campaign; this will be dependent on how the vaccine can be administered. Executive Committee has approved a paper which describes these plans.

8.2 Business Continuity and Adverse Weather Plan

The Trust Adverse Weather Plan was revised in March 2021 and provides action cards for dealing with cold weather and how to access 4X4 vehicles for staff to travel to / for work. Details of how Business Continuity incidents are escalated into Critical and Major Incidents are laid out in the Trust Business Continuity Plan.

8.4 Communications Plan

The communications team will be supporting a comprehensive approach to sharing the key messages regarding this year's winter schemes, building on previous year's and lessons learned.

Key messages will be cascaded across the Trust via the existing communications channels including Chief Executive's The Week Ahead, the monthly Staff Brief, the weekly staff bulletin, and accompanied by screensavers. Where appropriate the Trust's social media channels will also be used to share key messages for staff.

Regular updates will be shared throughout the winter period, utilising the all staff weekly bulletin - detailing updates and changes to the plan, what's working well, areas of focus/challenge and where we have listened and acted upon staff feedback.

In addition, there will be a dedicated 'Winter schemes' section on Staff Room, which acts as a one stop shop for information, local plans and resources.

Internal plans will see the plan briefed at a range of key forums including the Executive Board and key BRONZE Command meetings.

Associate Chief Operating Officers will take the lead in ensuring staff in their Care Group are briefed on the plans specific to their own area of work.

Externally, the Trust will continue to work with system partner organisations to deliver a system-wide communication plan. This will focus on preventative messages, infection control good practice, vaccinations and signposting alternatives to the Emergency Department.

9. Summary

The complexity of winter operational pressures has increased incrementally year on year with the added pressure of managing the COVID-19 pandemic. The Winter Resilience Plan is no longer a plan to implement schemes for the duration of the winter season but a plan that draws together the responses required in multiple areas across the Trust and the local system in order to deliver robust service delivery.

10. Recommendations

The Board is requested to:

- Note the significant and comprehensive planning that has been conducted to mitigate the multiple work strands that will be implemented this winter.
- Note the £1.153M expenditure identified to implement specific Winter Schemes (see Appendix 1).

Appendix 1 – Winter Planning

Winter Schemes 2021 - 2022 (Version 4)

PRIORITY 1

Ser	Care Group	Scheme Detail	CG Lead 2021-22	2020 - 2021 Plan			Dec 20 - Mar 21 Expenditure			2021 - 2022 Plan			Expected Impact of Scheme	Measure of Success	Notes
				FY 20-21 (Dec - Mar)	FY 21-22 (Apr +)	Total	Budget	Actual	Variance	FY 21-22 (Dec - Mar)	FY 22-23 (Apr +)	Total			
1	1	CRT - staffing	Laura Robson	150,000	50,000	200,000	150,000	150,000	0	150,000	50,000	200,000	Continue to provide additional capacity to support delivery of the national standard of all rehabilitation discharges commencing within 48hrs of referral (local ambition remains for same day discharge - or next day for later referrals), maintaining capacity for admission avoidance and continued ambulance diversionary pathways.	Waiting time data for starting CRT; activity data (referrals/contacts)	Already in post Billing VoYCCG in excess of this match to plan
2	1	ED - FY3 /CT ED jnr doc additional evening shifts	Billie Cameron	26,318	13,159	39,477	26,318	26,318	0	26,318	13,159	39,477	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to see a doctor in ED	Filled using bank/locum
3	1	Additional overnight acute floor doctors - York	Jamie Todd	167,400	41,040	208,440	167,400	18,095	149,305	83,700	20,520	104,220	To ensure all patients are seen and clerked in a timely manner to avoid delays to patients care	Clerking times	Filled using bank/locum as able JT reduced totals by 50% - 290721
4	1	ED - Senior streamer at front door (10 hours - 7 days a week)	Billie Cameron	0	0	0	0	4,250	-4,250	33,620	16,810	50,430	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to streaming, number of patients streamed away from the dept	Appointed 0.8 L Palmer 01/02/21
5	1	Extra Physio for Pulmonary rehab and resp out patients	Sally Ann Richardson	19,495	0	19,495	19,495	19,495	0	19,495	0	19,495	Timely intervention		Need to ensure we start recruitment early enough to catch the recently graduated AHPs
6	1	Additional Elderly Consultant Weekend cover	Jamie Todd	18,900	0	18,900	18,900	22,950	-4,050	20,000	0	20,000	To maintain elderly medicine cover and process through the weekend	Reduced performance dips during the weekend	Filled with ECPs as necessary JT reduced to 20K - 270721
7	1	Additional Gen Med Consultant Weekend cover	Jamie Todd	18,900	0	18,900	18,900	21,000	-2,100	20,000	0	20,000	To maintain general medicine cover and process through the weekend	Reduse performance dips at the weekendn	Filled with ECPs as necessary JT reduced to 20K - 270721
8	1	ED Consultant non-admit stream	Jamie Todd	**Scheme not run 2020 -2021**			N/A	N/A	N/A	178,500	0	178,500	To reduce waits in ED and improve the patient experience particularly for patients who do not require admitting to the hospital	Improved ECS, reduced waits for non-admit patients within ED	New scheme, approx £125 per hour
9	1	RATS team B5 OT and PT	Sally Ann Richardson	**Scheme not run 2020 -2021**			N/A	N/A	N/A	22,914	0	22,914	to aid turnaround of additional ill patients in ED over winter		
10	1	Downstream wards B5 OT and PT	Sally Ann Richardson	**Scheme not run 2020 -2022**			N/A	N/A	N/A	22,914	0	22,914	Previous winter staff were seconded to wards during crisis proved to improve rate of discharges	Shorter LOS for downstream wards	
11	1	Virtual Respiratory Ward - Delivered by the Respiratory nurse specialists as it was during COVID.	Piper Wiles	**Scheme not run 2020 -2023**			N/A	N/A	N/A	28,782	0	28,782	Prevent patients staying on respiratory wards and be able to recover at home sooner.	More respiratory patient managed outside hospital	2x WTE B6 nursing **Link to OPAT expansion serial**
12	1	Care home support; Selby team to have more care home support / investment.	Piper Wiles	**Scheme not run 2020 -2024**			N/A	N/A	N/A	28,643	0	28,643	Prevent admissions into hospitals, keeping patients in a home whilst they recover.	Allow quicker flow from IPU into care homes	2.5 WTE B5 nurses
13	1	AHP provision to support a 7 day service to patients in IPU's.	Rachel Anderson	**Scheme not run 2020 -2026**			N/A	N/A	N/A	58,850	0	58,850	Community hospitalsarrivals with higher dependency than before will recieve an initial AHP assessment or rehabilitation over the weekend rather than waiting until the following Monday morning.	Providing patient care will have animpact on patient progress, speed of recovery and therefore reduce hospital length of stay.	Equivalent to 1.60 WTE B6 & 1.60 WTE B3 in total.This would equate to an overall investment of £12,426 per month (£62,130 for the period November – March 21),
14	2	Additional Middle Grade to support weekend discharge 12 hours per day (0800-2000 Sat and Sun)	David Thomas	22,400	11,200	33,600	22,400	22,698	-298	22,400	11,200	33,600	Continuous discharge process from 0800-2000	Number of discharges over the weekend	
15	2	ED - Ambulance handover senior nurse (Band6) (10 hours - 7 days a week)	David Thomas	33,620	16,810	50,430	33,620	62,032	-28,412	33,620	16,810	50,430	Maintaining timely ambulance handovers	Ambulance handover performance	
16	3	Ward 39 Staffing Increase	Liz Hill	**Scheme not run 2020 -2021**			N/A	N/A	N/A	0	0	0			**CG3 to provide indicative costs** **LH reports this cost is likely to be the difference in staffing costs between an Ortho ward and an elderly ward. Further discussions to determine if there is a cost - 290721.**
17	4	Pharmacy Support to Critical Care (1 WTE B7)	Liz Hill / Kim Hinton	**Scheme not run 2020 -2021**			N/A	N/A	N/A	17,069	51,206	68,274	Increased pharmacy support for critical care is required to manager the increased demand for critical care over the winter period	Reduction in medicatio errors, free up medical staff time, improved antimicrobal stewardship, cost saving through optimal drug use and waste reduction	Hard to recruit fixed term post, locum would be at 8a, propose permanent post at lower band 7, more cost effective than locum wages

18	4	Pharmacy Service in ED (York) - To develop an ED pharmacy service 5 days a week for a 6 month period.	Kim Hinton	N/A	N/A	N/A	N/A	N/A	N/A	26,086	0	26,086	Reduce prescribing errors for admission medicines • Release time to care for medical staff in writing up new medicines • Improve flow for discharge of ED/SDEC patients • Reduce missed doses of critical medicines for patients in ED	1. qualitative impact of pharmacy team advice to staff in ED, education and training of ED staff on medicines. 2. Reduce prescibing errors for admission medicines 3. reduce missed doses of critical medicine for patients in ED	Two options are presented for consideration: **Option 1:** Recruit 1WTE B7 locum pharmacist and 1WTE B5 locum technician at a cost of £81,088, with both posts recruited to from 1st October-21. However, locum posts will be difficult to recruit to for 6 months and there are alternative, better value for money options (see 2 below). **Option 2:** Recruit substantively to 1WTE B7 pharmacist and 1WTE B5 technician at a cost of £78, 259 per annum, with both posts recruited to from 1st October-21. Substantive posts are much easier to recruit in to, and would provide continuity of service year round and deliver additional benefits - a better value for money option that option 1. Option 1 is deemed essential, option 2 is deemed desireable. **Option 2 is preferred.** KH reduced total to Option 2 and 4 months - 290721
19	4	Support acute flow at SGH by deliving 7 day ultrasound	Kim Hinton	**Scheme not run 2020 -2021**			N/A	N/A	N/A	16,592	4,880	21,472	Late Friday and weekend acute patients requiring ultrasound are currently required to wait until at least Monday due to no weekend service at SGH - this would reduce delay for the patient and improve upon US turnaround times.	Reduced patient stay Reduced turnaround times for US	2 x B7 Sonographer, 1 x B2 Support Worker and 1 x B2 Porter required and costed. Funding pays for the required 3 hour shifts on Sat/Sun between December and April.
20	6	OPAT Expansion	Karen Cowley	92,560	0	92,560	92,560	89,763	2,797	203,772	50,943	254,715	Reduced LOS for patients on IV antibiotics who are otherwise fit to be discharged.This will allow for an extended working day 8-8 and weekend working 8-4 therfore providing a 7 day a week service with the possibility of on-call rota until 10pm.	LOS, increased patients under OPAT service	1.2WTE B7, 4.8WTE B6, 0.6WTE B3 A&C
21	6	Orthopaedic Elective work	Karen Cowley	341,138	0	341,138	341,138	182,491	158,647	81,762	20,440	102,202	This scheme will release the usual additonal winter ward required whilst maintaining elective orthopaedic work and maintain recovery of the elective programme post COVID	Number of elective cases completed compared to previous winters and impact on elective recovery of Orthopaedic wait times	2WTE RN, 1WTE ODP, 1WTE Jnr Doc
22	DIS	B7 Analyst 0800-1200 Sat & Sun to support Weekend UEC and Covid SITREP reporting (21 weekends & 5 Bank Holidays)	Nicky Slater	**Scheme not run 2020 -2021**			**Scheme not run 2020 -2021**			7,314	1,828	9,142	Ability to provide nationally mandated SITREP reporting	Deadlines achieved	
23	Corp Ops	Twilight Transfer Team	Fiona Sharpe	27,995	0	27,995	27,995	9,823	18,173	15,663	7,831	25,494	Improve transfer of patients in the late afternoon/evening period	Reduced RFT to bed time	
24	Corp Ops	Additional DLO Support	Fiona Sharpe	23,574	0	23,574	23,574	19,040	4,534	23,574	0	23,574	Prep of patients for discharge to enable better flow trough acute side of hospital	Improved ECS and early discharges	
25	Corp Ops	B7 Ops Manager 0800-1430 Sat & Sun to support On Call Management (21 weekends & 5 Bank Holidays)	Melanie Liley	11,885	2,971	14,856	11,885	11,884	1	11,885	2,971	14,856	Improved command and control over the weekend and bank holidays to support patient flow.	On Call Manager and Care Group feedback	
				954,185	**135,180**	**1,089,365**	**954,185**	**659,839**	**294,347**	**1,153,473**	**268,598**	**1,424,070**			

Appendix 1

North Yorkshire & York
System Resilience / Winter Planning
2021/22

Context (1)

Winter 2021/22 will be challenging – we will be expected to support the NHS recovery programme and ensure continued application of UK Infection Prevention and Control guidance to prevent and control COVID-19 infection.

Context (2)

NHSE are not wishing to be prescriptive with winter planning arrangements for 2021/22 and acknowledging that this is an iterative process and systems will need to adapt plans due to the competing demands as a result of the Covid-19 pandemic.

We are required to review and revise our planning, surge and escalation processes taking into account the learning from last the last 12mths.

Planning for Winter 2021/22
Principles to be adopted

- Systems should plan for COVID as part of Business As Usual arrangements
- Review command and control arrangements to support system escalation
- Staff Support and Wellbeing arrangements should be in place to enable a resilient workforce
- Evaluation of system wide learning from the previous winter to inform future planning including Operational Pressures Escalation Levels Framework (OPEL)
- Escalate early in anticipation of demand surges, not in response to them. e.g. collaboration with ambulance services and primary care to monitor illness patterns in the local community and weather changes that may affect specific patient cohorts
- Early identification of winter schemes (funding position tbc)
- Consideration of impact of wider transformational schemes on system plans
- System wide clinical engagement and leadership in the ongoing development of plans and oversight
- Development of communication plans with system partners and the public to influence behaviour
- Health inequalities integral to all plans

Considerations following learning from Covid

- **IPCC management**. Plans need to ensure the impact of outbreaks is minimised and managed. Regional learning to be shared with systems; consideration of cohorting and social distancing requirements
- **Vaccination** – to build upon success of this years flu campaign and Covid vaccination roll out and plan for any future Covid booster requirements
- **Critical care capacity -** Ensure enough critical care capacity is in place to deal with routine winter pressures, potential surge in Covid cases and to maintain recovery and restoration of planned care.
- **Paediatric Respiratory Infections** - Response to increase and expected surge in RSV/Childhood respiratory infections.
- **Robust testing -** Including routine testing for staff and inpatients, and sufficient rapid point of care testing within ED
- **Recovery -** Resilience plans needs to be aligned with recovery and restoration plans.
- **Surge and escalation – r**esilience plans must cover organisation, system and feed into ICS plans

Winter Planning 2021/22

Plans should (1):

1. include a brief overview of the system including geography, partner organisations and governance arrangements
2. include details of any risks and mitigating actions identified for 2021/22

Plans should (2):

3. include plans for flexing capacity that can be increased in the event of surge across the acute, community, residential / home care sectors and packages of care. This should include agreed multi-agency triggers for extending and withdrawing this extra capacity
4. ensure collaborative operational planning with social services and mental health services

Plans should(3):

5. Include a comprehensive local flu vaccination strategy and comprehensive local covid-19 vaccination strategy
6. Include a managed outbreak plan to avoid (and contain) any D&V / influenza / norovirus impact
7. ensure arrangements are in place to deal with COVID surge or outbreak

Plans should (4):

8. include plans for how primary care will work with the rest of the system to support the management of flow, particularly on Bank Holidays and out of hours and GP OOHs provision have plans for activity peaks
9. include robust plans for ambulance services and NHS 111 providers to deal with known activity peaks in demand across the period

Plans should (5):

10. include a comprehensive plan relating to staffing issues for system partners
11. ensure system demand and capacity planning needs have been conducted and tested before the end of September 2021 (8th Sept NHSEi scenario testing event). This should help local systems work together more closely to meet workforce demands during peak periods and avoid outbidding each other for locums especially during the November 21 to March 22 period

Plans should (6):

12. include an adverse weather plan which considers the clinical impact of cold weather and snow and also the impact on business continuity for example
    a. 4x4 driver schemes to support staff in adverse weather
    b. Staff availability and how to support
13. include cascading advance warnings and briefings with a focus on admission prevention amongst high risk groups. *Examples may include Met Office warnings of cold weather*

Plans should (7):

14. include system wide escalation plans in line with the national framework with agreed local multi-agency triggers for escalation and de-escalation
15. include an in hospital escalation plan supported by systems with measures in place to include the use of full capacity protocols to minimise ambulance queues and improve patient flow out of EDs
16. include plans / processes for system-wide operational sitrep / early warning and escalation reporting. This should include weekend reporting between December 21 and March 22 (tbc)
17. include operational and executive level CCG, provider and local authority on call arrangements
18. include a multi-agency proactive and reactive communications plan to promote appropriate use of local services
19. include arrangements for mutual aid

Plans should (8):

20. ensure there is a clear process for primary care referrals (including OOH) to acute specialties to bypass ED. There should be alternatives to immediate referrals, including 'hot' clinics e.g. primary care streaming models and details on navigation processes
21. ensure UTCs are fully compliant with standards and utilised effectively - utilisation of the enhanced profile where possible
22. ensure all the information within the Directory of Services is up to date and well connected with relevant ambulance service
23. ensure that EDs have sufficient clinical input from surgical and clinical specialities
24. ensure that intermediate care is sufficiently resourced and community services can meet the increased demand over winter including step-up/step-down beds and workforce capacity

System plans should include effective discharge processes ensuring:

25. full implementation of the Discharge to Assess model in line with discharge policy percentages
26. evaluation of use of national discharge funding to help inform challenges in the system and system solutions
27. daily morning ward rounds informed by the criteria to reside to avoid delay and improve outcomes for people
28. prompt transfer from the ward (1 hr for pathway 0 and same day all others)
29. onward transfer from discharge area - aim for majority in 2 hrs or same day
30. accurate data recording in line with Acute and Community SitRep requirements

A mechanism to test these arrangements ahead of the final plan submission.

Regional scenario testing - scheduled date 8th September 2021

Prevent inappropriate attendance at ED

- Every system is asked to set out plans to accelerate the roll out of the two-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022
- Promote NHS 111 as the primary route into all urgent care

Improve timely admission to hospital for ED patients

- Maximise the use of booked time slots into A&E, with an expectation that at least 70% of all patients referred to an Emergency Department by NHS 111 receive a booked time slot to attend
- Maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
- Adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 Emergency Department to avoid unnecessary hospital admissions

Reduce Length of Stay

Systems are expected to confirm the continuation of the discharge to assess policy, and work towards improving length of hospital stays, with a particular focus on stays of between 14 and 21 days.

(Position on funding additional care from an NHS setting post September yet to be confirmed)

Implementation of ECDS V 3.0

- To assist the transformation of the urgent and emergency care (UEC) pathway, better understand pressures and monitor recovery, trusts are asked to roll out the Emergency Care Data Set to all services and begin to collect data for a set of new measures tested as part of UEC clinical review of standards.
- Systems are asked to measure:

  -the time to initial assessment for all patients presenting to A&E

  -the proportion of patients spending more than 12 hours in A&E from time of arrival

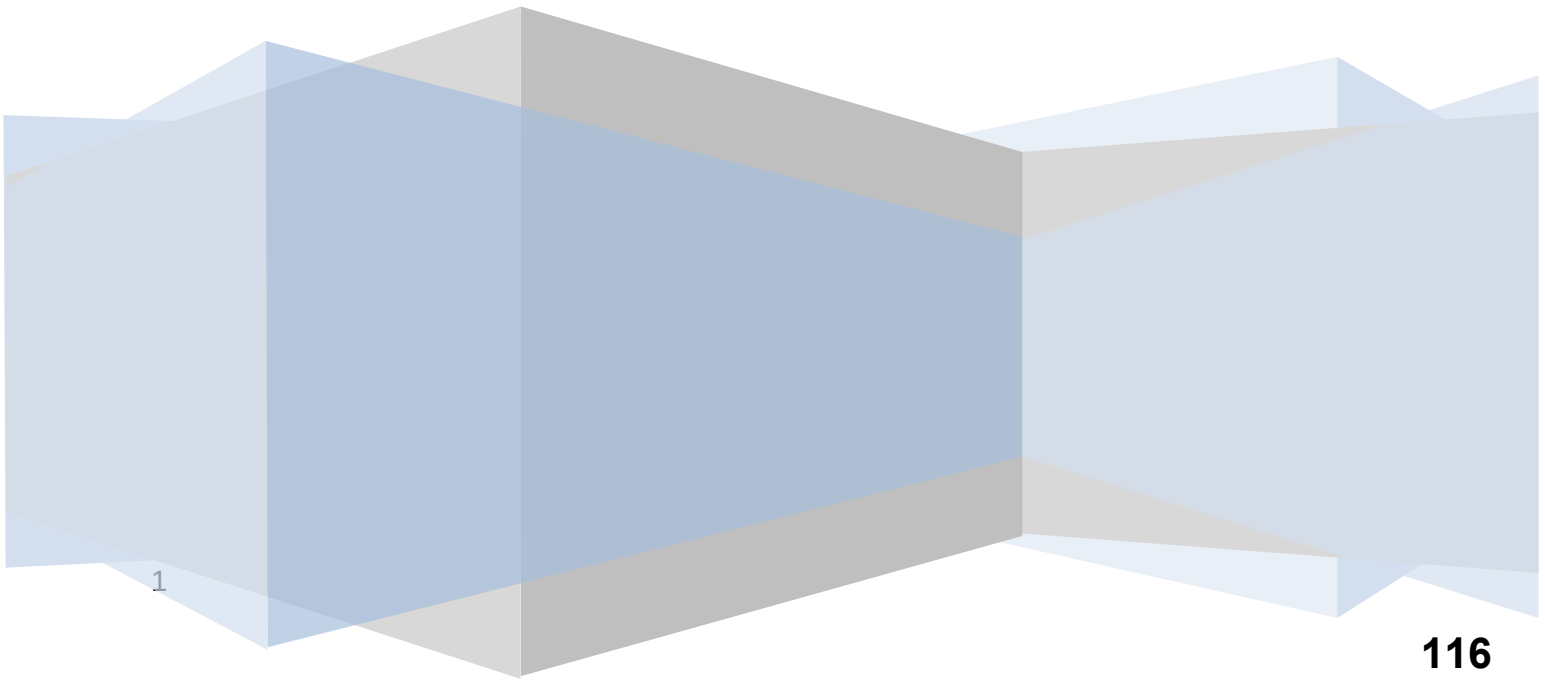
  -the proportion of patients spending more than one hour in A&E after they have been declared clinically ready to proceed

Appendix 2

North Yorkshire & York System

System Surge & Escalation Framework

30th July 2021



SECTION 1

NY&Y System - Escalation and De-escalation Response

Senior System Leaders

Silver Response (Guide = Opel 3 or 4)

Co-ordinated by escalating organisation who will:

- Be responsible to escalate further to senior leaders (i.e. Gold) if/when required).
- Be responsible for the establishment and co-ordination of a senior system call when all mitigating options to de-escalate that are available to Bronze are exhausted/frustrated and further escalation is required in response to the Bronze "ask" for further action/support from Silver.

  Escalating partner, as the lead agent, to contact the required supporting organisations using the embedded contact list (section 2 below) and "on call" list (section 3 below) to assist plus any additional support from other key contacts identified in the contacts list. CCG lead will set up bespoke Silver Teams meeting including all the required partner organisations in order to meet/respond to the Bronze "ask".

- **System Call via Microsoft Teams (or if not available telephone dial in details as per below)**

Silver Agenda.docx

Dial: 0800 917 1950
Passcode: 22868573 then #
Chair: 22425281#

Administrative support for the senior system call is available from Jasmine Sheppard (Service Transformation Officer, North Yorkshire CCG), or Alex Kilbride (Commissioning and Transformation Manager, VOY CCG) or John Darley (Head of Acute Care NY CCG) if/as required- Contact details in section 3 of this document:

- Coordination of partners communication plan as required
- System reporting as required
- Monitoring and assurance
- Follow up on agreed system actions post call
- Coordination of system actions

TACTICAL & OPERATIONAL
Bronze Response (Guide = Opel 2 or 3)

Co-ordinated by the escalating partner organisation who requires the escalation call.

Actions required:-

- Be responsible to escalate further to senior leaders (i.e. Silver) if/when required.

- Be responsible for the establishment and co-ordination (via support from CCG leads as embedded above in Silver section) of a Bronze call when BAU is no longer an option and all mitigating options to avoid service escalation available are exhausted and further escalation is required.

  Escalating partner, as the lead agent, to contact the CCG administrative support (identified in Silver section above) to set up the Teams call (they will also provide the necessary required admin support to the Bronze call (e.g. recording of actions and distribution) using the contacts list identified (Section 2 below) of this document to assist.

- **System Call Details via Microsoft Teams or if unavailable using the telephone dial in details below.**

  Bronze Agenda.docx

  Dial: 0800 917 1950
  Passcode: 22868573 then #
  Chair: 22425281#

Bronze call will be supported by Jasmine Sheppard (Service Transformation Officer, North Yorkshire CCG) or Alex Kilbride (Commissioning and Transformation Manager, VOY CCG) or John Darley (Head of Acute Care NY CCG):

- Coordination of OPEL actions
- Coordination of partners communication as required
- Provide NHSE/I updates as necessary
- Assurance and monitoring support
- Circulation and follow up (where appropriate) on agreed system actions post call

BAU Response

(Guide = Opel 1 and 2)

Coordinated by Jasmine Sheppard (Service Transformation Officer, North Yorkshire CCG), Alex Kilbride Commissioning and Transformation Manager, VOY CCG and John Darley (Head of Scute Care NYCCG) - contact details section 3.

- Daily monitoring of system OPEL levels per organisation
- Daily system reporting including collation of information and relevant KPIs, NHSE/I updates and coordination of response if escalation occurs.
- Assurance and monitoring of system actions as per OPEL framework
- Coordination of system partner communication across NY&Y as necessary.
- Attend weekly (or as necessary) NHSE/I winter assurance calls - John Darley as lead and Jasmine Sheppard (NY CCG) or Alex Kilbride (VoY CCG) as relief for A/L etc...

North Yorkshire & York System OPEL Escalation Framework

Escalation Level	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Organisation				
	Health and Care Resilience Board –System Escalation Plan			
	Opel 1 triggers	**Opel 2 Triggers**	**Opel 3Triggers**	**Opel 4 Triggers**
System	• All partner organisations reporting Level 1 No more than 1 organisation at Level 2 • Demand for service within normal parameters, as identified within individual organisational escalation processes, and capacity available for expected emergency and elective demand • Business as usual. Low pressure across A&E Delivery Board area, relevant actions taken in response if deemed necessary, no support required Where partner organisations cover a wider footprint than York and Scarborough Health and Care System, their escalated OPEL levels should only be considered when our specific locality is affected.	• 2 organisations at Level 2 No more than 1 organisation at Level 3 • System partners requesting support from the Seasonal Resilience Team • Business continuity plans being referred to	• 2 organisations at Level 3 No more than 1 organisation at Level 4 • Assessment by NY&Y Team that all organisations need to enact their level 3 responses • Predictions that patient flow becoming significantly compromised in 2 or more areas of the system • Unexpected reduction in staffing numbers (sickness, weather conditions) that have a direct impact upon patient care/patient flow • Cold weather/Heatwave Level 3 - Severe weather or Heatwave action required.	• 2 organisations or more declaring Level 4 • Problems reported with Support Services (IT< Transport, Facilities, Pathology etc.) that cannot be rectified within 4 hours • Unexpected reduction staffing numbers (due to sickness, weather conditions (e.g. cold weather/heatwave level 4) in areas where this causes increased pressure on patient flow that compromises service provision/patient safety) • Major incident or other major system challenge declared including external support for mutual aid. • Ongoing challenge to one or more organisation's business continuity leading to possible

				organisational/service failure.
	Opel 1 Actions	**Opel 2 Actions**	**Opel 3 Actions**	**Opel 4 Actions**
	NY&Y Team Actions – All OPELs: • Partners to report the pressures/Opel levels in the system via daily email by 10am. nyccg.urgentcare@nhs.nett • NY Team to report to NHS E/I impact of pressures on previous 24hrs, current status of pressures, mitigating actions and expected time of recovery by 1300hrs via england.yhwinter@nhs.net • NY Team to report into NHSE/I weekly resilience call on Thursdays at 11.30am via Microsoft Teams	• All actions at OPEL 1 are in place or considered, where not completed a rationale has been recorded. • Check with System Partner(s) that triggers for OPEL 2 reporting have been met • Communicate with System Partner(s) and ascertain which level actions they are carrying out in order to de-escalate the system as a whole or an individual system partner • Ensure that organisations are enacting their escalation plans/de-escalation plans and business continuity plans if required **Communications:** • NY&Y Team actions completed from Opel 1. (reporting/Calls) • Partners to report the pressures/Opel levels in the system via daily email by 10am to: nyccg.urgentcare@nhs.net	• All actions at OPEL 2 are in place or considered, where not completed a rationale has been recorded. • System at Opel 3 status and no de-escalation via Bronze partner call. • Check with System Partner(s) that triggers for OPEL 3 reporting have been met • Communicate with System Partner(s) and ascertain which level 3 actions they are carrying out in order to de-escalate the system as a whole or an individual system partner. • If sustained level 3 consider arranging an extraordinary A&E Delivery Board **Communication:** • NY&Y Team actions completed from Opel 1/2. (reporting/calls) • Partners to report the pressures/Opel levels in the system via daily email by	• All actions at OPEL 3 are in place or considered, where not completed a rationale has been recorded. • Check with System Partner(s) that Triggers for OPEL 4 reporting have been met. • Communicate with System Partner(s) and ascertain which level 4 actions they are carrying out in order to de-escalate the system as a whole or an individual system partner • Through system call, ascertain as to whether all actions identified within plans have been considered fully and whether these actions have had time to have an effect. • Through System Call, ascertain as to whether the system is at the point of system failure. • Continue to update NHS

		• Partners to ensure when escalating to the next Opel level, during the day nyccg.urgentcare@nhs.net updated. • NY&Y CCG Team to support with advising/communicating to external partners any additional cross organisational support requested. • System partner that is escalating to consider if a system call is required to support? If so: Follow process identified in Bronze response as above using the names and contact details in section 3 to assist. Call should include all system partners they require to support. Send Teams invite/details to partners to join call. - Use the draft agenda and 'York and Scarborough partner responses document ("gives and gets") to support. • Consider requirement for a repeated Bronze escalation call and if so agree date/time.	10am to: nyccg.urgentcare@nhs.net • NY&Y CCG Team to support communication between the relevant systems partners occurs in order for any actions to be taken. • Partners to ensure when escalating to the next OPEL level, during the day nyccg.urgentcare@nhs.net is updated. • Communicate with GP's practices and other partners as necessary dependent on escalating organisation requirements actioned. • All on-call senior managers and directors briefed as necessary. • System partner that is escalating to consider if escalation to "Senior System Leaders" (Silver) call is required to support? If so: Follow process identified in Senior System Leaders (Silver) response as above using the names and contact details in section 3 (and those embedded in	England of the current situation and request support via england.yhwinter@nhs.net and by phone call to NHS England lead. • To complete and submit NHS England proforma. If pressure continues for more than 3 days consider establishing an extraordinary A&E Delivery Board meeting with Director representation. **Communication** • NY&Y Team actions completed from Opel 3. (reporting/Calls) • Partners to report the pressures/Opel levels in the system via daily email by 9.30am. nyccg.urgentcare@nhs.net • On-call managers/directors to be briefed • Partners to ensure when escalating to the next OPEL level, during the day

			the Silver box above) to assist. Call should include all system partners they require to support. Send Team invite/details to partners. • Call details if Teams unavailable:- **System Call Details** **Dial:** 0800 917 1950 **Passcode:** 22868573 then # **Chair: 22425281** • Consider requirement for a repeated escalation call and agree date/time. • Partners at OPEL 3 to update the NY&Y Team during the afternoon via: nyccg.urgentcare@nhs.net Any actions taken between system partners to be communicated to: nyccg.urgentcare@nhs.net • NY&Y Team to report to NHS E/I impact of pressures on previous 24hrs, current status of pressures, mitigating actions and expected time of recovery by 12 noon and following afternoon update via england.yhwinter@nhs.net	nyccg.urgentcare@nhs.nett updated. • Any actions taken between system partners to be communicated to NY&Y Team via mailbox: nyccg.urgentcare@nhs.net • Communicate with GP's practices as necessary dependent on escalating organisation requirements. • Confirm position at the end of the day and understand if the system is showing any signs of recovery. Discuss next steps and look at what provisions are required for on-call staff overnight. Inform ALL on-call staff of the current situation. • CCG support team to report the pressures in the system and actions from system calls after each meeting / teleconference • System in OPEL 4 status and no de-escalation therefore

			• NY&Y Team to report the pressures in the system and actions from System Calls after each meeting/teleconference to NHSE/I Decisions to move to system OPEL 4 will be discussed between the Trust Director On Call and CCG Director on call, (NHSE/I director on call to be advised/briefed).	consider continuation of System Leaders calls (Silver) and consider further escalation to Gold. • Call details if needed:in event of Teams failure- **<u>System Call Details</u>** **Dial:** 0800 917 1950 **Passcode:** 22868573 then # **Chair: 22425281**

North Yorkshire & York System - Partner Organisation Surge & Escalation Plans

	York Scarborough Teaching Hospitals NHS Foundation Trust

OPEL Action Cards and Quick Links v4 J

	Yorkshire Ambulance Service - REAP levels

YAS_REAP template v2 July 2021.docx

	Vocare
Vocare	Vocare Surge Escalation Plan Upd

	Tees Esk and Wear Valleys NHS Trust (Mental Health Services)
Tees Esk and Wear Valleys Trust	TEWV Surge Escalation Plan Upd
	North Yorkshire County Council
NYCC	NYCC_Surge & Escalation Plan 2021
CYC	**City Of York Council**
	CYC Surge Escalation Plan Upd
CHCP	**City Health Care Partnership**
	CHCP Surge & Escalation Plan Upd

HTFT	**Humber Teaching NHS Foundation Trust**
	HTNFT Opel Escalation Levels Humber Community triOPEL 2021_22_Subm
ERYCC	**East Riding of Yorkshire Council (ERYC) Adult Social Care**
	ERCC Surge & Escalation Plan Upd
	Harrogate District Foundation Trust (HDFT)
HDFT	Harrogate and District NHS Founda

NY CCG	OPEL reporting Framework & Cover
VoY CCG	VoY CCG Primary Care OPEL Surge Es
Partner organisations 'gives and gets'	York & Scarborough - Partner organisatior

SECTION 2

NY&Y System partners contact details for Bronze Escalation Call – July 2021/22

Organisation	Name	Email	Contact Tel
North Yorkshire CCG	Jasmine Sheppard	jasminesheppard@nhs.net	07961 725342
	John Darley	john.darley@nhs.net	07970 492007
	Simon Cox	simoncox1@nhs.net	07917 093041
	Vanessa Burns	vanessaburns@nhs.net	07733 001652
	Lisa Pope	lisa.pope3@nhs.net	07979 011949
	Sam Haward	samhaward@nhs.net	07973 935584
	Andrew Dangerfield	andrew.dangerfield@nhs.net	07802 378675
Vale of York CCG	Alex Kilbride	alexandra.kilbride@nhs.net	07702 975887
	Steph Porter	stephanie.porter@nhs.net	07738 893010
	Shaun Macey	s.macey@nhs.net	07938 816483
	Gary Young	gary.young4@nhs.net	07772 477684

East Riding CCG	Emma Owen	Emma.owen7@nhs.net	07936 939156
	Lee Delves	Lee.delves@nhs.net	07936 939183
Y&SFT	Melanie Liley	Melanie.liley@york.nhs.uk	07736 364739
Y&SFT – Flow York	Fiona Sharp- Patient Flow Manger Deputy Anne Marie Blair	Fiona.Sharp@YORK.NHS.UK annemarie.blair@york.nhs.uk	07843 055645 07837 717768
Y&SFT – Flow Scarborough	Sara Kelly – Patient Flow Manger Deputy Nikki Wood	Sara.Kelly@york.nhs.uk Nikki.Wood@york.nhs.uk	07554 228455 07554 228455
Y&SFT – York	Jamie Todd Jennie Walker	Jamie.Todd@york.nhs.uk Jennifer.Walker@york.nhs.uk	07715 877222 07941 399245
Y&SFT – Scarborough	David Thomas Sally Alexander	David.Thomas2@york.nhs.uk sally.alexander@york.nhs.uk	07775 030148 07818 510731
Humber	Divisional manager – Helen Cammish Kerry Brown	helen.cammish@nhs.net Kerry.brown36@nhs.net	07921 609344 07813 391407

	Sonia Rafferty Rishi Sookraj Sarah Locker Carol Wilson Jeanette Hyam Katie Barraball Jo Marshall	sonia.rafferty@nhs.net rishi.sookraj@nhs.net s.locker@nhs.net carolwilson7@nhs.net j.hyam@nhs.net Katie.barraball@nhs.net joanne.marshall13@nhs.net	07971 599398 07801 455656 07976 939046 07801 260066 07973 693024 07850 853206 07917073118
YAS 111	111 24/7 Supervisor Line	wakefield.yas111@nhs.net	0300 330 5407
YAS PTS	Paul Goff Operations Manager	paul.gof@nhs.net	07760 998557
YAS A&E	YAS Regional Operations Centre (ROC)	yas.rocsm@nhs.net	0300 330 0299
CHCP	On-call manager DCOO Jackie Griffiths COO Carol Waudby DCOO Christy Francis	Via Care Co-Ordination Hub Jackie.griffiths@nhs.net Carol.waudby@nhs.net christyfrancis@nhs.net	01482 247111 07816 645404 07921 609118 07816 645990

East Riding Council	Marianne Swaine Hospital Team Manager Heather Tasker Service Manager Liz Hardy Service Manager Anita Brigham Strategic Lead Lee Thompson Head of Adult Services	Marianne.swaine@eastriding.gov.uk heather.tasker@eastriding.gov.uk liz.hardy@eastriding.gov.uk anita.brigham@eastridng.gov.uk lee.thompson@eastriding.gov.uk	
NYCC	Peter Hopkins (Head of Vale of York) Tina Simpson (Head of Scarborough/ Whitby) Rachel Kemp (Head of Integration)	Peter.hopkins@northyorks.gov.uk Tina.simpson@northyorks.gov.uk Rachel.kemp@northyorks.gov.uk	07791 224720 01609 536572 07980 949013
Vocare	Angela Frankish Sean Gribben Operational Manager	angelajane.frankish@nduc.nhs.uk sean.gribben@nduc.nhs.uk	07990 002717 07471 214413

	Sacrborough Malton Whitby Julie Gallimore Operational Manager York and Selby Gavin McCallum: Assistant Regional Director	Julie.gallimore@vocare.nhs.uk Gavin.McCallum@Vocare.nhs.uk	07551 039256 07553 641662
TEWV	Naomi Lonergan	Director of Ops for North Yorkshire, York & Selby naomi.lonergan@nhs.net	07771 936993
	Lucy Prowse	Operational Support Manager, North Yorkshire & York lucy.prowse@nhs.net	07880 429578
	Carol Redmond	Head of Service CAMHS carol.redmond@nhs.net	07973 946605
CYC	Belinda Jones Samantha Watts Mandy Welsh Michael Melvin	belinda.jones@york.gov.uk sam.watts@york.gov.uk mandy.welsh@york.gov.uk michael.melvin@york.gov.uk	07919 398384 07980 111990 TBC 07836 380774

HDFT (inc. GP OOHs)	Russel Nightingale Rachael Stray Mike Forster Caroline Reid Helen Siewruk-Barnes	Russel.Nightingale@nhs.net r.stray@nhs.net mike.forster1@nhs.net caroline.reid4@nhs.net Helen.siewruk-barnes@nhs.net	 07827 834145 07799 797956

Section 3

NY&Y System Partners

On Call Contact Details 2021/22

YSFT

Director on call / 1st on call contacts

Scarborough Hospital	**Ask for Director on Call- Scarborough**	**01723 368 111**
York Hospital	**Ask for Director on Call - York**	**01904 631313**

NYCC

01609 780780 (who will contact AD).

NYCC Emergency Duty Team - 01609 780 780

NYCC Resilience and Emergency Team - Tel: 0845 0349437

Email: emergency.dutyofficer@gmail.com

TEWV

Switchboard 01642 838 050 and ask for on call Director

For Telephony Failure only: 07780 228 911

Yorkshire Doctors / Vocare

Yorkshire Services Operational Manager Tel: 0300 1231 780 (Single contact Number)

National Operational Director/Manager On-call Tel: 020 316 24336 (Single contact Number.)

YAS 999 / 111

999 - ROC (Regional Operational Centre) – 24/7 Senior managers and Directors 0300 330 0299

111 – 24/7 Supervisor Line - 0300 330 5407

YAS PTS

Out of hours issues Monday to Friday 1800 to 0800 and Friday 1800 to Monday 0800 call 0300 3302000.

Humber FT

Switchboard at Miranda House for the attention of the "on call" manager, 01482 301700.

CHCP

Hull and East Riding intermediate Care Team contacted via Care Co-ordination Hub 01482 247111

East Riding CCG

Request CCG Director on call via 01482 223191

ERYCC

Out of Hours AMHP and Out of Hours Team 01377 241273 to access on-call manager

CYC

Out of hours through NYCC EDT for on call mangers/director – 01609 780780

VOY CCG

Director on call via 0844 589 5915

North Yorkshire CCG – senior manager and director on call via 07534 904270

HDFT - (including GP OOHs Service)

Director/senior manager on call (as appropriate) via switchboard 01423 885959

NHS England and NHS Improvement

0333 012 4267

Appendix 3

Clinical & Operational Pressures Escalation Planning (OPEL)

The purpose of this document and attachment is to provide information relating, and to summarise the OPEL policy and escalation plan.

Local Escalation Plans:
YTHFT OPEL Framework has been developed to facilitate the Trust's response to surge and site pressure. Our response to surge activity is managed at the daily Operational site meetings where an action focused agenda is followed to ensure we rigidly monitor key activities and where possible proactively respond to surge using predicted activity.

Key activities include:

1. Ambulance handover delays are kept to a minimum by complying with the regional ambulance handover policy, monitoring the handover screen which is located in the operations centre and the department and ensuring we have an identified member of ED staff to take the handover in a timely manner.
2. All patients in ED have a clear plan to admit or discharge by **2 hours** and are closely monitored both in the department and the operations centre thus ensuring we have a robust process to eliminate the risk of **12 hour trolley waits**.
3. Patient flow is maintained by using the command and control process to escalate issues and ensure a speedy resolution.
4. Opening of escalation beds and boarding are agreed at the Operational site meetings where staffing levels are confirmed.

The Operational site meetings are chaired by a silver commander, Patient Flow Manager (or deputy) at **OPEL 1 and OPEL 2** and is supported by a gold commander at **OPEL 3 and above**. The meeting is also attended by bronze commanders for ED, Medicine, Elderly Medicine and Surgery, discharge management, Matrons, Therapy and other supporting staff members and are held on both acute sites.

In essence, linked OPEL is split into two main categories:

1. **OPEL Management Action Cards:** These action cards are implemented at the Operational Site meetings in real time to ensure a rapid management response to the escalating situation that is often brought about as a result of a surge event and site pressure. The actions are often cascaded via the bronze commanders. One of the actions is to implement OPEL Clinical Escalation Plans.
2. **OPEL Clinical Escalation Plans:** These take the form of action cards and provide detailed actions for each speciality to follow. All areas of the Trust have OPEL Clinical Escalation Plans to follow and they are implemented at ED / ward level.

Please refer to the next page for a breakdown of YTHFT OPEL process and below for other supporting documentation.:

Operational Pressures Escalation Level (OPEL) Acute & Community (To be added when ratified)	Regional Repatriation Pathway  NYHMTODN Updated Repatriation Policy flc

OPEL Overview: – In general terms OPEL levels are confirmed every 2 hours times and at the Operational site meetings. Each OPEL level triggers the relevant OPEL Management Action Plan which is managed in the Operation Centres. These in turn trigger our suit of OPEL Clinical Escalation Plans (action cards) which are aimed specifically at speciality level (e.g. ED, AMU, Wards, Support Services)

OPEL Management ACTION CARDS

Click on the relevant word icon of the OPEL Framework at the base of this sheet.

Site Meeting Agenda below:-

Site Status Meeting Agenda.docx

OPEL 1

Business as normal. Operational Site meetings monitor key activities as detailed in word document below

OPEL 2

OPEL 2 site action card v1- new.docx

Click above for site OPEL 2 actions. Last action is to invoke OPEL 2 Clinical escalation plans below

OPEL 3

OPEL 3 site action card v1- new.docx

Click above for site OPEL 3 actions. Last action is to invoke OPEL 3 Clinical escalation plans below

OPEL 4

Click above for site OPEL 4 action. Last action is to invoke OPEL 4 Clinical escalation plans below

ED OPEL 2 action card 2021 v1.docx	PAEDIATRICS OPEL 2 - Action card.docx	ED OPEL 3 action card 2021 v1.docx	PAEDIATRICS OPEL 3 - Action card.docx	ED OPEL 4 action card 2021 v1.docx	PAEDIATRICS OPEL 4 - Action card.docx
AMU EAU SDEC OPEL 2 action card 2021 v1	STROKE OPEL 2 - Action card.docx	AMU EAU SDEC OPEL 3 action card 2021 v1	STROKE OPEL 3 - Action card.docx	AMU EAU SDEC OPEL 4 action card 2021 v1	STROKE OPEL 4 - Action card.docx
Med COE OPEL 2 action card 2021 v1.c	MATERNITY OPEL 2 - Action card.docx	Med COE OPEL 3 action card 2021 v1.c	MATERNITY OPEL 3 - Action card.docx	Med COE OPEL 4 action card 2021 v1.c	MATERNITY OPEL 4 - Action card.docx
Surg T&O OPEL 2 action card 2021 v1.c		Surg T&O OPEL 3 action card 2021 v1.c	Site Out of hours OPEL 3 action card 2(	Surg T&O OPEL 4 action card 2021 v1.c	Site Out of hours OPEL 4 action card 2(

FULL CAPACITY PROTOCOL

Full Capacity action card 2021 v1.docx

Appendix 4 – Winter Planning

Winter Schemes 2021 - 2022 (Version 4)

PRIORITY 1

				2020 - 2021 Plan			Dec 20 - Mar 21 Expenditure			2021 - 2022 Plan					
Ser	Care Group	Scheme Detail	CG Lead 2021-22	FY 20-21 (Dec - Mar)	FY 21-22 (Apr +)	Total	Budget	Actual	Variance	FY 21-22 (Dec - Mar)	FY 22-23 (Apr +)	Total	Expected Impact of Scheme	Measure of Success	Notes
1	1	CRT - staffing	Laura Robson	150,000	50,000	200,000	150,000	150,000	0	150,000	50,000	200,000	Continue to provide additional capacity to support delivery of the national standard of all rehabilitation discharges commencing within 48hrs of referral (local ambition remains for same day discharge - or next day for later referrals), maintaining capacity for admission avoidance and continued ambulance diversionary pathways.	Waiting time data for starting CRT; activity data (referrals/contacts)	Already in post Billing VoYCCG in excess of this match to plan
2	1	ED - FY3 /CT ED jnr doc additional evening shifts	Billie Cameron	26,318	13,159	39,477	26,318	26,318	0	26,318	13,159	39,477	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to see a doctor in ED	Filled using bank/locum
3	1	Additional overnight acute floor doctors - York	Jamie Todd	167,400	41,040	208,440	167,400	18,095	149,305	83,700	20,520	104,220	To ensure all patients are seen and clerked in a timely manner to avoid delays to patients care	Clerking times	Filled using bank/locum as able JT reduced totals by 50% - 290721
4	1	ED - Senior streamer at front door (10 hours - 7 days a week)	Billie Cameron	0	0	0	0	4,250	-4,250	33,620	16,810	50,430	To ensure the increased numbers of patients attending ED will be seen in a timely manner	Time to streaming, number of patients streamed away from the dept	Appointed 0.8 L Palmer 01/02/21
5	1	Extra Physio for Pulmonary rehab and resp out patients	Sally Ann Richardson	19,495	0	19,495	19,495	19,495	0	19,495	0	19,495	Timely intervention		Need to ensure we start recruitment early enough to catch the recently graduated AHPs
6	1	Additional Elderly Consultant Weekend cover	Jamie Todd	18,900	0	18,900	18,900	22,950	-4,050	20,000	0	20,000	To maintain elderly medicine cover and process through the weekend	Reduced performance dips during the weekend	Filled with ECPs as necessary JT reduced to 20K - 270721
7	1	Additional Gen Med Consultant Weekend cover	Jamie Todd	18,900	0	18,900	18,900	21,000	-2,100	20,000	0	20,000	To maintain general medicine cover and process through the weekend	Reduse performance dips at the weekendn	Filled with ECPs as necessary JT reduced to 20K - 270721
8	1	ED Consultant non-admit stream	Jamie Todd	Scheme not run 2020 -2021			N/A	N/A	N/A	178,500	0	178,500	To reduce waits in ED and improve the patient experience particularly for patients who do not require admitting to the hospital	Improved ECS, reduced waits for non-admit patients within ED	New scheme, approx £125 per hour
9	1	RATS team B5 OT and PT	Sally Ann Richardson	Scheme not run 2020 -2021			N/A	N/A	N/A	22,914	0	22,914	to aid turnaround of additional ill patients in ED over winter		
10	1	Downstream wards B5 OT and PT	Sally Ann Richardson	Scheme not run 2020 -2022			N/A	N/A	N/A	22,914	0	22,914	Previous winter staff were seconded to wards during crisis proved to improve rate of discharges	Shorter LOS for downstream wards	
11	1	Virtual Respiratory Ward - Delivered by the Respiratory nurse specialists as it was during COVID.	Piper Wiles	Scheme not run 2020 -2023			N/A	N/A	N/A	28,782	0	28,782	Prevent patients staying on respiratory wards and be able to recover at home sooner.	More respiratory patient managed outside hospital	2x WTE B6 nursing **Link to OPAT expansion serial**
12	1	Care home support; Selby team to have more care home support / investment.	Piper Wiles	Scheme not run 2020 -2024			N/A	N/A	N/A	28,643	0	28,643	Prevent admissions into hospitals, keeping patients in a home whilst they recover.	Allow quicker flow from IPU into care homes	2.5 WTE B5 nurses
13	1	AHP provision to support a 7 day service to patients in IPU's.	Rachel Anderson	Scheme not run 2020 -2026			N/A	N/A	N/A	58,850	0	58,850	Community hospitalsarrivals with higher dependency than before will recieve an initial AHP assessment or rehabilitation over the weekend rather than waiting until the following Monday morning.	Providing patient care will have animpact on patient progress, speed of recovery and therefore reduce hospital length of stay.	Equivalent to 1.60 WTE B6 & 1.60 WTE B3 in total.This would equate to an overall investment of £12,426 per month (£62,130 for the period November – March 21),
14	2	Additional Middle Grade to support weekend discharge 12 hours per day (0800-2000 Sat and Sun)	David Thomas	22,400	11,200	33,600	22,400	22,698	-298	22,400	11,200	33,600	Continuous discharge process from 0800-2000	Number of discharges over the weekend	
15	2	ED - Ambulance handover senior nurse (Band6) (10 hours - 7 days a week)	David Thomas	33,620	16,810	50,430	33,620	62,032	-28,412	33,620	16,810	50,430	Maintaining timely ambulance handovers	Ambulance handover performance	
16	3	Ward 39 Staffing Increase	Liz Hill	Scheme not run 2020 -2021			N/A	N/A	N/A	0	0	0			**CG3 to provide indicative costs** **LH reports this cost is likely to be the difference in staffing costs between an Ortho ward and an elderly ward. Further discussions to determine if there is a cost - 290721.**
17	4	Pharmacy Support to Critical Care (1 WTE B7)	Liz Hill / Kim Hinton	Scheme not run 2020 -2021			N/A	N/A	N/A	17,069	51,206	68,274	Increased pharmacy support for critical care is required to manager the increased demand for critical care over the winter period	Reduction in medicatio errors, free up medical staff time, improved antimicrobal stewardship, cost saving through optimal drug use and waste reduction	Hard to recruit fixed term post, locum would be at 8a, propose permanent post at lower band 7, more cost effective than locum wages

18	4	Pharmacy Service in ED (York) - To develop an ED pharmacy service 5 days a week for a 6 month period.	Kim Hinton	N/A	N/A	N/A	N/A	N/A	N/A	26,086	0	26,086	Reduce prescribing errors for admission medicines • Release time to care for medical staff in writing up new medicines • Improve flow for discharge of ED/SDEC patients • Reduce missed doses of critical medicines for patients in ED	1. qualitative impact of pharmacy team advice to staff in ED, education and training of ED staff on medicines. 2. Reduce prescibing errors for admission medicines 3. reduce missed doses of critical medicine for patients in ED	Two options are presented for consideration: **Option 1:** Recruit 1WTE B7 locum pharmacist and 1WTE B5 locum technician at a cost of £81,088, with both posts recruited to from 1st October-21. However, locum posts will be difficult to recruit to for 6 months and there are alternative, better value for money options (see 2 below). **Option 2:** Recruit substantively to 1WTE B7 pharmacist and 1WTE B5 technician at a cost of £78, 259 per annum, with both posts recruited to from 1st October-21. Substantive posts are much easier to recruit in to, and would provide continuity of service year round and deliver additional benefits - a better value for money option that option 1. Option 1 is deemed essential, option 2 is deemed desireable. **Option 2 is preferred.** KH reduced total to Option 2 and 4 months - 290721
19	4	Support acute flow at SGH by deliving 7 day ultrasound	Kim Hinton	Scheme not run 2020 -2021			N/A	N/A	N/A	16,592	4,880	21,472	Late Friday and weekend acute patients requiring ultrasound are currently required to wait until at least Monday due to no weekend service at SGH - this would reduce delay for the patient and improve upon US turnaround times.	Reduced patient stay Reduced turnaround times for US	2 x B7 Sonographer, 1 x B2 Support Worker and 1 x B2 Porter required and costed. Funding pays for the required 3 hour shifts on Sat/Sun between December and April.
20	6	OPAT Expansion	Karen Cowley	92,560	0	92,560	92,560	89,763	2,797	203,772	50,943	254,715	Reduced LOS for patients on IV antibiotics who are otherwise fit to be discharged.This will allow for an extended working day 8-8 and weekend working 8-4 therfore providing a 7 day a week service with the possibility of on-call rota until 10pm.	LOS, increased patients under OPAT service	1.2WTE B7, 4.8WTE B6, 0.6WTE B3 A&C
21	6	Orthopaedic Elective work	Karen Cowley	341,138	0	341,138	341,138	182,491	158,647	81,762	20,440	102,202	This scheme will release the usual additonal winter ward required whilst maintaining elective orthopaedic work and maintain recovery of the elective programme post COVID	Number of elective cases completed compared to previous winters and impact on elective recovery of Orthopaedic wait times	2WTE RN, 1WTE ODP, 1WTE Jnr Doc
22	DIS	B7 Analyst 0800-1200 Sat & Sun to support Weekend UEC and Covid SITREP reporting (21 weekends & 5 Bank Holidays)	Nicky Slater	Scheme not run 2020 -2021			Scheme not run 2020 -2021			7,314	1,828	9,142	Ability to provide nationally mandated SITREP reporting	Deadlines achieved	
23	Corp Ops	Twilight Transfer Team	Fiona Sharpe	27,995	0	27,995	27,995	9,823	18,173	15,663	7,831	25,494	Improve transfer of patients in the late afternoon/evening period	Reduced RFT to bed time	
24	Corp Ops	Additional DLO Support	Fiona Sharpe	23,574	0	23,574	23,574	19,040	4,534	23,574	0	23,574	Prep of patients for discharge to enable better flow trough acute side of hospital	Improved ECS and early discharges	
25	Corp Ops	B7 Ops Manager 0800-1430 Sat & Sun to support On Call Management (21 weekends & 5 Bank Holidays)	Melanie Liley	11,885	2,971	14,856	11,885	11,884	1	11,885	2,971	14,856	Improved command and control over the weekend and bank holidays to support patient flow.	On Call Manager and Care Group feedback	
				954,185	**135,180**	**1,089,365**	**954,185**	**659,839**	**294,347**	**1,153,473**	**268,598**	**1,424,070**			

APPENDIX 5 - SURGE PLAN

York and Scarborough Hospitals NHS Foundation Trust - COVID Surge & Escalation Plans Wave 3

Surge Plan (Steps 1-3)

York Hospital

Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL SD	Additional RED capacity - no social distancing	Additional AMBER capacity - no social distancing	Capacity TOTAL - no SD	Impact on Staffing	Impact on Elective IP Programme	Impact on Outpatients	Impact on Ward/ space function
Emergency Department	AAA	0	6	6	0	0	6		No impact	No impact	
	Cubicles	14	10	24	0	0	24		No impact	No impact	
	Resus *1cold flex	3	4	7	0	0	7		No impact	No impact	
	TOTAL Capacity	**17**	**20**	**37**	**0**	**0**	**37**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Adult Inpatient	Y **Step1** Ward 25 (Covid suspected and confirmed)	24	0	24	0	0	24	Medical rota required to support COVID ward. To open to 21 (from 18) requires nurse staffing from Care Group 3 and 6	No impact	No impact	NOF Elderly on Ward 29 Elderly on Ward 28 Trauma on Ward 26 Elective Orthopaedics on Ward 39
	Y Step 2 Ward 29 (nIV)	21	0	21	0	0	21	Staffed with nurse support from CCG3	Potential impact 'on the day cancellations' due to outliers	No impact	NOF moves to combine with Trauma on Ward 26 (trauma outliers to surgery)
	Y Step 3 Ward 28	25	0	25	5	0	30	n/a	Potential impact 'on the day cancellations' due to outliers	No impact	Elderly on Ward 28 condense in remaining Elderly wards
	Y Step 4 Ward 26	23	0	23	0	0	23	Redeployment of staff required to support ward RN: 6 WTE	Routine Ordinary Elective Orthopaedic work paused (Ward 39 repurposed to NOF/ Trauma)	Redeployment of nurse staffing - OP clinics to be reviewed	NOF and Trauma move to Ward 39.
	Y Step 5 Ward 35	20	0	20	5	0	25	Redeployment of staff required RN: 22.75 WTE (10 beds) HCA: 22.71 (10 beds	Increased likelihood of cancellations due to bed pressures. Endoscopy capacity reduced through redeployment to wards. **Cancellation of routine ordinary electives** Theatre prioritisation panel stepped up to ensure priority patient access to theatres	Redeployment of nurse staffing - Reduction in OP (including Sexual health)	Elderly Function move to Ward 15. Consolidation of Surgical Wards.
	Y Step 6 Ward 36	20	0	20	4	0	24	Redeployment of staff required RN: 5 WTE	Increased likelihood of cancellations due to bed pressures. Endoscopy capacity reduced through redeployment to wards. **Cancellation of routine ordinary electives** Theatre prioritisation panel stepped up to ensure priority patient access to theatres	Redeployment of nurse staffing - Reduction in OP (including Sexual health)	Medical function on Ward 36 condensed in remaining Medical wards.
	Y Step 7 Ward 39	19	0	19	5	0	24	Redeployment of staff required RN 1 WTE HCA 4 WTE	Increased likelihood of cancellations due to bed pressures. Endoscopy capacity reduced through redeployment to wards. **Cancellation of routine ordinary electives** Theatre prioritisation panel stepped up to ensure priority patient access to theatres	Redeployment of nurse staffing - Reduction in OP (including Sexual health)	?NOF Trauma
	Y Step X Ward 37 (Dementia)	19	0	19	3	0	22	n/a - staffed from Ward 37	Potential impact 'on the day cancellations' due to outliers		Convert to Red ward if higher numbers of COVID patients with dementia. Cold dementia to be managed within the remaining bed base. Can be implemented at any time within surge as required
	Ward 32 -medical	0	23	23	0	5	28				
	Ward 34- respiratory	0	25	25	0	5	30				
	Ward 33- medical	0	25	25	0	5	30				
	Ward 23 - Acute stroke	0	25	25	0	5	30				
	Ward 21 (AMB)	0	25	25	0	5	30				
	Ward 24	0	9	9	0	0	9				
	Ward 31- Oncology/ Heam	0	15	15	0	0	15				
	Ward 11- Surgical Vascular & Ortho	0	26	26	0	4	30				

Total Capacity - YTH		Total YTH Capacity not SD
Total Hot Beds	Total Cold Beds (Social Distanc	Total Beds
201	350	626

Total Capacity - SGH		Total SGH Capacity not SD
Total Hot Beds	Total Cold Beds	Total Beds
62	201	261

G&A adult COVID Capacity		
York	Scarborough	Total
169	49	218

	Ward 14- Surgical	0	21	21	0	4	25				
	Ward 22 (AMU)	0	23	23	0	6	29				
	Ward 16 (Surgical)	0	17	17	0	3	20				
	Ward 16a (NEU)	0	8	8	0	0	8				
	G1 (pre-assessment)	0	0	0	0	0	0				G1 remains as pre-theatre and pre-assessment while the Site has a dedicated COVID ward. Surgical function moved to Ward 15
	ESA	0	17	17	0	4	21				
	CCU	0	8	8	0	0	8				
	Ward 15	0	23	23	0	5	28				
	TOTAL Capacity	**171**	**290**	**461**	**22**	**51**	**534**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Paediatric Inpatient	Ward 17	8	10	18	0	2	20	Staffing covered	No impact	No impact	8 beds available seperated by double doors as required.
	TOTAL Capacity	**8**	**10**	**18**	**0**	**2**	**20**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Maternity, Obstetrics & Gynaecology	**S2** Labour Ward	2	10	12	0	0	12	Staffing covered	No impact	No impact	
	G3 (Antenatal)	3	8	11	0	0	11	Staffing covered	No impact	No impact	hot beds not protected but available as required
	G2 (Post natal)	0	21	21	0	0	21	Staffing covered	No impact	No impact	
	Maternity theatre 1	0	1	1	0	0	1	Staffing covered	No impact	No impact	
	Maternity theatre 2	0	1	1	0	0	1	Staffing covered	No impact	No impact	
	TOTAL Capacity	**5**	**41**	**46**	**0**	**0**	**46**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
	ICU (L2&3)	17	0	17	0	0	17		n/a		
	Day Unit PACU (L2 & L3)	0	9	9	0	0	9	Redeployment of CCG3 nurse staffing	Stand down of routine surgery within York main Theatres (Bridlington and Eye theatres continue) Theatre prioritisation panel stepped up to ensure priority patient access to theatres Reduced Day Case capacity - urgent and cancer operating only	n/a	Day Case Theatres repurposed to ICUU facility.
	TOTAL Capacity	**17**	**9**	**26**	**0**	**0**	**26**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Out of Hospital YFT	Selby	0	22	22	0	0	22	Staffing covered	No impact	No impact	
	Nelson's Court 1 (prev WXC)	0	19	19	0	1	20	Staffing covered	No impact	No impact	Intermediate Care
	Nelson's Court 2 (prev St Helen's)	0	15	15	0	5	20	Staffing covered	No impact	No impact	
	St Monica's	0	12	12	0	0	12	Staffing covered	No impact	No impact	
	White Cross Court	0	23	23	0	0	23	Staffing covered	No impact	No impact	Stroke/ Neuro-rehab relocated Ward 39
	TOTAL Capacity	**0**	**91**	**91**	**0**	**6**	**97**				

YH CCU (8 beds) will remain cold capacity

NB: ALL BAY SPACES ON ALL WARDS SHOULD BE USED TO A MAXIMUM BEFORE TRIGGERING NEXT STEP

Scarborough Hospital

Hospital Zone	Ward / Department / Area	Capacity - HOT	Capacity - COLD	Capacity - TOTAL	Additional RED capacity - no social distancing	Additional AMBER capacity - no social distancing	Capacity TOTAL - no SD	Impact on Staffing	Impact on Elective IP Programme	Impact on Outpatients	Impact on Ward/ space function
Emergency Department	First Assessment	0	5	5					No impact	No impact	
	Main Floor	0	11	11					No impact	No impact	
	Old SDEC	0	6	6							
	Resus	0	3	3					No impact	No impact	
	EAU (SDEC & HFU)	0	22	22					No impact	No impact	
	UTC	0	5	5					No impact	No impact	
	Respiratory Assessment Zone	4	0	4					No impact	No impact	
	TOTAL Capacity	**4**	**52**	**56**	**0**	**0**	**56**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
	S. Step 1 Beech NIV + transfer to YDH	3	12	15				Staffed	No impact	No impact	Frail, EoL or not fit for transfer patients only
	S. Step 2 Aspen	5	0	5				Staffed	No impact	No impact	Consolidate medical wards

	S. Step 3 Anne Wright	9	0	9				Staffing plan	Step down ordinary electives	No impact	Consolidate medical wards. Outlier into Lilac.
	S. Step 4 Holly	20	0	20				Staffing plan	Step down ordinary electives	No impact	Trauma and NOF move to Maple. Surgial Wards consolidated
	S. Step 5 Ash	15	0	15				Staffing plan	Step down ordinary electives	No impact	
	Oak (Medicine)	0	25	25	0	8	33				
	Cherry (elderly)	0	28	28							
	Chestnut (Elderly)	0	28	28							
	Lilac (Elderly)	0	32	32							
	Maple (Surgical)	0	28	28							
	Haldane Day Case	0	0	0							
	Stroke (stroke/ elderly)	0	16	16							
	CCU (cardiology)	0	13	13	0	20	20				
	TOTAL Capacity	**52**	**182**	**234**	**0**	**28**	**262**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
	S2 Duke of Kent	2	0	0							2 cubicles for patients pending transfer to York
	CAU Assessment Space	0	2	2							
	TOTAL Capacity	**2**	**2**	**2**	**0**	**0**	**2**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Maternity, Obstetrics & Gynaecology	**S2** Labour Ward	2	2	4							
	Hawthorn	0	14	14							
	Maternity theatre	0	1	1							
	TOTAL Capacity	**2**	**17**	**19**	**0**	**0**	**19**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Critical Care	ICU (L2 & 3) flex either	6	0	6							Escalation plan to critical care in York.
	PACU (L2 & L3)	0	0	0							
	TOTAL Capacity	**6**	**0**	**6**	**0**	**0**	**6**				
Hospital Zone	**Ward / Department / Area**	**Capacity - HOT**	**Capacity - COLD**	**Capacity - TOTAL**	**Additional RED capacity - no social distancing**	**Additional AMBER capacity - no social distancing**	**Capacity TOTAL - no SD**	**Impact on Staffing**	**Impact on Elective IP Programme**	**Impact on Outpatients**	**Impact on Ward/ space function**
Bridlington	Johnson	0	24	24	**0**	**0**	**24**				

Level S2 (Surge) - YORK Hospital

Decision Support Tool & Action Card Guidance

Ward Areas and Departments Identified

Those areas are identified as follows in order:
(ward function will be allocated on opening the ward, either as admissions for suspected cases or comfirmed postive ward). Admissions should be managed in isolation to prevent the need for contact wards to be implemented.

Escalation of Adult COVID wars in order:
- Ward 25
- Ward 29
- Ward 28
- Ward 26
- Ward 35
- Ward 39
- Labour Ward - Suspected / Confirmed labouring, antenatal or postnatal women (2 rooms)
- ICU - COVID Confirmed Patients (32 beds)

Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.

Impact on Services

Routine Elective Surgical Care
Urgent Elective Surgical Care
SDEC
Outpatients
Diagnostics (Endoscopy, Radiology, Lab Med)

Impact on Workforce

AHP: staff redeployment to be commenced to provide enhanced ward cover (SA)

Nursing: staff redeployment to be commenced, ward nursing teams will be reviewed and individuals allocated to ensure specialist care can be provided appropriately.

Medical: tiered rotas according to demand to be used. JC/GR owners for adult COVID

Governance - Decision Making

Decision to plan escalation into next phase of the plan (In Hours) - Care Group 1 BRONZE Command
Decision to implement the escalation plan (In Hours) - SILVER Command
Decision to plan escalation into next phase of the plan (Out of Hours) - 1st On Call Manager
Decision to implement the escalation plan (Out of Hours) - 2nd On Call

Triggers, Escalation and Decision Making

The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.
If any of the below triggers are met then the action card at the front of this Appendix is to be followed.

Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)	Authority to Implement
Emergency Department	N/A	CG Bronze Command	YTH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Adult Inpatient - confirmed	< 4 beds available on ward 25 and or any additional postive wards consideration of next step in surge plan.	CG Bronze Command	YTH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Paediatrics	>5 transfers in 24 hours from SGH or >2 cubicles remaining at York	CG Bronze Command	YTH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Maternity	> 2 Women requiring 'Hot' Area in a singe 24 hour period	CG Bronze Command	YTH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Critical Care	15 positive COVID patients and/or 7 non-positive COVID patients	CG Bronze Command and Critical Care Consultant	YTH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call

Level S2 (Surge) - SCARBOROUGH Hospital

Decision Support Tool & Action Card Guidance

Ward Areas and Departments Identified

Those areas are identified as follows:

ED/FRONT DOOR:

- HOT ED: Coverting all of the current ED main cubicle area into a HOT zone including HOT RESUS bays (2 RESUS trollies / 9 majors trollies/ 5 side rooms).
- COLD ED: 1st Assessment (5 trollies), COLD RESUS (3 trollies), converting current SDEC and Home First Unit in COLD ED majors (5 trollies / 10 chairs).
- COLD SDEC/HFU: GRAHAM ward (16 chairs).
- COLD AMU: GRAHAM ward (10 trollies / 2 side rooms).

IN-PATIENT AREAS:

- BEECH NIV
- ASPEN
- HOLLY
- BEECH All

Please refer to Trust COVID SOP for the steps to be taken to mobilise the above areas.

Impact on Services

Routine Elective Surgical Care
Urgent Elective Surgical Care
SDEC
Outpatients
Diagnostics (Endoscopy, Radiology, Lab Med)

Governance - Decision Making

Decision to plan escalation into next phase of the plan (In Hours) - Care Group 1 BRONZE Command
Decision to implement the escalation plan (In Hours) - SILVER Command
Decision to plan escalation into next phase of the plan (Out of Hours) - 1st On Call Manager
Decision to implement the escalation plan (Out of Hours) - 2nd On Call

Triggers and Escalation

The Daily Operational meetings and Bed management team are responsible for monitoring the site and escalating when decisions are required to escalate or de-escalate within the surge plan.
If any of the below triggers are met then the action card at the front of this Appendix is to be followed.

Area	Trigger	Decision Made by (In hours)	Decision Made by (Out of hours)	Authority to Implement
Emergency Department	N/A	CG Bronze Command	SGH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Adult Inpatient - Confirmed	Once Beech full and York can no longer support, covert ASPEN. Once ASPEN <1 bed, consider escalation to HOLLY	CG Bronze Command	SGH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Paediatrics	>10 patients seen within 24 hours or > 5 transfers to York	CG Bronze Command	SGH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Maternity	> 2 Women requiring 'Hot' Area in a single 24 hour period	CG Bronze Command	SGH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call
Critical Care	5 positive COVID patients and/or 5 non-positive COVID patients	CG Bronze Command and Critical Care Consultant	SGH 1st On Call in discussion with Consultant on-call	In Hours - SILVER Command Out of Hours -2nd On Call

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Executive Committee 15 September 2021
Resources Assurance Committee 21 September 2021
Board of Directors 30 September 2021

Half-year Review of the Capital Programme and Priorities for the Remainder of 2021/22

/ 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 update the Executive Committee and Board of Directors as to the half-year position in relation to the Trust's Capital Programme. Each Care Group and Corporate Directorate has provided their urgent requirements for prioritisation this financial year. This paper proposes a way forward with these requirements.

/ Executive Summary – Key Points

The Trust's Capital Programme was presented and approved by the Executive Committee and Board of Directors in March 2021. Further urgent and emergency spend has been incurred and the programme has been updated accordingly. This was reviewed in June. There are limited residual funds left for the remainder of the financial year and this report takes the priority requests from the Care Groups and Corporate Directorates for emergency schemes and proposes a way forward.

/ Recommendation

The Executive Committee and Board of Directors are asked to note the current position at the half-year point with regard to the Trust's Capital Programme.

Additionally the Executive Committee and Board of Directors are asked to review the prioritisation schedule and approve the described allocations. Approved schemes will then be able to commence in the autumn subject to the normal business case approval processes (note: business cases are still required as these will consider associated revenue implications and ensure these are covered).

Care Groups and Corporate Directorates are urgently asked to confirm that there are no other known urgent and critical capital requirements that will require resource this financial year.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: September 2021

1. Introduction and Background

The Executive Committee and the Board of Directors approved in March 2021 the capital programme for the 2021/22 financial year and received an update in June 2021. This report is the 6-month capital programme review report and proposes a way forward for the remainder of the 2021/22 financial year.

As part of the 6-month review all Care Groups and Corporate Directorates were asked to provide details of their URGENT and CRITICAL capital requirements for the remainder of the financial year. These have been provided and collated into this report.

Requests have been allocated into capital funding, revenue lease agreement funding, revenue funding and charitable funding.

2. The Capital Programme at Month 6

The table below is the latest position (at month 6) for the existing approved Trust capital programme. All costs have been updated to reflect the current position.

Table 1. Updated 2021/22 Capital Programme

Sources of Funding in 2021/22:	£m	Programme Expenditure:	£m
Depreciation Funding (our own funds)	12.370	York – HV Infrastructure	0.245
Existing Loan/Lease Repayments	-3.150	York – HV Infrastructure Contingency	0.250
		ICU – Modular Build contingency	1.486
		Community Stadium – Small Lantern	0.100
		Minor Schemes	0.577
		Medical Equipment (MERG)	0.350
		Fees (Feasibility for new schemes)	0.300
		Capital Staff	0.770
		SNS Staff	0.350
New PDC Funding – Scarborough Fees	1.365	STP Wave 4 Fees for Scarborough ED	1.365
Charitable Funding	0.517	Charitable funds Butterfly Scheme/ Other charitable	0.517
*New PDC Funding York ED Phase 2	13.000	York ED Phase 2 Scheme*	13.000
VIU – Loan funding	6.900	VIU/PACU	6.900
		SNS Phase 1 Investment Programme	1.650
		Backlog Maintenance Programme	1.000
		Ward Refurbishment Programme	0.400
		Cardiac Telemetry Replacement	0.248
		Microbiology Covid Laboratory Configuration	0.150
		STP Wave 4 Fees for Scarborough ED Works	0.000
		Unallocated Capital Programme	**1.344**
TOTAL	**31.002**	**TOTAL**	**31.002**

Considering all available funds we have £1.344m in terms of capital funding available to allocate for the remainder of the financial year.

3. Suggested Way Forward

Appendix 1 includes all the urgent and critical schemes referenced by Care Groups and Corporate Directorates which are recommended for approval and **Appendix 2** are

schemes which require further work and discussion and are not recommended for approval at this stage.

Table 2 below summarises the position

	Suggested Allocation				Total Programme Allocation
	Capital Programme £m	Revenue Leasing Programme £m	Revenue Expenditure £m	Suggested for Charitable Funds £m	£m
Total Value of Urgent and Critical Capital Items	1.502	4.931	0.955	0.042	7.430

Proceeding with capital schemes to the cost of £1.502m will result in a modest over commitment of available funding at this stage of £0.158m, however this is considered as low risk as there are a large number of small schemes and there will inevitably be slippage and some schemes maybe appropriate for funding through the minor schemes allocation.

The revenue leasing programme is essentially equipment replacement needs where we have assessed that we can successfully enter into a lease arrangement and avoid the capital cost of ownership. This programme allows the Trust to significantly extend its capital programme spend.

A small number of items have actually been assessed as revenue items and can be supported as non-recurrent charges to our income and expenditure position.

We have also assessed a small number of items that should be considered for Care Group Charitable Funds and potential general fund bids.

Details of items in each category can be found at appendix 1.

All items put forward by Care Groups and by Corporate Directorates, with the exception of the DIS Essential Services Programme, the LLP's backlog maintenance assessment and the EAU development have been included in this programme, the latter EAU request would require a separate development business case.

4. Other Issues for Consideration

There are a number of other issues for consideration.

- The York ED scheme will not be completed before the end of March 2022. We have had confirmation that we must draw all £13m funding down before the end of March and we need to make our own arrangements to manage the expenditure. We cannot carry funding forward. The most likely spend profile is £8.5m in 2021/22 and £4.5m in 2022/23. We need to identify £4.5m of extra spend this year that we can repay to the York ED scheme next year. The proposal is that:
    - Scarborough UTC fees funding of £1.4m is not drawn until 22/23. We believe this is possible and have formally requested deferral.
    - We bring £1m of next year's DIS Essential Services Programme forward. This would not be available in 22/23 for DIS and other funding would need to be sought.

    - We bring £1m of next year's back log maintenance programme forward, this again would not be available in 22/23 for the LLP and other funding would need to be sought.
    - We seek to deliver £1.1m of expenditure early from the Scarborough UTC scheme in 21/22 following expected BC approval in December 2021.
- The nuclear medicine business case is currently outside of this schedule of capital work. We are seeking both capital and revenue costs from the equipment manufacturers for turnkey solutions to the room preparation at both York and Scarborough. We will be seeking to manage these schemes though either the contingency capital reserve or via a revenue leasing solution. The costs are not yet known. We do know we will lease the equipment and provision has been made for this.
- We are continuing our bid through the unified tech fund to facilitate further and faster delivery of the DIS essential services programme.
- We are preparing an emergency capital bid for £10m. These bids are due in by November at the latest. There is no guarantee of success and early the bids only come with cash and not CDEL cover. This is frustrating and will require a multi-year spend profile working with the ICS and the regional NHSE/I team to secure CDEL cover. This comprises three essential items:
    - Backlog maintenance of £5m
    - Critical plant room repairs to support radiology at Scarborough £3m
    - DIS essential services programme £2m

5. Recommendation

The Executive Committee and Board of Directors are asked to note the current position at the half-year point with regard to the Trust's Capital Programme.

Additionally the Executive Committee and Board of Directors are asked to review the prioritisation schedule and approve the described allocations. Approved schemes will then be able to commence in the autumn subject to the normal business case approval processes (note: business cases are still required as these will consider associated revenue implications and ensure these are covered).

Care Groups and Corporate Directorates are asked to confirm that there are no other known urgent and critical capital requirements that will require resource this financial year.

APPENDIX 1 - Schemes recommended to progress

CG	CG Priority	Funding source Approved	Scheme Name	Scheme Summary	Statement as to why MUST this scheme be completed during 2021/22	Estimated Value (no consideration can be given without an estimated value)	Summary of revenue implications (excluding Capital Charges)	Is this a Replacement Asset? (give details of what is being replaced, including if currently leased)	Latest Date necessary for approval to assure scheme completion before 31 March 2022	MERG Required YES/NO	BC Required YES/NO	Suitable for Leasing YES/NO	Are Other Options for Financing being explored YES/NO (if YES give details)	CG Notes	Selection guidance for Executive Committee	Charitable funding	Revenue Funding	<£5k Equipment funding	Lease Revenue	>£5k Equipment funding - Capital	Capital programme 2021/22	Capital programme 2022/23	DIS - Capital programme 2021/22
1		Yes	Reverse Osmosis Machine	Purite 5000 reverse osmosis machine replacement required at Harrogate renal	The RO at Harrogate is now 17 years old and was thought to be fully supportable. It has recently been discovered this is not the case with only limited support from the suppliers provided. There is significant risk to patient treatments when the plant fails as has happened recently. There is no surplus capacity in the Renal service. This equipment supplies the dialysis water for the main unit supporting 48 patients.	£85,000		Yes asset 121121 is owned by the Trust having been purchased after the lease expired.		YES	YES	No	no	Cost includes installation	Recommend to approve subject to all governance been met and revenue implications identified . Capital budget						£85,000		
1		Yes	Replacement ECG x9	Spacelabs Cardiocall VS290 Ambulatory ECG , YH , OPD Cardiology	Technomed monitors that were rented during Covid will be going back in November 2021. This will leave us with the original analysis system which is ~ 30 years old. Of the 17 monitors we have for the original system 12 are either damaged or broken. Technomed system is expensive rental £47,000 for the year. The new equipment would be expected to last approx. 20 years.	£150,000		Yes for Synescope system which is owned and Technomed/ECG on demand which is on lease until November 2021	Nov-21	Yes	Yes	NO	No		Recommend to approve subject to all governance been met and revenue implications identified . Capital budget					£150,000			
1		yes	Bladder scanners for community nursing	Provide each community nursing team with a bladder scanner (five in total) to ensure patients receive prompt scans when in retention and to prevent avoidable referrals to the specialist bladder and bowel team	This was originally identified as a requirement in 2019 but was not progressed. An increasing number of patients are being identified as requiring scans which is exacerbating the previous delays.	£41,970		No	Nov-21	YES	No	Yes	Yes - potential for Selby charitable funds (and maybe St Monica's for Easingwold) to buy machines for those localities (would reduce requirement from 5 to either 3 or 4 depending on charities responses)		Recommend approve and fund from Charitable funds as additional equipment. Subject to all governance been met and revenue implications identified	£41,970							
1		Yes	TELEMETRY	Server and network costs - DIS plus minor works to install additional data lines and electric points including additional cabling		£30,500	£5,000			no	yes	no			Must do - New DIS costs identified, costs need to be added to original BC . Recommend to approve. Subject to all governance been met and revenue implications identified						£30,500		
1		Yes	x6 Braun dialysis machines (leased LG17643) x7 Braun dialysis machines (leased LG19036)	Lease due to expire in March for 6 Braun dialysis machines after 7 years use. Purchase x2 and renew lease for 4 Lease due to expire in September for 7 Braun dialysis machines after 7 years use	If the machines are not replaced, there will be significant risk to the patients due to not being treated for kidney failure, with both cost and patient health implications for the trust to deal with. The Renal service is under significant pressure from increased patient numbers and cannot provide this service without these machines being replaced.	£202,141	£14,137	Yes LG17643 and LG19036- two machines are being purchased and retained for use 141493 and 141495	MERG approved, BC awaiting approval	YES	YES	YES	NO		Recommend to approve. Capital budget. Subject to all governance been met and revenue implications identified				£202,141				
1		Yes	CCU	Door access control	Would like to install door access control to the relatives room as there has been a security incident.	£5,000				no	no	no			Ensure receive quote and does not exceed £5k as will need to be funded from capital. Subject to all governance been met and revenue implications identified		£5,000						
1		Yes	CCU	Replacement of bathroom	the shower needs replacing and two basins have been condemned by infection prevention,	£8,000				no	no	no			Recommend to approve. Capital budget. Subject to all governance been met and revenue implications identified						£8,000		
2	4	Yes	Ventilation on Beech Ward	Improve the ventilation on Beech ward which contains Aerosol Generating Procedures	Beech Ward is Scarborough sites respiratory ward and as such it contains patients who require CPAP and NIV During Covid air conditioning units were deployed which have achieve 6 air changes per hour. For the AGP's experienced in this area the air changes should be 10 per hour.	£15,000	£0			No	No	No		Info on cost of Extra requirement to previous Beech / ICU ventilation issue (covered by Capital in l 20/21 is available from LLP (estimated £15K whilst waiting for the info)	Recommend to approve. Capital budget. Subject to all governance been met and revenue implications identified						£15,000		
2	1	Yes	Stryker Trollies	Replacement of 30 trollies in ED.	There has been a review and audit of the trollies currently used in ED. The results have concluded that many of the trollies are not fit for purpose in an emergency setting. 30 trollies were inspected with the recommendation full systems are replaced due to degradation, IPC issues and non-compatibility with x-ray systems. The Committee agreed with the findings. It was also agreed that older Stryker trolleys can be utilised on Lilac ward for patient transfers.	£180,000	0			yes	yes	yes		Merg approved, need a BC , apparently part of a bigger scheme to replace all trollies.	Urgent requirement in SGH , recommend to approve. Subject to all governance been met and revenue implications identified				£180,000				
2	7	Yes	Cardio Respiratory Equipment	Replacement of current cardio respiratory equipment.	Equipment has been identified to require updating replacing obsolete models for improved efficiency. Additional echo machines and respiratory monitors required to meet an expansing service and demand and capacity across Scarborough and Bridlington sites. Replacement of 4 electric couches for echo and pacing as identified by IPT as no longer fit for purpose. To purchase IV pump for stress echo service currently use CCU but not always available due to poorly patients on the unit. Currently use CCU pump. Purchase portable hand held echo machine and a second echo machine for Bridlington to support ward echos and demand and capacity for patient echos across both Scarborough and Bridlington sites.	£80,000	0			yes	yes	yes		There is a composite list of equipment, most under £5K individually, but all need to go through MERG committee, if taken as a 'project', might be capitalised ... (otherwise needed at revenue) - Overall value - currently just an estimate	BC will be required, need full list to determine all funding options. Recommend to approve. Subject to all governance been met and revenue implications identified			£80,000					
3		Yes	ICU Ventilation	Scarborough ICU Ventilation Improvement		£60,000				no	yes	no			Urgent requirement in SGH , recommend to approve. Subject to all governance been met and revenue implications identified						£60,000		
3		Yes	Stryker Power Tools	Stryker Power tools, Large bone, small bone and electric saws/drills. Plus batteries and battery chargers.	Stryker are unwilling to extend the current lease and tools are failing causing cancellations.	£483,000	Replacement equipment so no additional revenue required	Yes - currently leased	Dec-21	YES	YES	YES			Already gone to MERG and we are looking at as one big project. IW working with CG. Recommend to approve. Subject to all governance been met and revenue implications identified				£483,000				
3		Yes	ITU beds	Replacement of 8 ITU beds at SGH and 17 ITU beds at York	The current ITU beds are falling apart and cannot be repaired.	£250,000	Replacement equipment so no additional revenue required	Yes - currently owned	Jan-22	YES	YES	YES			MERG will be required. Recommend approving funding. Subject to all governance been met and revenue implications identified				£250,000				
3		Yes	Micrel Rhythmic PCEA pumps	Replacement of 8 Micrel Rhythmic PCEA pumps	no supported maintenance anymore, kit keeps breaking	£29,000	Replacement equipment so no additional revenue required	Yes - currently owned	Dec-21	YES	no	NO			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified			£29,000					
3		Yes	Epidual pumps	Replacement of 23 Epidual pumps	no supported maintenance anymore, kit keeps breaking	£75,000	Replacement equipment so no additional revenue required	Yes - currently owned	Dec-21	YES	YES	no			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified			£75,000					
3		Yes	Ureterscopes and stack	Replacement of 4 ureterscopes and replacement stack	Ureterscopes are over 15 years old and are frequently breaking (there have been consistently 4 scopes away being repaired. New scopes require a new stack as the old stack does not support the new technology	£249,000	Replacement equipment so no additional revenue required	Yes - currently owned	Jan-22	YES	YES	YES			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified				£249,000				
3		Yes	Transfer trollies	Replacement of transfer two trollies (one at York and one at Scarborough)	Current trollies are unable to be repaired.	£25,000	Replacement equipment so no additional revenue required	Yes - currently owned	Jan-22	YES	NO	YES			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified					£25,000			
3		Yes	Anaesthetic machines	Replacement of two Penlon anaesthetic machines in the anaesthetic rooms	A definite need to replace due to the age of the machines and the inability to get spares	£90,000	Replacement equipment so no additional revenue required	Yes - currently owned	Jan-22	YES	YES	YES			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified				£90,000				
3		Yes	Choledoscope	Choledoscope	The current and only Choledochoscope is unusable due to damage and is beyond economic repair costs are expected to exceed £10,000 for outdated technology	£33,000	Replacement equipment so no additional revenue required	Yes - currently owned	Jan-22	YES	NO	YES			MERG . Recommend to approve. Subject to all governance been met and revenue implications identified					£33,000			
3		Yes	Urology laser	Replacement of the holmium laser in urology theatres at York	The laser has broken and the department is having to current pay monthly to loan a laser	£135,000	Replacement equipment so no additional revenue required	Yes - currently leased	Oct-21	YES	YES	YES			MERG . Recommend to approve. Subject to all governance been met and any revenue implications identified				£135,000				
3		Yes	Replace Theatre Blinds	Blinds required to enable laser work to be carried out in theatres	Causing a delay on lists	£30,000				no	no	no			Need to identify which Theatres require blinds. Recommend to approve, Subject to all governance been met and any revenue implications identified		£30,000						
4	1	Yes	Reconfiguration of room for the installation of a cone beam CT	In December-20, funding was awarded for the purchase and install of a cone beam CT to replace an existing, non-functioning OPG x-ray machine. Following the award of funding, a cheaper provider was identified through competitive tender and the equipment purchased. Subsequently, it's been identified the room where the cone beam CT will be installed needs to be reconfigured. Additional money is being sought in order to progress with the install of machinery we have already purchased. The business case number linked to this is 2020/21-46.	The equipment has been purchased already, therefore funding is required urgently in order to progress with the room reconfiguration and install to utilise the machinery as soon as possible.	£35,000	None	No	Sep-21	No	No	No	No	Included in the B Table of the capital programme and the Cone Beam CT replacement BC	MERG . Recommend to approve. Subject to all governance been met and any revenue implications identified						£35,000		

CG	CG Priority	Funding source Approved	Scheme Name	Scheme Summary	Statement as to why MUST this scheme be completed during 2021/22	Estimated Value (no consideration can be given without an estimated value)	Summary of revenue implications (excluding Capital Charges)	Is this a Replacement Asset? (give details of what is being replaced, including if currently leased)	Latest Date necessary for approval to assure scheme completion before 31 March 2022	MERG Required YES/NO	BC Required YES/NO	Suitable for Leasing YES/NO	Are Other Options for Financing being explored YES/NO (if YES give details)	CG Notes	Selection guidance for Executive Committee	Charitable funding	Revenue Funding	<£5k Equipment funding	Lease Revenue	>£5k Equipment funding - Capital	Capital programme 2021/22	Capital programme 2022/23	DIS - Capital programme 2021/22
4	2	Yes	York Hospital Pathology Refurbishment	To refurbish the Pathology Department to accommodate consolidation of pathology services at the York Hospital site.	Lord Carter's Independent Review of NHS Pathology Services in England in 2008 gathered data and information that pointed strongly towards the consolidation of pathology services 'as a means of improving both service quality and cost effectiveness'. Further analysis confirmed that consolidated pathology organisations are the most efficient in the NHS. The Review recommended that all Trusts should achieve the acute pathology model hospital benchmarks by April 2017, or have agreed plans for consolidation with, or outsourcing to, other pathology providers by January 2017. The award of funding during 2021/22 allows for project milestones to be recalculated for a project initially projected to be delivered by Jan-25, had funding for the design been awarded in May-21. Subject to the award of this money and further consideration beyond the design phase, delivery of the project in late 24/25 or during 25/26 would see the Trust delivering the recommended service model as per the independent review.	£182,000	None	No	Mar-22	No	Yes	No	No	Possibly spend some fees this year ???	Recommend to approve. Subject to all governance been met and any revenue implications identified . Need to identify from the capital team how much can be spent this financial year and therefore how much next year.						£182,000	
4	3	Yes	Lab Med - Replacement and modernisation of Mass Spectrometry Instrumentation	To replace and modernise the Liquid Chromatography Tandem Mass Spectrometry instrumentation (mass spectrometer) used for specialist biochemistry testing within the Blood Sciences Department. This request relates to Business Case number 2021/22-18.		£215,000	None	Yes	Sep-21	Yes	Yes	No	No	Need to speak with dept. to see if suitable for leasing , this is possibly revenue items as instruments.	MERG . Recommend to approve. Subject to all governance been met and any revenue implications identified . Need to understand whether suitable for lease funding.				£215,000				
4	4	Yes	Nuclear medicine gamma camera replacement	To replace a SPECT CT at York and Gamma Camera at SGH. This request relates to Business Case number 2021/22-01.	The gamma cameras are overdue replacement and we now experience increased number of breakdowns. The cost per machine is approx. £300,00 - £500,000 plus additional works costs, but the priority for 21/22 is to replace 2 machines: a SPECT CT at York and Gamma Camera at SGH.	£2,100,000	None	Asset ID: 510187, 122862.	Sep-21	Yes	Yes	No	No	lease equipment, works fund from capital, but possible to have a turn key project and fund all from leasing	MERG . Recommend to approve. Subject to all governance been met and any revenue implications identified . Need to understand whether both turnkey costs and equipment can be leased as one lease. This will avoid using capital budget.				£2,100,000		£0		
4	5	Yes	York Body Store Replacement	To replace a body storage cabinet which is now in poor condition. The proposed replacement will increase freezer capacity from 2 to 5, fridge capacity would remain unchanged (14). A quote has been provided in order to obtain an estimated value, which includes removal of the existing equipment and installation of the new.	A site visit was conducted in July-21 by a supplier, who estimated the cabinets were approximately 19 years old. They concluded the cabinet is in a state of poor condition and beyond economic repair, and recommended cabinets have a typical lifespan of 20 years. The freezer drawers in this cabinet no longer work, therefore an entire fridge bay (5 drawers) in another cabinet has had to be converted to a freezer. This has increased our freezer capacity to 5 (from 2), but has decreased our fridge capacity to 83 (from 88). Leasing the equipment is an option, but is not as cost efficient as purchasing outright.	£57,000	None	Asset ID: 41962	Sep-21	Yes	Yes	Yes	No	Could possibly lease but I think it needs to be purchased due to life.	Recommend to approve. Subject to all governance been met and any revenue implications identified .					£57,000			
4	6	Yes	Replacement of Histology Stainer/Cover slipper	Replacement of an automated staining machine with integrated cover slipper due to age of machine and old technology	Our current piece of equipment is now 13 years old and requires replacement to ensure continuity of service. The volume of slides processed by the machine has increased by 13,000 during its life and it does not benefit from more up to date technology that would increase efficiency with increasing demand.	£85,000	£27,000	Yes - the existing Histology Stainer/Cover slipper	Sep-21	Yes	Yes	yes	No	Could lease	MERG . Recommend to approve. Subject to all governance been met and any revenue implications identified . Need to understand whether suitable for lease funding.				£85,000				
4	7	Yes	Purchase of additional on demand blood fridge for Pathology at York	The hospital is currently served with one issue blood fridge at the south end of the hospital in the theatre reception. By adding additional blood storage into the hospital there are benefits for patients clinicians and laboratory staff. By investing in an on demand fridge we can capitalise on the success we have had at Bridlington hospital for orthopaedic/urological procedures and further roll out the facility within the Trust	To mitigate the risk to the York hospital site in only having one on demand blood fridge for the site. To provide faster access to blood for acute emergencies for the service located at the opposite end of the hospital to the current on demand fridge.	£50,000	£3,730	No	Sep-21	Yes	Yes	No	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£50,000			
4	8	Yes	Replacement of room 3 Fluoroscopy equipment	To upgrade the room to replace the equipment and the AHU unit	The current equipment is on a lease that expires in January 2022 when the kit will be 16 years old. The manufacturer has confirmed that they will no longer support this equipment. The Trust only has one Fluoroscopy room and therefore this will impact inpatient/ outpatient activity should we not be able to provide this service.	£460,000		yes	Sep-21	Yes	yes	Yes	Turnkey works could be included with equipment costs and all leased . AHU will need to be funded from capital .,		Recommend to approve. Subject to all governance been met and any revenue implications identified . Need to confirm costs with procurement.				£360,000		£100,000		
5		Yes	CTG Monitors	Full replacement of all 15 cardiotocography monitors at SGH Maternity Unit (Huntleigh CTG with Dawson Redman analysis capability). This system allows the monitoring of foetal movements and provides computerised analysis, providing a constant risk assessment of foetal well being during labour. The Huntleigh with Dawes Redman is the only monitoring system which meets the full requirements of SBLV2.	The Trust must deliver all elements of the Saving Babies Lives Care Bundle v2 by September 2021 (original date was March 2020) in order to continue reducing the rates of still birth and pre-term births in line with national requirements. Currently the Trust does not meet some of these requirements in Action 6 Elements 2,3 & 4 and in turn is not CNST compliant with a risk of a 10% of CNST premium of £536K and the Trust reputational impact of failing to deliver care pathways which are in line with Saving Babies Lives requirements, and patients having to be notified and potentially treated elsewhere. Additionally, the current monitoring system requires on-going medical engineering support at a cost of £1,300 per machine per annum.	£116,833	6% of total capital cost for maintenance £6,409	Yes replacement of 11 year old Omniview system	ASAP - would need mobilisation during September 2021	Yes (approved)	Yes (TBC)	Yes	No - insufficient charitable funding aligned to Obstetrics	£116, 833 (of which IT costs for implementing would be c. £10K)	10 monitors Trust / 5 charitable . Recommend to approve. Subject to all governance been met and any revenue implications identified .					£116,833			
5		Yes	Echo Machine Paediatric	Replacement of existing Echo ultrasound machine due to age and poor quality imaging to support diagnosis and monitoring.	The current echo machine image quality is now so poor children are having to be referred to Leeds to get diagnosis and monitoring which the Trust should be able to provide.	£80,371	£16,200 for 6 years leasing	Yes replacement of existing echo machine (obsolete)	Sep-21	Yes (approved)	Yes (TBC)	Yes (6 years)	Yes - SGH Children's Fund		Need to check if the existing is owned or leased. Recommend to approve. Subject to all governance been met and any revenue implications identified .					£80,371			
5		Yes	Neonatal Incubators & Bassinettes	Replacement of 2 existing incubators and 2 bassinettes in York SCBU due to old age	Existing incubators have been assessed as not fit for purpose and at full capacity the York SCBU would be using this equipment if not replaced, creating risk of equipment failure.	£33,562	£1,893.66 (6% of capital costs)	Yes replacement of unfit existing equipment	ASAP - would need replacement during September 2021	Yes (TBC)	Yes (TBC)	Yes	Yes - York SCBU Equipment	£31,561.73 for 2 Drager Isolette 8000 Plus incubators and £650-£1000 each for two bassinettes (costs not confirmed as yet) Total c. £33,561.73	Need to check if the existing is owned or leased. Recommend to approve. Subject to all governance been met and any revenue implications identified .					£33,562			
5		Yes	Ward 17/18 Paediatric Cots replacement (Tom2 Linet cots)	Replacement of 17 cots on York paeds ward as condemned.	Existing cots condemned. These were not included in Trust bed replacement programme but indicated that CG5 would not bear cost of replacing these (remains a Trust cost pressure).	£97,001	£3,779.26 (6% of capital costs) p.a. for 10 years	Yes replacement of condemned equipment	ASAP - would need replacement during August/September 2021	Yes (approved)	Yes (TBC)	Yes (10 years)	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£97,001			
5		yes	Hysteroscopes	Replacement of 5 x broken scopes for gynaecology outpatient and day case procedures SGH	Existing equipment broken and not fixable. Increased activity has resulted in increased use. Reduced availability of equipment is a risk to delivery of planned elective activity.	£37,609	£615.60 (6% of capital costs)	Yes replacement of unfit existing equipment	ASAP - would need replacement during Aug/ Sept 2021	Yes (being submitted in August)	Yes (internal CG5)	yes	No	These scopes and the stack should be included in one BC as they are interlinked.	Recommend to approve. Subject to all governance been met and any revenue implications identified .					£37,609			
5		Yes	Hysteroscopes stack SGH Women's unit	The Stack is 13 years old, and is no longer supported by the manufacturer . Current image quality procured on the screen is poor which can lead to an uncertainty of diagnosis and in some ases leads to p[patient having to be booked for a theatre slot to be examined and or treated with a highter spec theatre stack and scope system. This causes wasted appointments , leads to poor and inappropriate use of a theatre list and causes higher levels of anxiety and patient dissatisfaction.	The breakdown of this particular stack (as it's the only one in the unit) would create a real challenge with business continuity and lead to significant patient cancellations and delays. Any delays in diagnostics and treatment could lead to poorer clinical outcomes and increased levels of patient dissatisfaction and or complaint.	£30,000		Yes replacement of a 13 year old stack	ASAP	yes	Yes	no		This stacks and the scopes above should be included in one BC as they are interlinked.	Recommend to approve. Subject to all governance been met and any revenue implications identified .					£30,000			
6		Yes	CLARITY RETCAM II RETINAL CAMERA	Asset ID 125124 is 14 years old and in need of replacement	It reaches high escalation in Dec 21 and is risking patient safety.	£45,000	0	Yes - Asset 125124	31st Jan 2022	Yes	No	Yes	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£45,000			
6		yes	Medical Elective Service	Blood fridge required for essential activity undertaken by MES	MES currently off site and likely to remain off site; separate blood fridge is required	£50,000	3000/year	No	31-Jan-22	Yes	Yes	Yes	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£50,000			
6		yes	Ophthalmology - Micro perimeter	Replacement micro perimeter	Equipment is 11 years old and in need of replacing to ensure service is able to continue and reduce risk to patient safety	£32,500		Yes - 11 years old. NIDEK MP-1 MICROPERIMETER	31-Mar-22	Yes	No	Yes	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£32,500			
6		Yes	Ophthalmology - laser scope	Replacement Laser scope	Equipment is 15 years old and in need of replacing to ensure service is able to continue and reduce risk to patient safety - well beyond high escalation	£15,000		Yes - 15 years old LASERSCOPE IRIDEX OCULIGHT TX LASER	31-Mar-22	Yes	No	No	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£15,000			
6		Yes	Ophthalmology - Slit Lamp	Replacement Slit Lamp	Equipment is 28 years old and in need of replacing to ensure service is able to continue and reduce risk to patient safety	£7,600		Yes - 28 years old HAAG STREIT BM900 SLIT LAMP	31-Mar-22	Yes	No	No	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£7,600			
6		Yes	Ophthalmology - Tonometer	Replacement Tonometer	Equipment is 12 years old and in need of replacing to ensure service is able to continue and reduce risk to patient safety	£5,350		Yes - 12 years old HAAG STREIT AT900 TONOMETER OPHTHALMIC	31-Mar-22	Yes	No	No	No		Recommend to approve. Subject to all governance been met and any revenue implications identified .					£5,350			
6	1	Yes	Ophthalmology - Works for installation of Microscope	Works to install illumaire 700 zeiss microscope in Theatre 1	Works to install illumaire 700 zeiss microscope in Theatre 1	£15,000	none	Yes	31-Dec-21	yes	no	no	no	Works included in BC but not costed	Recommend to approve. Subject to all governance been met and any revenue implications identified .						£15,000		
6	1	yes	Relocation of SGH Outpatients services team	the existing portacabin that the team work from has been condemned by the LLP. An alternative location has been proposed (Old physio dept.) but this requires some minor works for it to be made suitable to move into. (flooring/replastering/redorating/joiner/ replace castors on chairs !!)	the staff have to move out by October as the condemned portacabin is being removed from site.	£15,000	0	no, this will not replace, but the portacabin is being removed.	31-Aug	No	No	No	No		Needs to be actioned as staff have been displaced. Recommend to approve						£15,000		

CG	CG Priority	Funding source Approved	Scheme Name	Scheme Summary	Statement as to why MUST this scheme be completed during 2021/22	Estimated Value (no consideration can be given without an estimated value)	Summary of revenue implications (excluding Capital Charges)	Is this a Replacement Asset? (give details of what is being replaced, including if currently leased)	Latest Date necessary for approval to assure scheme completion before 31 March 2022	MERG Required YES/NO	BC Required YES/NO	Suitable for Leasing YES/NO	Are Other Options for Financing being explored YES/NO (if YES give details)	CG Notes	Selection guidance for Executive Committee	Charitable funding	Revenue Funding	<£5k Equipment funding	Lease Revenue	>£5k Equipment funding - Capital	Capital programme 2021/22	Capital programme 2022/23	DIS - Capital programme 2021/22
6		Yes	Ultrasound machine	Additional ultrasound machine to increase the number of ultrasound guided injection and diagnostic ultrasounds that the MSK department can complete	Currently the radiology wait for ultrasound is 18 months, meaning that patients do not have timely access to treatment and causes patient to need additional interventions and more likely to progress through the pathway and require orthopaedic input / surgery sooner. The addition of this machine to the MSK department will also reduce demand on radiology and reduce number of patient visits required	£40,000	0	no - new machine	31st Dec 21	Yes	yes	Yes	No		Would this require additional staffing ? Recommend to approve. Subject to all governance been met and any revenue implications identified .				£40,000				
LLP		Yes	Domestic Services HPV	HPV Machines	KPI and Risk - For business continuity and additional demands	£136,000	7200 per annum maintenance			No	Yes	Yes			Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.				£136,000				
LLP		Yes	Domestic Services HPV	Carriers for HPV Machines	KPI and Risk - For business continuity and additional demands	£5,000				yes	as above	no			Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.		£5,000						
LLP		Yes	Microfiber roll out - BDH	Roll out of the microfiber mopping system at Bridlington Hospital, in line with the cleaning systems within the other hospital sites	This is expected to provide an overall improvement to the health and wellbeing of staff in relation to MSK issues, it is also the system that the cleaning timings are based on. Roll out in SGH commenced earlier in the year.	£23,264	There will be a cost for laundering of microfiber	Replaces current wet mop system - no saving		No	Yes	No			Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.		£23,264						
LLP		Yes	Microfiber roll out - SGH	The roll out of the microfiber mopping system started in Scarborough earlier this year but only a percentage of the equipment could be funded.	This is expected to provide an overall improvement to the health and wellbeing of staff in relation to MSK issues, it is also the system that the cleaning timings are based on. This would complete the work that started earlier in the year.	£34,481		Replaces current wet mop system - no saving		No	yes	No			Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.		£34,481						
LLP		Yes	Replacement of Floor Cleaning Machines - SGH	Replacement of floor cleaning machines which have failed or are failing at Scarborough Hospital	Not replacing this equipment impacts on the cleanliness that can be achieved	£24,550				No	No	No			Recommended to approve.		£24,550						
LLP		Yes	Replacement of Floor Cleaning Machines - BDH	Replacement of floor cleaning machines which have failed or are failing at Bridlington Hospital	Not replacing this equipment impacts on the cleanliness that can be achieved	£19,640				No	No	No			Recommended to approve.		£19,640						
LLP		Yes	Replacement of Waste Barrow at Bridlington	Replacement of Waste Barrow at Bridlington as this equipment failed some time ago and the work is being completed manually.	Risk to staff from additional manual lifting and movement of waste, additional time required to move smaller loads.	£25,000				No	No	No			Recommended to approve.					£25,000			
LLP		Yes	Replacement Dishwasher - BDH	Replacement of the dishwashers which are failed or failing	Equipment failure	£10,400				No	No	No			Recommended to approve.					£10,400			
LLP		Yes	Replacement Dishwasher - SGH	Replacement of the dishwashers which are failed or failing	Equipment failure	£15,600				No	No	No			Recommended to approve.					£15,600			
LLP		Yes	Replacement Food trolley - MDH	Replacement of food trollies as units are failing	Equipment failure	£9,155				No	No	No			Recommended to approve.					£9,155			
LLP		Yes	Replacement Food trolley - SGH	Replacement of food trollies as units are failing	Equipment failure	£128,170				No	No	No			Need to explore lease options. Recommended to approve.					£128,170			
LLP	LLP Priority	Yes	Radio equipment - BDH	Mobile phones and existing radios are not capable of maintaining current contact across the site. The bottom third of the site, including the waste compound area are dead zones for all existing equipment. Lone workers work in these areas throughout the night-time period and need to make contact for safety reasons. The mast allows for suitably powerful mobile radios to be used.	Safety of staff requires this asap.	£6,500				No	No	No			Recommended to approve.		£6,500						
LLP	LLP Priority	Yes	Laundering of microfiber	The new microfiber mopping system that is being rolled out is currently being laundered by synergy. This could be done at the Bridlington Laundry if the machines were upgraded.	Asap	£10,000	£1860 revenue costs for leasing.	No		no	yes	no		On Estates sheet this cost is £25k ??	Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.		£10,000						
LLP	LLP Priority	Yes	CCTV	The existing Trust wide CCTV system has grown dramatically over the last 5 years, and is set to further expand as the new ED and ICU units are built, as well as the VIU. The system has continually been added to as required, and where elements have failed they have been replaced on an "as and when" reactive basis. However the overall integrity of the system is now at risk due to a number of factors including; Life Cycle expired infrastructure, System Capacity and Technology improvement. Last year we funded the installation of fibre-optic cabling into the MSCP which has helped to improve the data flow from higher resolution technology, but in general the majority of the system needs to be renewed over the next 5 years. We have therefore put together a 5 year Asset Renewal Plan that will ensure the on-going integrity of the CCTV system and also ensure future expenditure is managed to reduce larger "one-off" costs.	We have determined that although the total cost to replace all CCTV infrastructure would be in the region of £200k over a 5 year period, we believe that an upfront investment of £65k would cover off any further capital investment for a period of 3 years. The required investment could be delivered prior to the end of the 2021 / 22 financial year, as our existing suppliers have the available items and we have the internal resources to deliver the investment.	£65,000	None (unless any electrical or data infrastructure currently in-situ has failed)	The majority of the funding will be for replacement items (LFL) or upgrades from Analogue to Digital cameras as well as Server upgrades and Replacement Monitors.	Sep-21	No	Yes	No	As per the above ANPR item, the RV of the CCTV system infrastructure is limited post-installation, therefore it would not be viable to finance the equipment, especially as the relatively low value of the single assets and the risk with all IT based systems becoming obsolete over a relatively short period		Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.					£65,000			
LLP	LLP Priority	Yes	CAFM System Upgrade	The roll out of a new CAFM system has already been approved, with 130 mobile phone handsets being included in the business case in 2020. The CAFM system is designed to monitor the completion of work within the LLP and provide management data to monitor the performance against many of the 91 KPIs. The new system has been rolled out across Estates departments in 2021 using the handsets agreed in the business case. A further 100 mobile phone handsets are required to allow the roll out to continue into the Soft FM Services, at a cost of £10,800 .If we proceed with the Soft FM roll out a consultancy fee of £6000 will also be payable for this element of the roll out.	To ensure the CAFM system is rolled out across all relevant departments of Estates and Facilities, further handsets are required. If this is not achieved in 2021-2022, the roll out will have to be paused until further funding is available.	£16,800	The cost per phone is £208 however a 24 month contract for the phone is then required. The contract comes with a £100 equipment credit, which brings the phone price down to £108 revenue costs for each year of the contract are £12,000 for the 100 phones required. Additional revenue costs for this roll out are £1625 for the device management software.	This replaces the current CAFM system which uses PDAs - the PDA technology is outdated and the handsets are failing, with a cost of £1000 per handset for replacement. The PDAs are not compatible with the new CAFM system.	Oct-21	No	Yes	No	No		Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.					£16,800			
LLP	LLP Priority	Yes	PPM Module Roll out of CAFM system	The Repairs module of the CAFM system has been rolled out to Estates staff, resulting in each worker now having to carrier 2 handsets instead of 1. The PPM module is now required to complete the roll out to Estates. The capital costs of this relate to initial training on the software and the Micad consultancy involved	Until the PPM module is rolled out, Estates staff are carrying 2 handsets, one set of which are obsolete, beyond their lifecycle, failing and expensive to replace.	£11,300	£23,350 in software leases will also be payable in year.	No	Dec-21	No	yes	No	This may need to form part of a Business Case regarding the next set of costs for the CAFM roll out.	Revenue impact £23k	Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.					£11,300			
LLP		Yes	Laser Scanning and Mapping of Trust Premises	As part of the introduction of the new CAFM system it has become apparent that the drawings in existence for the Trust estate are not up to date. The scanning of all areas of the Estate, with 3D mapping, would allow us to improve the data being supplied for national returns, such as ERIC, would assist with the lease drawings required for the MSA contract terms and, in relation to CAFM specifically, allow the data fed into the system to be accurate and therefore ensure the output is correct. In addition to the £347,600 scanning costs, a high performance PC and several software packages would be required, at a cost of £15,000.	Funding this work in the current financial year is essential to ensure the new CAFM system maximises its potential benefits to both the Trust and the LLP.	£362,600	No obvious revenue costs.	N/A	Oct-21	No	Yes	No	Other quotations are being sought.		Possibly revenue as we will be paying for a service . Recommend to approve.		£362,600						
LLP		Yes	Catering CPU	Installation of door access controls		£15,000				no	no	no			Recommend to approve, check quotes.						£15,000		
LLP		Yes	Bariatric bed store	From CPEG	Currently bariatric equipment is hired as there is no room to store purchased equipment, therefore there is a revenue saving .	£10,000	Yes								Value unknown at this stage, £15K for fees to work it up. There is a revenue saving if we can provide this as equipment is currently hired due to lack of storage facility. Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve fees at this stage.					£10,000			
LLP		Yes	Disability accessibility	From CPEG		£49,500	£1,000			no	yes	no			Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.					£49,500			
LLP		Yes	Waste compound	Noise reduction measures due to neighbours complaining of noise	York conciller has got involved - reputational damage if seen to be doing nothing.	£125,000		no		no	yes	no	if do a living wall, could we use charitable funding		Agreed with LLP that a BC needs to be completed to understand the on going revenue consequences. Recommended to approve.					£125,000			
LLP		Yes	Bariatric Bed Mover	Bariatric Bed mover to mobilise patients moving between wards and the rest of the hospital	Following a potential staff grievance it has been raised to support with muskeloekto and health and safety concerns by staff member. There is a request for a safe mobilisation of bariatric patients.	£16,000	0	no , we currently don't own one	30-Sep	no	no	no	no		Recommend to approve.					£16,000			
LLP		Yes	Full site condition survey	To assess the full condition of the back log maintenance requirements of the whole estate it is recommended we undertake a full condition survey	The national allocation of CDEL is in some part driven by the Trust backlog maintenance requiremnets and it is important this is assessed accurately	£250,000	This is a revenue cost	No	ASAP	no	Yes	no	no		Recommened for discussion		£250,000						
		Yes	Easingwold renal sluice	possibly fund from ward refurb																			
						£7,430,397																	

Total		**£41,970**	**£771,035**	**£184,000**	**£4,931,184**	**£664,108**	**£656,100**	**£182,000**	**£0**
									£7,430,397

Total Revenue		**£955,035**						

CG	CG Priority	Funding source Approved	Scheme Name	Scheme Summary	Statement as to why MUST this scheme be completed during 2021/22	Estimated Value (no consideration can be given without an estimated value)	Summary of revenue implications (excluding Capital Charges)	Is this a Replacement Asset? (give details of what is being replaced, including if currently leased)	Latest Date necessary for approval to assure scheme completion before 31 March 2022	MERG Required YES/NO	BC Required YES/NO	Suitable for Leasing YES/NO	Are Other Options for Financing being explored YES/NO (if YES give details)

CG Notes	Selection guidance for Executive Committee	Charitable funding	Revenue Funding	<£5k Equipment funding	Lease Revenue	>£5k Equipment funding - Capital	Capital programme 2021/22	Capital programme 2022/23	DIS - Capital programme 2021/22
	Total Leasing				**£4,931,184**				
	Total Capital costs						**£1,320,208**	**£182,000**	
	Total Charitable funds	**£41,970**							

CG	CG Priority		Scheme Name	Scheme Summary	Statement as to why MUST this scheme be completed during 2021/22	Estimated Value (no consideration can be given without an estimated value)	Summary of revenue implications (excluding Capital Charges)	Is this a Replacement Asset? (give details of what is being replaced, including if currently leased)	Latest Date necessary for approval to assure scheme completion before 31 March 2022	MERG Required YES/NO	BC Required YES/NO	Suitable for Leasing YES/NO	Are Other Options for Financing being explored YES/NO (if YES give details)
5		yes	Uterine Artery Doppler Flow Velocimetry for Foetal Monitoring	New monitoring equipment and software to support foetal monitoring in high and moderate risk pregnancies in line with SBLV2 requirements (Action 6 element 2)	The Trust must deliver all elements of the Saving Babies Lives Care Bundle v2 by September 2021 (original date was March 2020) in order to continue reducing the rates of still birth and pre-term births in line with national requirements. Currently the Trust does not meet some of these requirements in Action 6 Elements 2,3 & 4 and in turn is not CNST compliant with a risk of a 10% of CNST premium of £536K and the Trust reputational impact of failing to deliver care pathways which are in line with Saving Babies Lives requirements, and patients having to be notified and potentially treated elsewhere.Currently working to see if the current RIS Soliton development can fully accommodate all measuring, graphical presentation and reporting requirements in line with SBLV. If this is the case then the potential costs will be significantly lower than sourcing a solution with an external supplier (Viewpoint).	£195,000	TBC	No	By September 2021 if to meet requirements of the Maternity Incentive Scheme/ NHS Resolution to meet CNST compliance.	Yes (TBC)	Yes (TBC)	No	No
2	2	No	General clinical equipment - extension to EAU	Provide the clinical equipment for the extension to EAU	There is no spare equipment to kit out this area. Therefore to make it a fully functional it will have to be fully fitted out with trollies, furniture, IT equipment etc.	£75,000	0			yes	yes	yes	
2	3	No	EAU Trollies	Purchase of additional trollies for EAU.	This will enable EAU to increase its patient capacity.	£60,000	0			yes	yes	yes	
2	5	No	Patient Monitoring Equipment - EAU	Purchase of additional monitoring systems.	This will enable EAU to increase its patient capacity.	£25,000	0				Yes		
2	6	No	Medical Equipment Front of House	Purchase of additional medical equipment.	To support the anticipated expansion and capacity of clinical areas such as EAU various items of medical equipment will be required to be purchased to support patient care. These will include such as ECG machine, bladder scanners, etc. There are currently pacing defibs on the high escalation list for replacement on 3 wards.	£75,000	0			yes	yes	yes	
2	8	no	Cardiology Equipment to replace Cath lab equipment	Replacing equipment under the Cath Lab contract	For activity currently undertaken in Cath Lab, which will not be transferrable to York VILI. Work will be undertaken in Radiology and the screening room refurbishment is in CGS capital plan	£200,000	£60,000			yes	yes	yes	
2	1	No	Information Technology - EAU	Full IT and digital input will be required to support a fully functional EAU following any planned expansion into the current Respiratory Office area.	An expansion of a clinical area will require IT input to support technology required to provide safe and efficient patient care. This will include appropriate sockets, trunking, computer equipment and support.	£50,000	£0				Yes		
2	2	No	Relocation of Respiratory Unit	Provision for adequate office space for the respiratory unit personnel.	Should the current respiratory unit space be converted into a clinical work area the displaced current respiratory personnel would require suitable alternative accomodation. The respiratory team are required to work within close proximity to ensure continuity of patient care.	£10,000	£0						
2	3	No	Development of the Emergency Assessment unit (EAU)	Extending the EAU into the respiratory unit to provide additional clinical space for SDEC medical/frailty services (Conversion of the Respiratory Office space into a clinical work area. To include replacement flooring, windows and patient toilet.)	The medical /frailty SDEC service is currently at full capacity on a daily basis with 20 patients, leaving several patients suitable of the service to be seen by the ED time. Therefore the service needs to expand to allow approximately 10 patients per day to be treated. As the respiratory unit is adjacent to the current EAU it is ideally placed to provide the additional space.	£80,000	£0			No	Yes	No	
3		No	Secuity Doors - Main Theatres	Security doors plus swipe access for Main Theatres to move to the end of bridge to secure Trollies and oxygen from to the public	Health & Safety inspection have highlighted this as a risk as public can get access to this area.	£25,000	None	No	30-Sep	No	No	NO	
6		No	Malton Skin Cancer service	To enable MDT clinics work is required to convert 2 old delivery suites to MOP rooms with ventilation. The rooms would then require some minor works, decorating, flooring, electrics, plumbing etc. as well as the purchase of equipment required (Lights, benches, operating equipment, storage etc).	Skin surgery capacity at Malton is down to 50% because of requirements for PPE3 and donning & doffing (surgery involves use of Hyfractor which is an aerosol generating procedure). This is set against continued growth in skin cancer referrals.	£350,000	0	No	1st Oct 2021	Yes	Yes	No	No
6		No	Repurposing of eye clinic rooms vacated by move to Community Stadium	Several rooms are vacant following the move of Eye Clinics to the Community Stadium. This scheme is to repurpose them towards other sub specialities in the department.	Ophthalmology already had a significant waiting list prior to the pandemic which suffered further from cancelled clinics.	£45,000	0	No - this is a refurb of existing rooms	31-Dec-22	No	No	No	No
6		No	Shockwave Therapy	Development of a shockwave therapy service for MSK patients	Shockwave therapy is provided by an external provider, this causes delays in patients treatment, poor pathway management due to no feedback on when patient is receiving treatment or improvements with treatment. It is part of the commisioning agreement that shockwave therapy is audited adn this isn't provided currently. In addition it is delivered by one member of staff with no business continuity plans and currently no service provided due to staff resignation. This is delaying patients and patients require additional input from MSK and orthoapedics because of this.	£12,000	0	No - new machine	31-Dec-21	Yes	No	Yes	Yes - recent submission link with a research project, but this was not successful
DIS			Delivery Project Management Resources and Governance	Programme Management and Project Management required to initiate and manage the Essential Services Programme. The experience and expertise to manage large scale, complex Infrastructure and Digital enabling programmes cannot be found internally, so external resources will be utilised to deliver the programme while helping to build in-house capability that can lead in the later years of the programme	The role of programme and project management/governance is essential to the successful delivery, against agreed KPI's of each project and the overall programme, including alignment to parallel strategic programmes in the Trust and ICS	£280,000		No		no	yes	no	
DIS			CPD Infrastructure Replacement (Compute, Storage)	The current infrastructure (server and storage) that underpins the CPD solution is end of life (out of support and no provision of updates/upgrades). Given the criticality of CPD we will be replacing the whole of the Infrastructure in year 1. The new solution will provide improved performance, security, resilience, capacity and fail over.	The compute and storage infrastructure that hosts the Trusts core system is end of life and as such is a significant risk (System failure and security) to The Trust	£250,000		Yes - this will replace the whole server estate that currently houses CPD, both compute and storage. This is not leased.	August 31st		Y	Y	Discussion has taken place with vendor and 3rd party delivery partner re leasing options
DIS			CPD RAC 2 Upgrade (CPD DB/DW)	CPD data base/data warehouse is not fit for purpose , the Programme is looking at a new cloud based solution (as a service) - this will mitigate risk and provide a future proofed, enhanced solution that's highly performant, resilient and provides flexibility re Capacity	The data warehouse solution that hosts the CPD (critical Trust service) is not fit for purpose and requires a new solution to ensure secure, resilient, performant and flexible data hosting and provision	£75,000	£48,000	Yes - this will replace an on-premise solution with a cloud based solution, delivered by Oracle. The existing solution is not leased	September 30th		Y	Y	Discussion has taken place with vendor and 3rd party delivery partner re leasing options

CG Notes	Selection guidance for Executive Committee	Revenue Funding	<£5k Equipment funding	Lease Revenue	>£5k Equipment funding - Capital	Capital programme 2021/22	Capital programme 2022/23	Service expansion - further work & BC required	DIS Schemes
TBC (£195K if external Viewpoint provider)	Department has discovered an alternative , therefore do not require.					£195,000			
Need list of detailed requirements - pure estimate at present	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£75,000	
Estimating 10 trollies in EAU	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£60,000	
Need to understand how many units - pure estimate of 10 units at £2500	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£25,000	
Ie just 1 x bladder scanner is £8.5K	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£75,000	
Consumables for activity still undertaken on East Coast , replacing Cath Lab contract. Capital for equipment needed in Radiology	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£200,000	
Pure Estimate	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£50,000	
Pure Estimate	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£10,000	
£79,710 plus VAT email 17/07 with quotes	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£80,000	
	Does this risk just need managing, as there has never being a issue in the past, Caregroup are investigating.							£25,000	
	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£350,000	
	Service expansion, therefore need full BC to understand revenue consequences incl staffing.							£45,000	
	This was approved at MERG 20-002 and ordered last year. This was for Brid OPD as there was no service on the East coast and patients sent to Clifton park. Will require a full BC to understand activity and any revenue consequences.					£12,000			
	DIS has seprate funding identified								£280,000
	DIS has seprate funding identified								£250,000
	DIS has seprate funding identified								£75,000

DIS			UCS and 3 Par Storage replacement	The infrastructure solution that houses the remaining storage requirement for the Trust becomes end of life (no support, updates) in 2022 which is a significant risk to the Trust and the trust's data. The programme is working with 3rd party SME's to look at the architecting a solution that can provide holistic storage capability utilising a hybrid on premise/Cloud solution. the solution will provide a layered capability for data, data archive, back up and restore.	The storage solution will become end of life in 2022 and the DIS team want to pro-actively mitigate the risk this will cause the Trust (again a solution that will not be supported or updated).	£300,000		Yes - this will replace the current on premise server infrastructure that makes up the existing solution - the hardware is not leased.	September 30th		Y	Y	Discussion has taken place with vendor and 3rd party delivery partner re leasing options
DIS			End User Refresh (Levelling up to lifecycle)	DIS would like to implement a device refresh lifecycle for end user hardware (laptop, desktop, tablet, mobile). In order to level our starting point for refresh we would need to refresh circa 60% of entire laptop and desktop estate (above 5000 devices). Once we level our position we can implement the refresh lifecycle as part of standard IT operations and finance funding. We could look at funding this via lease/opex schemes or through capital buy. NB. The introduction of VDI and other mobile devices as part of Unified Tech Fund means that not as many devices need a refresh.	Currently the Trust has circa 5500 devices that are over 5 years old, which need replacing/change of solution as soon as possible to enable the Trust to enter in to an annually device refresh. The refresh/change will enable performance, reliability, end user efficiency and security	£1,650,000		Yes - this will replace existing devices (desktop,laptop) within the overall end user estate. The existing devices are not leased. In some cases we will replace existing hardware with a new virtual solution.	August 31st		Y	Y	No discussion as yet, however large scale leasing opportunity in Refresh
DIS			LAN Modernisation (across sites and data centre)	The kit that enables site networking (all sites) is aged and in many cases end of life. This is a significant risk to operations, security and the enabling of key strategic objectives. Work has already been completed with the Trusts network 3rd party partner to detail the existing state of the LAN assets and the to-be requirements, with associated costs. Once the Trust has the funding the programme will develop a LAN roadmap that will ensure the Trust has the right network "backbone" on which to build operational and strategic services and products we need to modernise the network.	The LAN infrastructure is well architected, however is in need of modernisation as many aspects of the Infrastructure is aged and end of life, which others going end of life in 2022. Work in this FY will mitigate the risk that aged LAN infrastructure presents (performance, resilience, transaction speed and security)	£640,000		Yes - this will replace old LAN kit (switches, routers) with new. In some cases this may require new infrastructure as the need for the solution grows across the Trust. The current LAN infrastructure is not leased.	August 31st		Y	Y	Discussion has taken place with vendor and 3rd party delivery partner re leasing options
DIS			Wi-Fi heat map audit (SCC) Wi-Fi Solution enhancement (Remediation, Modernisation, Growth)	The Trust has a number of programmes and projects (including Virtual Desktop, Scan 4 Safety, Mobile Access to the EPR, Mobile Obs, Mobile EPMA) that will enable paperless working. However, these require robust, performant and resilient Wi-Fi. This piece of work will see a SME 3rd party carry out a full review of our Wi-Fi needs (back end and front end), develop a to-be blueprint and a roadmap to enable the Trust to implement a solution that meets the need of the trust operational and enable strategic transformation programmes. Utilising the roadmap developed in the heat map survey work stream the Trust wide team will work on delivery of the changes required to the Wi-Fi solution to remediate issues and risk, mitigate gaps in the network and develop a solution that can be exploited to meet future growth - this is across 8 hospital sites	The demand on the wireless solution across the Trust is growing, both at an operational level (day to day provision of service) and strategically as the Trust embarks upon transformational programmes (Better Care, IDCR, Mobile Obs, Agile and Flexible working). All these elements will increase demand on wireless in the next 12 months and we need to ensure we have the right solution in place to enable	£270,000		Yes - the heat map survey could lead to the swap out of existing kit for new and it may also state a requirement for new kit to grow the wirless capability to meet every changing operational and startegic need	August 31st		Y	Y	Discussion has taken place with vendor and 3rd party delivery partner re leasing options
DIS			Redesign and redeploy distribution layer within Network	The network distribution layer (which supports network redundancy and load balancing) was removed a number of years ago as part of consolidation exercise. best practise network architecture calls for a 3 tier solution (core network, access layer and distribution layer) and the recommendation is the Trust moves back to the 3 tier model.	The layer is necessary to enable operations and project/programme deliverables, while allowing DIS to ensure its network tiering meets technology standards	£50,000	£15,000	No this will not replace anything within current infrastructure	November 30th		Y	N	No
DIS			IT Security maturity and posture transformation	During quarter 3 DIS will be carrying out an as-is exercise on security, which will provide information on current security posture, the Trusts to-be target and a roadmap to deliver improved posture maturity over 3 years. This will include the delivery of current action sets under the DSP Toolkit compliance. This piece of work will support the mitigation of the Trust Level Cyber Security risk.	The Trust has not initiated the level of work required to meet regulatory standards for a number of years. While the Trust understands the risks and actions required to mitigate, it now needs to start the actions required, which will take some time (years) to fully mitigate, however 2021/2022 is a start	£100,000	£100,000	No this will not replace anything within current solutions	August 31st		N	N	No
DIS			IT Service Management Maturity	The maturity of IT Service Management and CX (Customer Experience) is very low (current level is <1). The aim is to progress to a target level of 4. To enable transformation the Trust needs to fund a service platform (with self service capability), service tools, processes, procedures and resource to help implement and establish	DIS has to start to improve the services it provides the Trust and Patients and the way in which it operates its infrastructure and applications (Inc CPD). At present its level of maturity will not allow DIS to provide sustainable services at an operational level, nor will it be transform ready for the strategic programmes of work that are being delivered.	£400,000	£40,000	No this will not replace anything within current solutions	August 31st		N	N	No
						£5,217,000							

	DIS has seprate funding identified								£300,000
	DIS has seprate funding identified								£1,650,000
	DIS has seprate fundign identified								£640,000
	DIS has seprate funding identified								£270,000
	DIS has seprate funding identified								£50,000
	DIS has seprate fundign identified								£100,000
	DIS has seprate funding identified								£400,000
		£0	**£0**	**£0**	**£0**	**£207,000**	**£0**	**£995,000**	**£4,015,000**
								Total	**£5,217,000**

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Resources Assurance Committee Minutes
20 July 2021

Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (ABert), Polly McMeekin (PM), Dylan Roberts (DR), Andrew Bennett (ABen), Penny Gillyard (PG), Michael Taylor (MT)(Observer), Matt Morgan (MM), Jill Hall (JH), Rebecca Bradley (RB), Cheryl Gaynor (for minutes)

Apologies for Absence:

Jim Dillon

Welcome and Introductions

LM welcomed Matt Morgan to the meeting as supporting Non-Executive Directors in the absence of Jim Dillon. LM also welcomes Mike Taylor to observe the meeting as the new Associate Director of Corporate Governance due to join the organisation in September 2021. ABert introduced the committees terms of reference for the benefit of Mike.

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 the 22 June

The minutes of the last meeting held on 22 June were agreed as a correct record.

Matters arising from the minutes

Action log updates:

Action 78 – DR to discuss with Adrian Shakeshaft and will update at next meeting. Adrian was organising a desk top scenario of a cyber attack incident and was working with Richard Chadwick – DR will report back at the next meeting.

Action 77 – To be amalgamated with action 78

Action 76 – DR noted that this action was part of the essential services programme therefore it was picked up as standard practice. This action can be noted and assurance be given that the next peak of information will include this detail.

Actions 50 – ABert advised that this was now locked in and timetabled, 6 and 12 months post implementation. Building on this becoming the new norm going forwards including business case guidance being updated with all post implementation work.

Action 57 – ABert reported that the agenda has the proposed terms of reference for the Resources Committee and describes the LLP in relation to where it stands with this Committee. ABert raised one outstanding issue around the signed members' agreement of the LLP following the current Chair's tenure coming to a close, he advised that the appropriate clarification was being sought and the members' agreement will be updated accordingly to reflect any outcome. Action closed following update from ABert.

Action 53 – This action was detailed as a report on the agenda therefore was closed.

New Start Programme

LM clarified that although the report identifies that the Resources Committee was asked to approve the report, the Committee was in fact just taking assurance and discussing anything to note.

PG highlighted work stream 10 of the 13 work streams detailed in the progress report. She noted that the 5 people work streams remained on track and identified that work stream 10 was now complete. PG emphasised that this was a key piece of work for the trust Business Development Manager and the LLP Business Manager with some significant work. Some new processes around new work requests provided greater internal control from a budget perspective for the Trust but also ensured that the LLP is funded for new or additional work.

LM noted that it was good to see some really comprehensive reports and the progress overall on the new start programme. She noted that there were 4 working groups that were to meet on a fortnightly basis for 4 to 5 months commencing from August and queried this decision given the programme was due to run for a long period of time and the working groups were to give assurance that things were on the right track. PG clarified that there was a really good cross section of individuals and had just initially thought of 4 to 5 months but it may roll on longer than this. The aim was to get value from the working groups and because it would be such a time commitment with other priorities, it was important to give an end goal of 4 to 5 months - it is at this point that an assessment of value and what has come through can be made. PG also highlighted that the programme was linking in with the roll out of the new Trust values and behaviours and would be also having values ambassadors enveloped as part of the work with the volunteers.

LM referred to the CAFM system (NSP Ref 06) and the target completion date. She noted that there had been discussions earlier in the year about the system where it had been raised there were a number of KPIs (initially had gone from 40 to 33) that couldn't be measured. This raised concerns that there was still a risk in that the system in place in April 2022 was too far away. PG provided an update on the interim CAFM systems and advised that the actual roll out had gone well and feedback received in York, particularly from the supervisors, was that it was a little 'clunky'. PG advised that the progress on KPIs had recently fallen to 21 which were not now able to report on and It was hoped that by the end of August there would be a further 3 KPIs within estates to report on. PG

advised that one of the key issues had been a lack of any system for 'soft services' such as portering, domestics etc. within facilities. She also advised that there had been the development of an app and it had been agreed that the Trust would like to become early adopters in line with a few other Trusts. This would become a trial initially and there was work being undertaken to map some of that out. PG noted that it was hoped to report on the remaining KPIs through this.

LM clarified that it was assuring for the committee to hear that there was some mitigation for some of the KPIs and the app sounded interesting, **the committee requested a progress report back on this**. However, concerns remained around the remaining KPIs and it was stressed that consideration be sought into manual work around what could be done to mitigate these until such time when systems and the app are working.

LM noted that it would be good if the Committee could see some notes in the gaps on the work stream table (page 16) as the gaps give the impression the work has perhaps not commenced. It was also noted that it would be useful for the Committee to understand what barriers prevent any progress of the work streams. PG advised that the agreed priority was the five working groups and other work streams were being scoped out. All work streams were currently on track and the only risk areas that would be of any concern or hold a barrier were those where business cases were required.

MM highlighted that item 8 and 11 were not yet started however they were due to be completed in the next 6 months or less. He questioned whether these were achievable and whether they would in fact be delivery dates that may be pushed. PG agreed that there might be some slippages around the processes and system streams as it was reliant on the business cases and it was common knowledge that this would not happen in the current year.

It was agreed that PG would report back to the Committee with an interim update (in September) before the next quarter report was due, to include a short written update where there are gaps in the work stream action plan at present along with some assurance statements.

Annual Compliance Report

PG noted that it was pleasing to present the progress over the last 12 months. She highlighted the monthly contract management meeting was in place and working well by providing a robust challenge at its monthly meeting. PG advised on trying to improve the sickness absence performance which when comparing against other key core benchmarking LLPs, this was high. Key areas to note were MSK, stress and anxiety – mitigation work lead by the Director of Facilities are in place by means of a task and finish group focussing on how to support and address these issues. Also with support from workforce colleagues, where there has been a backlog they are being worked through.

LM raised her concerns around the increase in number of KPIs from 65 to 92, great to introduce more but need assurance that they were necessary. PG assured that the KPIs had been reviewed and were now down to 91 which will naturally come down with the maturity of the LLP, initially this has come down from 120 which shows good progress. She advised that the original MSA had a series of reporting and accountability measures in place which have since been refined and reduced.

LM noted that a particular area of concern was the sickness absence rates around portering, domestics, catering and waste. She noted the work that the Trusts workforce team had done around mental wellbeing and sickness and raised whether this work was being brought into the LLP. PG confirmed that the LLP HR Business Partner was a member of the task and finish group and provided a link into the Trust work. PM confirmed that the LLP was actively engaging with all of the Trust initiatives in particular around sickness and absence.

MM highlighted that in terms of the sickness figures, there was a clear disparity against groups and wanted to understand if there was any understanding of what might be driving this as there were concerns that figures this high had not yet been seen by the board. It was important to understand what was being done about it and was there a plan, when might there be sight of a significant improvement. PG advised that there were a lot of contributing factors to the figures such as culture issues with teams, low morale as lowest paid workers or often there are external influencing factors. **The task and finish group were pulling together a plan of how they were going to address the figures with the teams and understand where their key focusses were as a group, which would be shared with the committee.**

PM highlighted that a learning point picked up through the Executive Committee had been around the update of the flu vaccination campaign as there was a struggle in 2020 to get an uptake despite there being specific clinics arranged so there was a need to have a conservative push this year. It was recognised that although there may well be a national push, there needed to be something more targeted for the LLP.

LM referred to the uptake of the covid vaccine in the LLP. PM noted the recent stats that were produced in June 2021 where the covid update for the LLP was 74.5%. Consistently across the organisation there was around a 5% drop from those going from dose 1 to 2. The LLP 82.3% for 1st dose and then 74.5% for 2nd dose. LM queried whether this was a concern or worry and if there was anything in place to manage – PM advised that there were plans to be discussed for a booster campaign from September to December and the Trust was also looking at an 'evergreen' offer (both doses at once) which will be launched again however it is always available and offered frequently to staff and new starters. PM acknowledged that there was some work to be done around communication methods with the LLP as there is a reliance on other sources of communication and have always relied on staff attending the vaccination hub and would question whether it would be helpful to be going out to them instead.

Action – PG to discuss with Mark Steed (LLP Director of Property and Asset Management) and Malcolm Veigas (LLP Director of Facilities Management) on a vaccination campaign out to departments/staff in the LLP areas.

LM identified that there were some issues around dementia and disability on the place scores which PG clarified there was a plan to work through these with Dave Biggins as the Inclusive Built Environment Lead and agreed to take this query away and to understand if there are any risks and what needed to be done to mitigate those risks.

LM also highlighted page 22 which questioned against ground maintenance and there being no requests but it was unclear what this meant in terms of statistics and how that was being managed. PG confirmed that the grounds maintenance result was due to there

being no queries received for this area however, PG did emphasise the need for a grounds maintenance strategy as visits to some of the Trust sites has identified a considerable amount of work required. Although there had been no requests there was a lot of work that needed to be done to improve the approach by being more proactive in relation to grounds maintenance. **LM requested to see an action plan around what was being done or planned to be done around this.**

LM raised the continuous red high risk areas in cleanliness despite this having been raised previously. There were concerns that the KPI was not being met and this was continuing to be the case and queried what could be done from a patient safety point of view. ABert identified to the Committee that the report didn't indicate any red areas (page 21 & 22) but that there were high and very high risk areas and in domestics the very high risk in the year reported had risen from 97.82% to 98.14% but in terms of meeting the cleaning standards, the Trust was at least achieving by an amber rating in all areas.

Surplus Land and Property Disposals Report

ABen presented the report and highlighted that this work was part of a national Department of Health process which had shifted from annual to quarterly. ABen advised that as part of the project schedule, backlog maintenance was a key consideration as well as strategic developments.

LM clarified that Springhill House in Scarborough, Cherry Tree Avenue Properties in Scarborough and the Social Club property in York were three potentials for the next 12 months bringing the total cost of ownership and an opportunity cost saving. ABert advised that the sites will be presented through single business cases. Springhill and Cherry Trees were due to be presented to the Board in early Autumn however, it was noted that that the Board had already agreed the disposal of the Social Club. The Board signed the York Community Stadium contract and approved the business case which detailed for the training and facilities carried out at the Social Club would move over to the Stadium on completion of its build and consequently the Social Club would be dispersed. ABert advised that conversations had begun with the Social Club Committee (a separate organisation to the Trust) but due to some controversy, it was likely to come back to the Board.

LM – highlighted the water with the VIU scheme which appeared to be still ongoing after some time and for assurance to the Committee, requested an interim report of how this was progressing. ABert confirmed that ABen, Mark Steed and himself were in discussions around the VIU scheme and stressed that it was understood an imminent decision was required with a £6.9m loan if not drawn would be lost. **It was agreed that an update would be provided to the next meeting of the Committee on progress.**

The Resources Assurance Committee noted the potential surplus land and property disposal opportunities. The committee also noted the high-level delivery plans.

Backlog Maintenance Update

ABen presented the backlog maintenance update which provided the Committee with a comprehensive overview of the current position in relation to the Trusts estate related backlog maintenance and associate costs and risks. ABen advised that this was

developed following a recognised structure process as per the NHS guidelines. It was important to note that the report described impending backlog maintenance and the beginnings of a 5 year programme. Year 1 was robust and aired at the Capital Programme Board at its meeting on the 15th July 2021.

ABert noted that this was a critically timed report as the Trust was currently undergoing a process with all of the Care Groups around urgent capital needs. The report describes that the Trust would fall short for year 1 but stressed that there was a need to begin materially pursuing the backlog maintenance programme then there would likely be difficulties in the coming years.

Following queries around the plan to try and mitigate some of the risk, ABen advised that the level of investments that the Trust was able to make to the backlog maintenance would continue to grow despite any mitigation as the maintenance will realistically not become stable or diminish over time. ABert highlighted that at the August board meeting there would be a submission of a proforma, which came from the Department of Health, to identify the next 8 new hospital builds in the country between 2021 and 2030. There was initial doubt that the Trust would get onto the programme.

MM raised that a lot of the maintenance costs were in the small and community based sites and considered how much this then fed into reducing the number of sites whilst taking into account that this includes large amounts of planning and there were clearly huge implications. ABen noted that some of the maintenance burden were an example of a direct link with the surplus land report and the capital projects. Although all of the Trust projects pick up backlog maintenance at some point, on some occasions a disposal of some properties is a favourable option. He also noted that the clinical strategy was a priority that worked in conjunction with the estates partners and bound by an estates strategy providing a holistic view and would include site rationalisation in terms of both backlog maintenance and people as services were being stretched and was recognised in the clinical strategy work.

LM highlighted the significant risks (page 50) and raised her concern of what could be done from an assurance perspective. ABert advised that the Trust could apply for additional funding and noted that he had already opened up conversations with the ICS around emergency capital given the statutory risks. Despite this process being something new to the Trust and there being a lack of clarity around the national capital strategy the Trust was opening up conversations.

ABen clarified that the report highlighted that in terms of the current risks for patients and for safety the report provided assurance that the highest risk areas were being targeting as a priority. It was acknowledged that the plan could have included the risk ratings to provide that extra assurance and to show the focus in a clearer way and would consider this in future updates to the Committee. ABen assured the Committee that any changes in terms of risk that would be a cause for concern would be flagged and would work with the Trust to identify funding to address it.

The Resource Committee noted the report and gained assurance that the estate-related backlog maintenance review process had been thorough, comprehensive and in accordance with NHS Guidance (NHS Estates' A risk-based methodology for establishing and managing backlog', 2004).

EPAM minutes and escalation report

The Resources Assurance Committee noted the minutes of the 29th June 2021 meeting of the Executive Performance Assurance Meeting.

SIRO Annual Report

DR and the Committee welcomed Rebecca Bradley, Head of Information Governance and also the Trusts statutory role of Data Protection Officer to the meeting. He advised that she was developing and resolving issues around the Information Governance strategy going forwards.

DR advised that it was a recommendation that there was an annual SIRO report to the Board which updated on what work was carried out but the information governance team and how it was complying with legislation. He also advised that the report describes a good practice basis accountability framework from the Information Commissioners Office (ICO) which helped to measure where the Trust was in terms of compliance with information governance best practice. The date security protection toolkit (DSPT), which was measured annually by NHS Digital, was linked to the ICO accountability framework. DR suggested that what was in place, for the purpose of assurance, was a good practice assessment method for measuring where the Trust was and as a result of that assessment there were actions suggested about how to move forward.

DR highlighted that the Trust didn't currently have an Information Asset Register which described what information it is processing, why it is processed and on what basis was it being processed. In order to develop a register there needed to be an audit of what information currently existed and in order to determine this, there was a need for an information asset owner (an individual who was nominated in each area) who understood the information the area held, what was added or removed, why and what the risks were.

DR highlighted that the Trust was currently at a baseline in terms of the state against the ICO accountability framework, the first step was agreement from the Executive Committee to gain the Information Asset owners in each of the service areas and update the register – from this the Trust would start to become significantly more compliant with requirements. He acknowledged that the Trust hadn't really previously had an understanding of data protection and the handling of information and was therefore expecting the number of information losses and incidents to increase due to not having recorded anything accurately previously.

RB advised that the 2 year strategy had been written to get the trust to a basic level of compliance but acknowledged that this may be ambitious given the size of the Information Governance team and the scale of the task. However, with engagement from the service areas and the Information Asset Owners, there should be a good level of information into the register which will then feed a clear understanding of where there may be gaps in compliance and where the risks are prominent. RB also advised that the strategy was around what GDPR was fundamentally there for and for the Trust to be accountable with the relevant documentation to support it.

MM questioned where this leaves the Trust in terms of the risk currently in reporting our compliance if there is a lack of awareness of what information is currently held and not

able to report accurately. RB assured the committee that there was a strong service input where individuals know what happens to information in there area which was just not currently documented in such a way that can be evidenced for compliance.

LM noted that she had asked for assurance at the last meeting (page 9) and an action was noted and re-requested at the meeting for:

- **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.**

LM referred to the charts detailed in the report (page 74) where around a 3rd of the breakdown of current status of all categories were not or partially meeting expectations and sought clarity on what the 'blank' referred to in the breakdown of current status per category. RB clarified the blank reference was anywhere that an answer was unachievable in the framework. With this being around 33% where there was potential high risk due to uncertainty LM stressed the importance of getting to grips with those blank areas of the framework.

There was understanding from the Committee that this was the first time there had been a clear assessment of data governance and also and understanding that those risks and that there needs to be mitigation**. It was agreed that a quarterly progress report on the information governance register be presented to the committee going forwards.**

RB left the meeting.

Integrated Business Report (Digital Indicators)

LM acknowledged that the Integrated Business Report was only recently set up and would be good to see what the targets were for each of these to provide something to measure against. DR suggested a progress that could be measured may be things like the numbers of calls to the helpdesk – are they reducing as a result of decent technologies, what the percentage of calls dealt with at the first point of contact, the number of open calls/incidents. LM clarified that there was not a request for new measures but an understanding of the indication of how the project was doing, a trend can be seen but without clear understanding of what they mean and what is good etc.

DR reported that the Board Assurance Framework had recently been updated therefore there was nothing further to add.

Tender Register

ABert reported that there had been no reportable tender action to report.

Integrated Business Report (Finance Indicators)

ABert advised that the report described month 3 which was showing a £10.6m surplus against a balance planned position – the Trust had recovered ELF funding and accounts

for £7.8m. It was not currently clear on whether the Trust would receive this but was a best estimate. A consequence of working in an integrated care system meant that the ICS would likely take this back or at least use it to support the pressures for the second part of the year. ABert advised that there was no position agreed with the Treasury on the second half of the year regarding health service funding and that this may be September.

Subtracting the £7.8m leaves a £2.9m operational underspend with £1m driven by spending slightly less than the covid allocation. The Trust was comfortably managing within the covid resource that is available.

AB advised that the Trust continued to work with its financial regime which was working somewhat from a financial perspective.

The Committee noted the finance update.

Library Annual Report

PM advised that the library annual report was not previously presented to the Resources Assurance Committee as it would ordinarily be discussed at the Education Review Group and fed up through to the Executive Committee but due to a review of the group, the report was presented to the Committee.

The report highlighted key challenges and successes over the year and described a little around staff health and wellbeing. The report also described how the library team were liaising with the patient safety team so that when there were SIs or incidents, they would be able to help and advise with any clinical research to inform SI responses.

ACTION - LM expressed that it would be good for the Committee to receive an interim progress report at a future meeting.

The Committee noted the report.

Integrated Business Report (Workforce Indicators)

PM advised that the staff sickness absence reporting for the business report was always reported with a six week lag. She reported that on the 10th July the Trusts absenteeism increased with a clear relation to covid isolation. Reporting on the 7th July there were 10 people off with covid positive which increased on the 19th Test and trace there were 16 off on the 7th July and increased to 31 as of the 19th July. Isolation due to caring responsibilities and as a consequence of the school bubbles diminishing meant that on the 7th July there were 21 off but this increased to 52 as of the 19th July. Overall there was a tripling of the impact of covid related absences. PM advised that the Trust was managing this really carefully and have introduced mitigations to try and reduce the impact. PM described the recent difficult weekend where there were two sporting event finals on and the bank or agency uptake just wasn't there. The following weekend was not a reflection at all which indicated that the lack of update was due to the sporting events. PM advised that between the 15th July and the 15th August the Trust was running a bank uplift of an additional 10% which was outside of normal practice for the Trust but there was a need to be seen to be acting on the staffing levels. PM also advised that the 15th August was the

chosen deadline following the government guidance changing on the 16th around double dosing and staff no longer needing to isolate if they are contacted by test and trace.

PM advised that another mitigation to reduce the impact was introduced the Friday prior to the sporting weekend where the Trust introduced a new policy, adapted from the Newcastle model, which was if staff were pinged by the test and trace app, it was not a legal requirement to isolate and therefore under certain caveats, the Trust would encourage staff to come into work. It was subject to anyone being double vaccinated and the second vaccine being more than 2 weeks ago, staff were to subscribe to daily testing and also subscribe to a PCR test on the 5th day subject to PPE etc. This was superseded by PHE guidance that came in on the 19th July which didn't limit to just being pinged by the NHS Covid app if staff were contacted by test and trace at all because with the national test and trace it was a legal requirement to isolate – as a result the Trust was adjusting its local policy on adapting the PHE guidance which was really restrictive and the Trust was only able to overrule when there was clear patient safety risk and with judgement required on a case by case basis. PM expressed that it was challenging for the Trust to manage because of the unpredictability of the app and social distancing, absences were appearing randomly and it was becoming difficult to manage a service on that basis. The update from the local test and trace team, which was part of the occupational health department, was that there were minor numbers being reported back through the local policy. An average of 24/25 per day that the team were assessing and getting a handful back because the view was that if their contact was a known contact i.e. they lived with them, it was a patient index case, the expectation was that they were a close contact and that was the advice of the Trusts Infection Prevention Control team.

MM referred to a recent patient safety walkround where the impact of staff absences on their wellbeing was obvious. He noted that the Trust was working to keep those absence rates down but wanted to understand what the Trust was doing to keep the morale up. PM suggested that the Executive team needed to work really closely with the ops team in understanding what services would need to close to consolidate staff. She also suggested that bank staff and agency staff were encouraged rather than suggesting/offering overtime as offering overtime may insinuate or imply that it was ok to work more hours and the health and wellbeing of the staff needed to be protected going forward. The Trust was working with mental health support because it was predominately mental health and were carrying out some targeting interventions.

PM noted that the Trust was progressing the covid and the flu vaccination campaigns and confirmed that the flu vaccination was in the pharmacy on the 9th September and were working up a programme to start on the 10th September but were awaiting advice on whether this could be given at the same time as the covid vaccine.

PM expressed her concerns to the Committee around the statutory and mandatory training of bank staff, although there was an improved compliance of uptake it remains to be a concern. She advised that the Chief Nurse had taken a view and was supportive of anyone not training complaint could not take up bank shifts. The Quality and Safety Committee had received a report which requested an increase in communication around the subject and giving until September to become compliant with training. If there were limitations then the Trust would look to mitigate and accommodate. The majority of training could now be completed online so easily accessible. If staff were not compliant by September the Trust would then suspend the account and give a further month to comply before removing from the bank completely. PM advised that a consequence would be that

this would leave the Trust with a risk and would need to make a judgement nearer the time as to how many active bank staff had done their training and how many hadn't.

PM reported that there was a glitch with the international nurse recruitment and welcomed 12 in June and another 46 in the last few months. She also reported that there had been trouble getting the nurses through their objective structured clinical examinations (OSCE). There were not many test centres and the Trusts local centre was Oxford which had a high fail rate at 55% and as a consequence, the Trust had a high fail rate after previously getting close to 100% pass rate. The Trust has since redesigned the programme where there was a 4 week boot camp approach and redeployed one of the Trusts key trainers for the OSCE but at the closed of the week had a 100% pass rate. The Trust was now working closely with Frimley Health NHS Foundation Trust who had a 100% pass rate consistently so the Trust we can understand what they are doing and share practice.

PM advised that the violence and aggression against staff had reduced with an average of 6 cases per week down from a 7.9 average of the previous 3 years. The Trust has developed some communication through the staff weekly bulletin around the importance of escalating concerns. PM assured that the security department followed up each Datix submitted to ensure that the welfare of the staff was supported. NHSEI had produced a framework in December 2020 (The people plan) and the security team were completing an analysis to identify where the Trust compare in relation to the framework which would be presented to the Board through the Chief Nurse (as the Trust's Health & Safety Executive lead).

LM noted the update on research and development (R&D) and reported it was good to see that external funding was growing in this area. The R&D team had previously presented to the Board where it was noted that there was a need for support around culture change in the organisation, LM considered whether this was a risk. PM clarified that the team were really busy and vibrant with business. Although culture takes time, the care groups were becoming much more perceptive. She also advised that the research strategy was finalised which was due to be presented to the Board in due course. LM wondered whether there would be an opportunity to publicise the success that the Trust was having and the funding around R&D to attract even more funding and potential employees. Especially linking to the brand and the teaching element of it, could the Trust be doing more?. PM clarified that it was early days however, would shortly be able to start to publicise on social media etc. LM expressed that it would be great for the Committee to see a quarterly R&D update rather than annually and it was also great to see the links with Matt Morgan and HYMS around the academic posts. LM noted that Matt had agreed to attend the Committee to join the quarterly R&D report.

The Committee noted the workforce update.

ACTION – to provide a quarterly R&D update to the Committee. Matt Morgan to join the committee for this item.

Terms of Reference

JH reported that in March 2021 previous Non-executive Director David Watson had assessed the terms of reference for the committee and an amended version was presented, reviewed and was asked to be reviewed again. The main changes were that

the terms of reference now detailed the duties and functions of the committee and provided a clearer direction for setting agendas and work plans to feed into the Board. JH also advised that the terms of reference allowed for items to be discussed at the committee so that less time was spent discussing the items at the Board – the detail was then done by this Committee to provide the assurance to the Board.

PM raised her concern around the detail under each of the executive portfolio. Her workforce and Organisational development section references equality and diversity but there are others to consider if there was a need to report aspects of this nature. LM suggested that this be amended to say 'to include and not exclusive of'. PM also suggested the removal of 'clinical' from the 'consider clinical workforce issues'.

AB highlighted that the workforce and OD section (2nd point) in relation to local pay, required an executive decision on local pay and would not be something that would ordinarily be brought to the this Committee.

LM suggested and it was consequently agreed to remove the verb 'to consider' from the document and add 'provide assurance of' with the points following.

ABert raised his concern around the finance section reference to presenting a business case to the Committee as this was not as described in the Trusts Scheme of Delegation which requires cases of a certain level to be presented and considered at the Board. If the general consensus was that the Committee would like to review business cases then this would require an amendment to the scheme of delegation therefore it was proposed that point 5 (to review proposals for major business cases…) be removed. ABert suggested, and it was subsequently agreed, that the Non-Executive Directors take the proposal of the Committee discussing major business cases to discuss and consider whether this would be something that they would benefit from going forwards and taking into account that the scheme of delegation would require to be amended as the change of process would hand over the assurance away from the Board to the Committee.

ACTION - Non-Executive Directors to consider the proposal to take assurance of major business cases and their respective funding from the Board to the Committee and report back the outcome of this discussion.

ABert noted that the following points from the finance section were to be removed as these were completed by the business of the Audit Committee:

- To consider the Trust's tax strategy.
- To annually review the financial and accounting policies of the Trust and make appropriate recommendations to the Audit Committee Board of Directors.
- To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy.
- To maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and NHSI's requirements.

ABert also requested and it was subsequently agreed, for the additional point under the finance section, 'seek assurance on delivery of the Trusts efficiency programme' as this was a fundamental part of resources and where the Board sought its assurance on this.

DR advised that he would email JH with some revisions offline.

Reflection on the Meeting and Any other business

- Concerns around dealing with balancing the least and worst things to consider and conscious items are being considered in silo.
- Long meeting
- Good discussion
- Covered a lot of ground
- Getting back into the discipline of two big and two small sections, really feel that is useful
- Concerns on agenda time allocation as there is a significant efficiency programme coming and the regulation around that will be intense and will need a discussion about the time commitment of this meeting
- Suggest a longer (3 hour) meeting when the LLP updates are on the agenda

Time and Date of next meeting

The next meeting will be held on 21 September 2021 at 9am face to face with Webex available for additional attendees.

York and Scarborough Teaching Hospitals NHS Foundation Trust

CHAIR'S LOG: Assurance summary

Committee/Group: Resources Assurance Committee	Date: 21 September 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 interim update from Penny and noted the launch of the New Start Programme went well. The Committee requested that the progress report is clearer to provide assurance i.e., an executive summary which highlights the programme as well as the forecast milestones, RAG status and any risk/mitigation. The Committee requested a further report back on the CAFM Pilot findings in November, having raised concerns once again about the CAFM programme and the delay in timescales from April to October 22. Assurance is sought around any impact the CAFM delay will bring on monitoring KPIs including around patient safety and impact on staff. The Committee expressed concern around sickness levels increasing for staff and VIU progress.	BOARD	INFORMATION
Workforce	Polly provided four update reports to the Committee: 1) WRES Report: The Committee raised concerns around lack of diversity particularly in the higher echelons of the Trust, including the Recruitment process where there has been a deterioration in BAME appointments (recognising international recruitment is counted separately). The Committee also discussed concerns regarding bullying, harassment, and discrimination issues highlighted in the Report. The Committee welcomed the plan to have a root and branch review of these issues and feedback to the Committee. 2) WDES Report: The Committee applauded the Trust retaining its Disability Confident Status. It noted the outcomes from the staff survey including the Trust making reasonable adjustments	BOARD BOARD	INFORMATION INFORMATION

	for staff responding who had declared a long-term health condition or illness (77.1%) compared to the national average of (75%). However, concern was raised re the increase in bullying and harassment scores. The Committee noted progress with the Race Equality Network (REN) and Enable networks. Assurance was sought around maximising the usage of networks where there are concentrations of ethnic communities e.g., Bradford, Leeds, Manchester and even nationally (i.e., as well as the ICS network). The Committee requested that the WRES and WDES reports go to Board with a clear linkage to the culture and comms plans in the Trust. 3) People Plan: A request from the Committee that a clearer executive summary of the status of the initiatives including how we provide assurance on reducing any risks associated with the 'grey areas' which are allocated to other organisations to deliver such as NHSEI / HEE. 4) IBR – Establishment was noted is an improvement on last year at the same time with 84 more FTE registered nurses in August (a further 60 in November and another 90 by the end of the year). Staffing was the main concern due to sickness although the August figure of 7.1% (compared to national average of 6.8%) has recently improved to 5.7%. 32% of shifts were unfilled in the four weeks to 15th August. The Committee was assured that a resilience model is being drawn up to plan ahead and mitigate some of the risk. However, it was noted medical compliance training however has dropped to 72% due to junior doctor change over.	BOARD BOARD BOARD	ACTION INFORMATION INFORMATION
Digital	Dylan introduced 4 reports: 1) Digital Information Services report. General recognition from the Committee that progress is being made particularly with the CTO programmes. A request from the Committee is that	BOARD	INFORMATION

	there is a greater transparency and communication on the impact digital is having on patients/staff including the cost/benefit analysis from a) programme delivery successes and also b) those delayed e.g., the dictation system. 2) NHSX – funding applications were welcomed, and the ask was how we mitigate any risk if the funding is not made available. 3) Cyber security – Adrian presented the report detail on the types of Cyber security issues, which was welcomed; however, the concern raised was the lack of a delivery plan with dates to address the issues. This plan must correlate with the Audit committee asks too. The Committee also asked for assurance on the desktop exercise noting its lateness and it is to be brought back again along with a cyber update to the next meeting. 4) Show and Tell demos were given on GP Connect, Ambulatory data, Expert opinion information and Palliative care. The Committee noted the excellent progress made with real value add for the Trust. The Committee agreed to review a video of the full demonstrations when available and requested a demonstration is given to Board with clinicians and partners present in the next few months.	BOARD BOARD BOARD	INFORMATION INFORMATION ACTION
Finance	Andy outlined the capital paper. Assurance was given that consideration had been given to all areas who have requested funding and risks have been considered for bringing forward funding. For August the Trust has an I&E expenditure position of £3.26M surplus against a £0.07M deficit plan. The Trust's forecast outturn position for I&E in H1 is expected to be break even. A budget announcement on funding is expected by the end of this week.	BOARD	INFORMATION
Risk	The Committee discussed the risks to the BAF and recognised some	BOARD	INFORMATION

	updates will be reviewed in alignment with the overall refinement of the risk profiles. The committee welcomed the deep dive on cyber security risk.		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021 (August data)
Integrated Business Report Executive Summaries

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

Executive Summaries from Integrated Performance Report

Executive Summary – Key Points

As contained in individual summaries

Recommendation

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

Author: Shown on individual Executive Summaries

Director Sponsor: Shown on individual Executive Summaries

Date: September 2021

EXECUTIVE SUMMARIES

Quality & Safety

The IPC position remains challenging for this financial year, there is a focus on quality improvement with work on-going with the Trust's QI team. The challenge is specifically against Clostridium Difficile, we have recently received a threshold of no more than 133 cases for this year from NHS England and Improvement. There is a risk already at this point in the year that we will exceed this threshold based on current performance. There is a planned external review by NHSE/I IPC team to assess our CDI plans. MSSA rates are also of concern and there is on-going work to improve this position particularly with ANTT toolbox teaching. As a result the IPC team have requested to be part of the Trust's improvement plans group which will provide greater governance, overview and assurance of the IPC work plan.

11 Serious Incidents were in August. These investigations are underway.

The amount of incidents that remain open more than 1 month has increased to 886 incidents. The Care Groups are working to review and close these.

There appears to be more claims settled this month; however this is due to a backlog of data for the claim to settle, this is explained in further detail on page 3.

There has been an increase in Falls and Pressure Ulcers, although there is a reduction in Medication incidents. These 3 categories of incidents have regular monthly meetings which focus on improvements.

Unfortunately, complaints data has not been updated. This will be resolved and updated in October's IBR.

There has been 1 confirmed case of MRSA in August, the first in over 12 months. A post incident review (PIR) is being undertaken.

Trust compliance with 14 hour post take remains below 80%, however Trust compliance with NEWS2 scores within 1 hour has improved and remains above 90% compliance. These are monitored by Care Groups and the SAFER meeting.

When compared to August 2020, the number of deaths per 1000 bed days has increased in August 2021 to 8.55 per 1,000 bed days. There were 11 Structured Judgement Casenote Reviews (SJCR's) requested. The SJCR's requested were as a result of the following; 7 x medical examiner review, 1 x Nok Concern/Complaint 3 x - learning disabilities.

In August 2021 the top 3 causes of death were Pneumonia, Sepsis and Myocardial Infarction. The learning from deaths group will focus on learning from deaths; the quarterly report will identify learning and actions.

For Maternity, there were 2 cases referred to HSIB for external investigations which met the national criteria.

The rate for caesarean sections has increased further at both sites; although emergency caesarean section rate at both sites reduced in August.

Author	Liam Wilson, Lead Nurse Patient Safety
Director Sponsors	James Taylor, Medical Director Heather McNair, Chief Nurse

Workforce

Staff sickness absence and unavailability has proved to be very challenging during August 2021, relative to the level of demand on the organisation. Analysis suggests that unavailability in the Trust has been slightly above the national average for the nursing and midwifery staff group. Temporary Staffing fill-rates have held up well despite these pressures, with August showing the 2nd highest FTE fill-rate in the last 6-months.

In August, the Trust reported a +84.26 FTE increase in the number of registered nursing and midwifery staff in post compared with 12-months previously. This position will improve further with the upcoming intake of newly qualified nurses. A total of 60 nurses are due to start in our hospitals throughout the period September to November 2021.

Author	Will Thornton, Head of Resourcing
Director Sponsor	Polly McMeekin, Director of Workforce & Organisation Development

Finance

This paper and individual summary reports on Trust's financial position for period to August 2021 (Month 5).

<u>Emergency Financial Regime</u>

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

With regard to the first half year of 2021/22 only (April 2021 to September 2021), the Trust will be subject to the same allocation based approach used in the second half year of 2020/21. NHSE&I have as yet made no formal announcement regarding the financial framework that will be in place for the second half year of 2021/22.

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

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

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

Since the April Board meeting, and at the request of NHSE&I, the Trust has submitted an updated plan to reflect both the income and costs of delivery associated with the Elective Recovery Fund. Initial projections for the Trust identify that our forecast activity levels for H1 could deliver an additional £21.5m of income under this scheme. The cost of delivering this activity has been estimated at £13m, although for planning purposes a risk provision has been created in the sum of £8.5m, thereby having a net neutral impact on the bottom line I&E plan.

Elective Recovery Fund (ERF)

The ERF is a system implemented at national level that incentivises provider organisations to accelerate the delivery of elective care to address the backlog that has developed during the covid-19 pandemic. Additional funding is being made available to providers to support this process.

The estimated income and expenditure linked to ERF is now included in the position to date and in the forecast, although this is not guaranteed and is subject to change. The amount of funding that the Trust will receive is dependent upon a number of factors including the performance of the other provider organisations within our Integrated Care System (ICS), and the actual receipt of ERF will be on a basis agreed by the ICS. The income figures included in the I&E position and forecast position at August are calculated based on the information available at present, and reflect an agreed position with our ICS partners. The figures will be refined as appropriate in the coming months as actual income allocations are notified to the ICS by NHSE&I. Due to the nature of counting the activity linked to the ERF scheme there is a three month delay in learning the actual income.

Month 5 Position

For August, the Trust is reporting an I&E position of £3.26m surplus against a £0.07m deficit plan, placing it £3.33m ahead of the system plan submitted to NHSE&I. This is primarily driven by the net impact of ERF income being behind plan with the associated cost of delivery also being behind plan (£7.3m); partially offset by other net underlying Trust performance being £4.0m ahead of plan.

The Trusts overall CIP target for the first half of 2021/22 is £2.8m. In August the Trust has delivered £0.5m of the £2.3m year to date target.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 90% of suppliers being paid within 30 days.

Forecast H1 Position

The forecast outturn position for H1 2021/22 (1st April 2021 to 30th September 2021) is a break even I&E position.

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

Research & Development

Our key outcomes in the last month are as follows:

- Our accruals (number of patients entered into a clinical trial) are very low at the moment, mainly due to the fact we are not seeing patients as much as we normally do, so this is really impacting on our service.
- We are currently designing a study to look at the Patient Experience of using Colon capsules to take photos of the gut and send them back to clinical staff to review. We are now extending this work to also assist (we hope) with the backlog of surveillance colonoscopies. This work will be funded by NHSE and sees our Trust at the forefront of this study as we will yet again be managing this England wide research study.
- The following grants for external funding were submitted in the last month
    - NIHR HTA application (£986K)
    - Rehabilitation study with a Canadian Group (£250K)
    - York Translational Haematology Unit – Research Nurse funding with UoY to support Jules Thorn application
- Commercial Research Manager post has gone back out for advert as no suitable candidate were identified at shortlisting
- We have held the first seeing group for the jointly funded Trust and CRN multimorbidity research Hub at Scarborough which went very well. We have appointed to the research practitioner post with the research fellow to follow. The Hub will go live in November 2021
- We are beginning a piece of work to try and create an academic research career pathway for our staff to model some of the larger Teaching Hospitals in England. We are bringing together key internal stakeholders to a meeting in October to begin planning this.

This is alongside delivering a large portfolio of clinical trials spread throughout all our six Care Groups. The challenges now are how to support this portfolio, alongside our Covid 19 trials (that still require a lot of support) and open up new opportunities, with the staff we have.

We are a very busy team!

Author(s)	Lydia Harris Head of R&D
Director Sponsor	Polly McMeekin Director of WOD

Operational Performance

Nationally, the COVID-19 Pandemic NHS Emergency Preparedness, Resilience and Response incident level moved back to a level 3 national response on the 25th of March.

A level 3 national response is defined as “an incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level”.

The Trust has continued to operate within its COVID-19 Command and Control structure throughout August and as at the 9th of September there were forty seven COVID-19 positive inpatients in our acute and community hospitals. The number of COVID-19 positive inpatients peaked on the 26th of January 2021 at 216.

The Trust has had 3,191 COVID-19 positive inpatients since 17th March 2020, with 2,487 patients discharged, sadly 656 patients have died. Since the end of July 2021 there have been 161 new COVID-19 positive inpatients and twenty two deaths.

As at the 9th of September, York Hospital has two COVID-19 positive wards with one COVID-19 positive ward at Scarborough Hospital. The three wards equate to sixty three beds that are COVID-19 only and are not available for general non elective admissions.

The Trust’s COVID-19 surge plan is in place to respond to further requirements for additional wards.

Trust Planning

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

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in 2021-22 to support the start of the recovery of elective activity, and the recovery of cancer services. Systems were asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021.

The Trust has engaged with partners in the HCV ICS and the finalised operational plan for the first half of 2021-22 was submitted on the 3rd of June.

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

The workforce risk that the Trust highlighted as part of the H1 2021-22 activity plan has materialised to a greater extent than was anticipated through quarter 1. This has affected not just the Trust but all partners. NYCC, TEWV, YAS, Primary Care and VOCARE who have all been operating at their highest level of escalation due to workforce pressures during August, limiting the availability of support from the system to reduce delays to patients or support urgent care demand. The Trust is currently circa 7-8% absence (circa 25% COVID-19 related). Currently at 580 daily absences, with summer annual leave and reduced bank/ agency pick up of shifts. This is an improved position from mid-August 2021 (circa 800 daily absences), with forecasted improvements in September and October in the nursing workforce.

The pressure on medical staffing has contributed to the cancellation of 269 outpatient clinics within fourteen days of the planned date and there were 109 elective patients cancelled by the Trust for either COVID-19 reasons (Staff isolating) or clinician/nursing unavailability during August 2021.

Elective inpatients are required to have a COVID-19 PCR test prior to admission, unfortunately in August 2021 forty nine patients did not attend their test and subsequently had their surgery or endoscopy cancelled (July 2021; 72). This is 'lost' activity as the Trust is unable to reallocate the theatre to other patients due to the need for the PCR test. This is a newly captured cancellation reason and the service modified the booking process on the 18th of August. This issue will continue to be monitored.

The above have contributed to the Trust not delivering the expected levels of activity in August 2021 although the Trust did achieve against the national activity 'ask' for follow up outpatient and day case elective points of delivery.

Point of Delivery	August 2019 Outturn	August 2021 Actual	Variance	Proportion of August 2019 delivered in August 2021
First Outpatient Appts	13,115	11,806	-1,309	90%
Follow up Outpatient Appts	29,309	31,638	2,329	108%
Ordinary Electives*	619	439	-180	71%
Day Cases	5,994	5,696	-298	95%

Please note: colour key denotes performance against national activity 'ask'. For August 2021 any elective Point of Delivery above 95% achieved the national activity 'ask'. *Ordinary Elective figures are based on discharge date.

Planning guidance for the period October 2021 to March 2023 is due to be released on the 16th of September, the Trust will engage with partners in the HCV ICS ahead of finalising the operational plan.

<u>August 2021 Performance Headlines</u>:

• 71.7% of ED patients were admitted, transferred or discharged within four hours during August 2021.
• July 2021 saw challenging cancer performance with the Trust achieving four out of the seven core national standards.
• 1,348 fifty-two week wait pathways have been declared for the end of August 2021.
• The Trust saw a decline against the overall Referral to Treatment backlog, with the percentage of patients waiting under 18 weeks at month end decreasing from 69.5% in July to 68.1% at the end of August 2021.

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

Sponsor	

Digital and Information Service

August has been quiet in terms of progress due to the necessity for folk to take much needed leave.

Although a quiet month overall it is great to see significant movements downwards in total number of service desk calls (circa 1000 down from the same time last year (20%)) and abandoned calls (down by 1300 on this time last year (over 50%)).

It is hoped that this is due to the resolution of some long term trust wide issues such as AO VPN, this reduction enables the Service Desk team to focus time and effort on other underlying problems and the reduction of backlog.

Within the Essential Services Programme the team are working in collaboration with Procurement on a large scale tender exercise, working through the NHS SBS framework to engage a strategic partner to augment the team in the delivery of services from concept to architecture/design, business case development, planning, delivery and adoption. Once completed this will simplify what has been a sporadic procurement approach in the past and bring in the necessary skills to help us deliver the Digital and Information Strategy as and when business cases are approved and funding secured. Further to this it will help raise the capabilities of the in-house teams.

NB – one issue of concern within the Essential Services Programme is the major delays in getting new devices and hardware due to issues with the supply chain worldwide and in particular into the UK.

• For example HP laptops due this month are delayed by a further two which impacts our ability to make necessary changes.

On the 31st August NHS X issued three online documents to support organisations and ICS improve, sustain, and to continually develop the use of digital technologies to support the delivery of high-quality patient care. The documents have also been developed from the learning gained on the use of digital technologies during the COVID pandemic.

The three online documents are;
• What Good Looks Like - builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. These will include an assessment framework to measure our level of digital maturity that we will need to demonstrate progress on.
• Who Pays for What – a proposal that all money for Digital investment will be devolved to the ICS level where spend will be determined from 2022/23 onwards which is out for consultation.
• Unified Tech Fund – a prospectus for what the ICS and organisations in the ICS, including our own, can bid for to improve their digital maturity.
Our current strategic outline cases and bids for funds for essential infrastructure and electronic patient record work may need to be adapted again to be in line with these policy documents and this will amend the timelines and approaches for funds from where we were.

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

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Freedom to Speak Up 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 purpose of this report is to update the Board of Directors on the Freedom to Speak Up culture in the organisation by reviewing data, trends, themes and outcomes.

Executive Summary – Key Points

The number of speak up cases, on average, is comparable to those organisations who are of a similar size nationally. 59% of the concerns raised to the FTSUG since August 2020 are in relation to inappropriate behaviours, bullying and harassment.

Recommendation

The Board are asked to:

- Consider the data in relation to behaviours, bulling and harassment;
- Consider the challenges of the role which impacts on the proactive work that could be done to help improve the overall culture, and then in turn worker health and wellbeing, worker experience, and patient outcomes;
- Consider its commitment to improving its FTSU index .

Author: Stefanie Greenwood, Freedom to Speak up Guardian

Director Sponsor: Simon Morritt, Chief Executive

Date: September 2021

1. Introduction and background

The appointment of a Freedom to Speak Up Guardian (FTSUG) in all NHS trusts was recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire. Sir Robert Francis concluded in the Francis Report in 2013 the importance for organisations providing NHS healthcare, to foster a culture of safety and learning, in which all staff feel safe and supported to raise concerns. He highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised.

In July 2015, the Secretary of State confirmed the steps needed to be taken to develop a culture of safety, and supported Sir Roberts's recommendations. The NHS contract 2016/17 specifies that NHS trusts should have nominated a Freedom to Speak Up Guardian by 1 October 2016.

The FTSUG needs to gain the trust of workers throughout the organisation so that everyone feels supported and empowered to speak up. It also requires both independence and the skills to work in partnership with an organisation's leadership team so that senior leaders are fully engaged in the "Speak Up" agenda and lead from the top.

Effective speaking up arrangements help protect patients and improve the experience of workers.

The priorities of the National Guardian include establishing and supporting strong regional networks of FTSU Guardians, highlighting NHS organisations who are successful in creating the right environment for staff to speak up safely and share this best practice across the NHS, independently review cases where NHS organisations may have failed to follow good practice and working with statutory bodies to take action where needed.

FTSU Guardians have a key role in helping to raise the profile of raising concerns/ speaking up in their organisation and provide confidential advice and support to staff in relation to concerns they have about anything that gets in the way of them providing high quality, safe care to our patients. Guardians do not get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly.

The Trust's FTSUG is Stefanie Greenwood, who was appointed in February 2020, but due to the global pandemic, commenced in the role in August 2020. Stefanie Greenwood did cover the FTSUG phone from May 2020, contracted to 4 hours per week, in addition to her substantive post as Operational Service Manager, until commencement in role in August 2020. The FTSUG role is 22.5 hours per week.

The FTSUG reports directly to the Chief Executive, and has monthly one to one meetings with the Chief Executive, Chair of the Board, and the Deputy Director of Workforce. The FTSUG also has access to the Senior Independent Director and Executive Director of Workforce. The FTSUG also has regular contact and support with the National Guardian's Office (NGO) and the Regional Network.

2. About "Speaking Up" as defined by the NGO

Freedom to Speak Up is for anyone who works in healthcare. This includes any healthcare professionals, non-clinical workers, senior, middle and junior managers, volunteers, students, locum, bank and agency workers, and former employees.

Patients and their families who have concerns or suggestions for improvement, should contact Patient Advice and Liaison Services (PALS).

What can workers speak up about?

Workers can speak up about anything that gets in the way of patient care, or that affects their working life.

That could be something which does not feel right, for example a way of working or a process which isn't being followed, or behaviours of others which the worker feels is having an impact on their well-being, the people they work with, or patients.

Speaking up is about all of these things.

Whistleblowing

Speaking up has no limitations – it is about anything which gets in the way of patient care and worker well-being.

The terms 'whistleblowing', "raising concerns", and 'speaking up' are often used interchangeably. They can cover raising matters about a wide range of legal and ethical issues.

The NGO and FTSUG's are working to make speaking up business as usual. That means workers being able to speak up about anything – whether that's something which doesn't feel right or an idea for improvement. Workers should feel confident that their voice will be listened to and action taken.

The term 'whistleblowing' can have negative connotations which may be a barrier to speaking up. Some people associate 'whistleblowing' with a formal process, or a matter that is escalated outside an organisation.

3. Implementing the role

Communication and marketing of the FTSUG role and the importance of "Speaking Up", "Listening Up" and "Following Up" in general is pivotal in establishing an open and honest culture, whereby staff feel respected, valued and safe: ultimately one that is continuously learning and improving.

The previous FTSUG was roughly in post from September 2016 to October 2019, resulting in a period of 10 months where there was no FTSUG in post. This meant that there was no opportunity for a handover, nor an opportunity for any direct training or support.

The NGO ordinarily provide a two day, face to face training package, but due to the restrictions of the pandemic, had to design an online training course. The current FTSUG undertook a 2 hour training session in September 2020 via Microsoft Teams although it was acknowledged that the session could not cover everything that would normally be delivered at the face to face training.

The 10 month gap also meant that there was a possibility that the message about how important it is to raise concerns and how staff can do this fell off the agenda. It also meant that staff did not have the option of obtaining impartial, independent advice and confidential support regarding any concerns they may have had.

Engagement with staff has its challenges, not only due to there being approximately 10,000 staff across multiple sites, but also due to the pandemic landscape, plus time constraints.

The FTSUG has been doing some work to raise the profile and awareness of the role, and the importance of raising concerns/ speaking up, however there is still a lot of work to do on this in order to achieve inclusivity and diversity.

Please see below examples of promotion completed to date:

- Article in the Chief Executive's Week Ahead bulletin
- Communication bulletins
- Updated information on Staff Room (intranet) re the FTSU role
- E-payslips
- Screensavers
- Staff Matters
- LLP Newsletter
- Training delivered to the Trust's Health and Safety Committee
- Junior Dr app (IGNAZ)
- Junior Dr handbook
- Corporate Induction booklet updated
- FTSUG information to Care Groups
- Attendance to GP trainee virtual meeting
- Virtual support session

The FTSUG regularly attends JNCC, LNC, Fairness Forum, Health and Safety Committee and the Emotional Wellbeing Steering Group as part of developing key relationships, promoting the role, reporting themes of concerns raised and driving culture change.

In between responding to speak up cases and promotion, the FTSUG is also actively trying to establish relationships and initiate collaborative working with the following networks and teams. The NGO stipulates to the FTSUG network the importance of collaborative working in order to make "Speaking Up" business as usual, triangulate data and drive culture change.

Examples include:

- Workforce
- ODIL
- Care Groups (including teams in the Community)
- LLP
- Staff Networks such as Race Equality, LGBTQ, Enable
- Staff Wellbeing Psychology
- Psychology in relation to Schwartz rounds
- Occupational Health
- Patient Safety

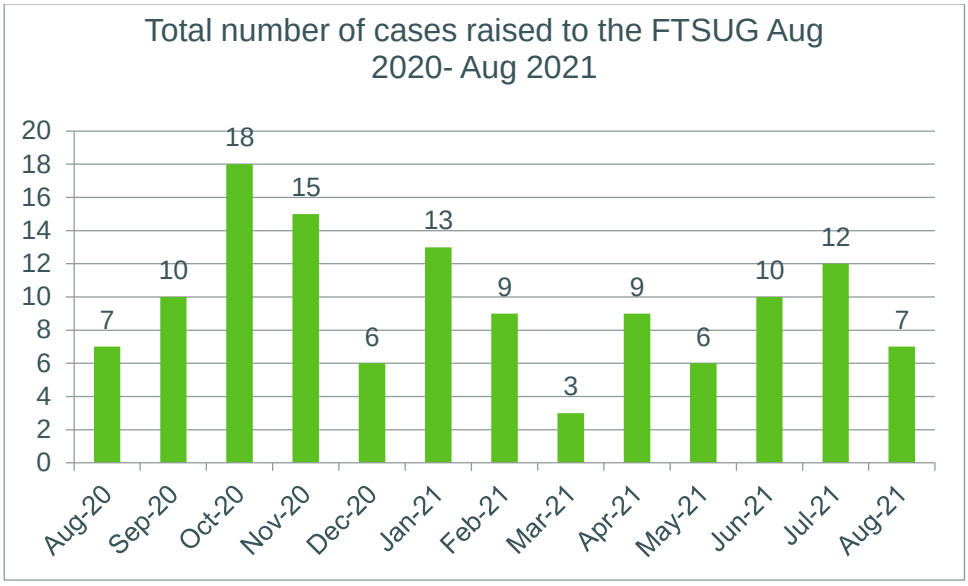
4. Summary of concerns raised

4.1 Number of concerns raised

Details of any concerns raised are recorded locally and securely via a 'concerns tracker', which is a local database held by the FTSUG. This records the action taken and the classification of the concerns that have been raised.

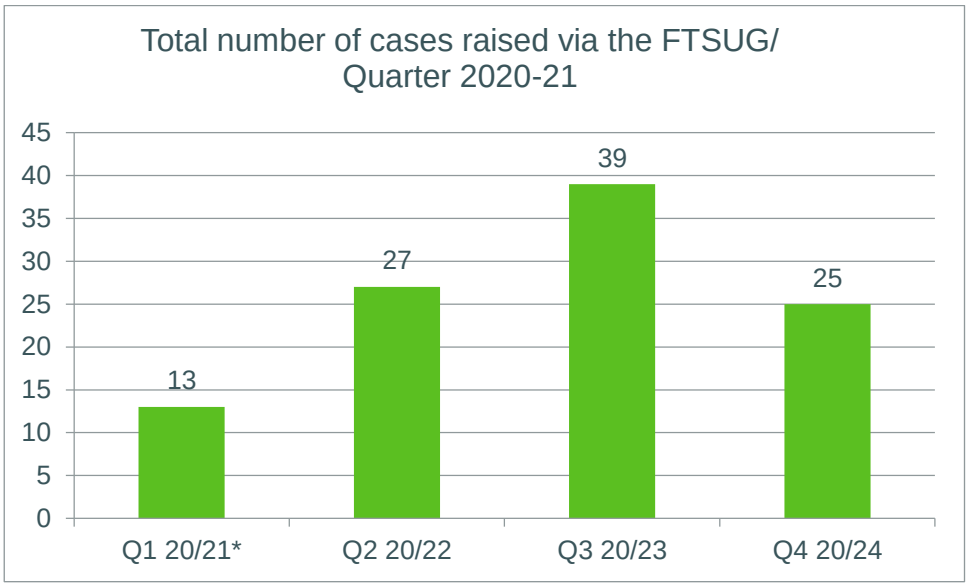
The FTSUG reports this data internally to the monthly JNCC, bi- monthly LNC and Fairness Forum, and externally to the NGO every quarter.

To date, 152 speak up cases have been brought to the FTSUG within York and Scarborough Teaching Hospitals. Between August 2020 and August 2021, 125 speak up cases have been raised to the FTSUG. This equates to, on average, a total of 10 speak up cases per month.



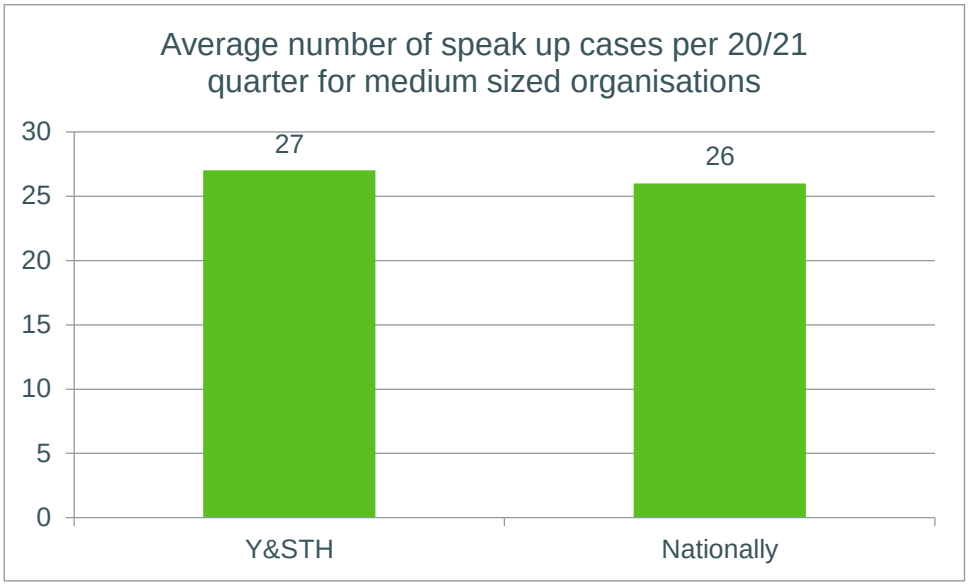
Referring to the last Board report produced by the previous FTSUG in June 2019, the average number of monthly “speak up” cases was 12.5 per month.

The number of speak up cases brought to the FTSUG for each quarter 2020/21 are as followed:



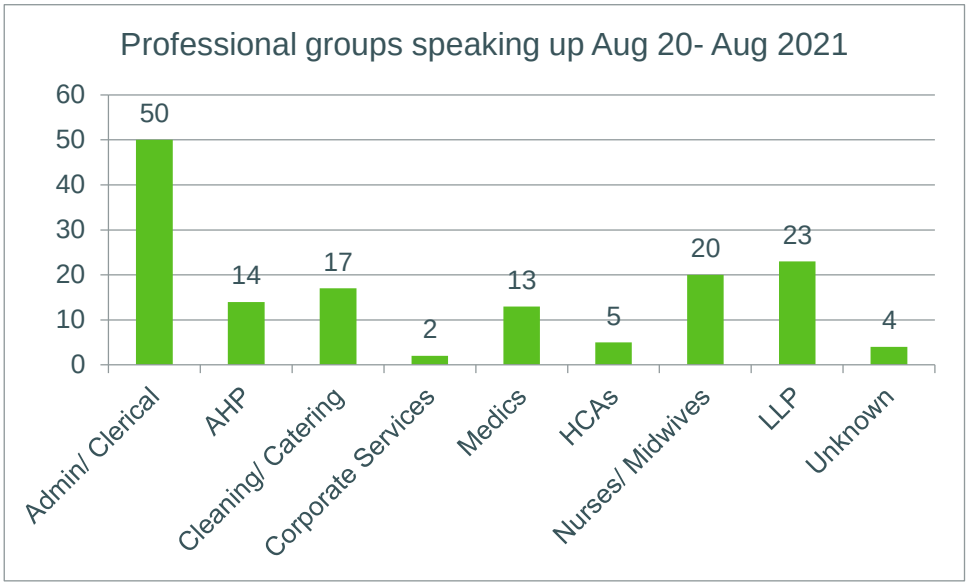
*Please note that for Q1 20/21 data there was no acting FTSUG in April 2020 and FTSUG was only covering the phone for 4 hours per week from mid- May 2020 and had not officially commenced in post.

The national average number of speak up cases brought to the FTSUG across similar sized organisations (medium sized 5,000-10,000), per quarter 20/21, are comparable to York and Scarborough Teaching Hospitals:



4.2 Professional Groups raising concerns/ speaking up

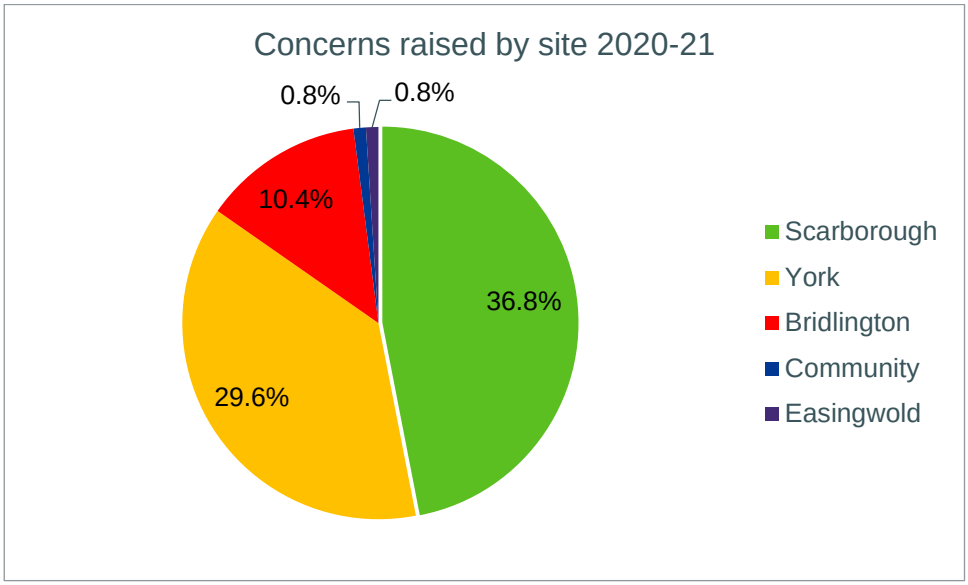
Between August 2020 and August 2021, the professional groups speaking up to the FTSUG are:



The data shows that the majority of concerns raised are from the Administrative and Clerical professional group, with the second highest being from staff groups within the LLP (York Teaching Hospital Facilities Management Group). The third highest professional group speaking up are Nurses.

4.3 Concerns raised by site

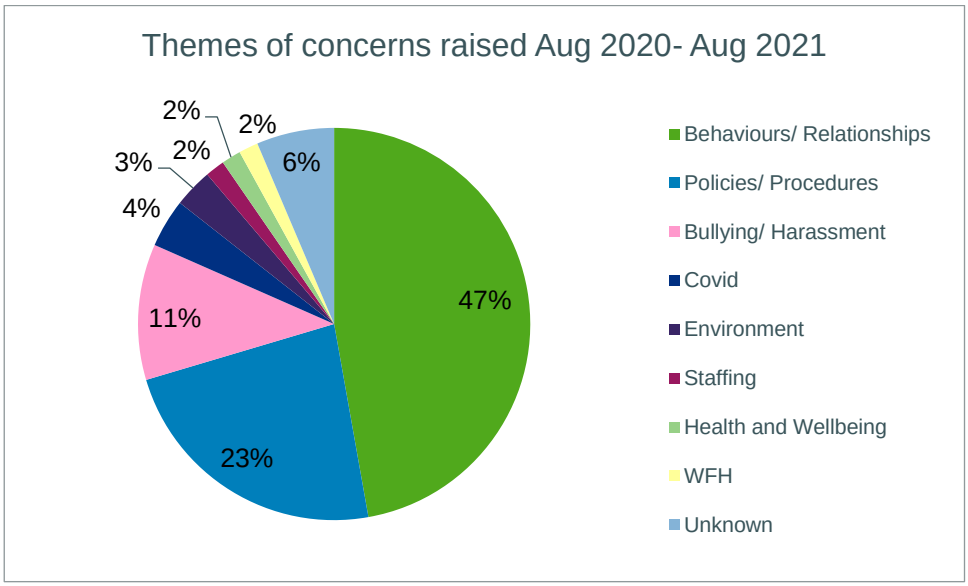
For concerns raised by site between August 2020- August 2021 please refer to the graph below:



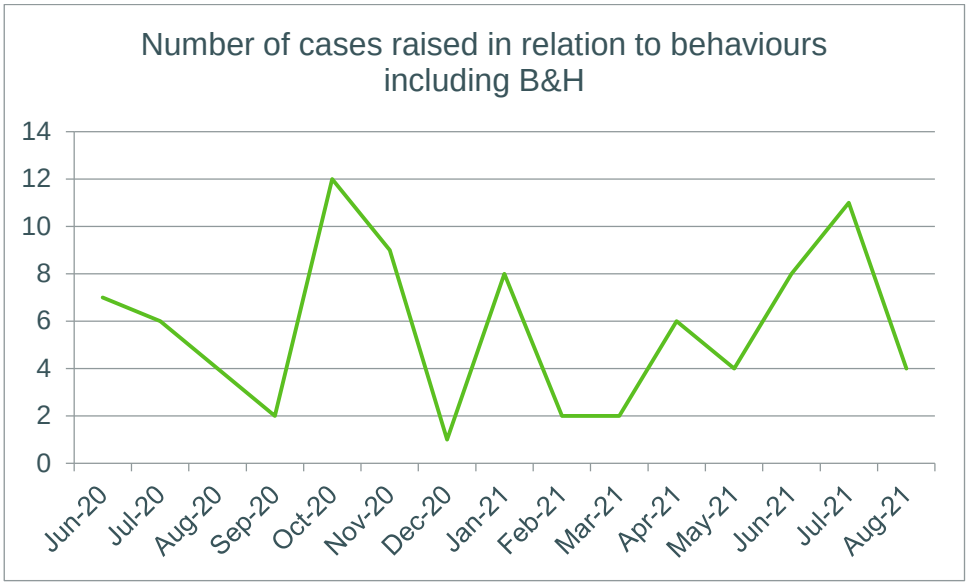
This data suggests that further work to promote the FTSUG role and the Speaking Up agenda is required across the peripheral community sites. The FTSUG is currently establishing relationships with key stakeholders within the Community to help promote this work. There is still a lot of work to be done.

4.4 Themes of concerns raised

In relation to the 125 speak cases raised between August 2020 and August 2021, the following themes have been identified (see chart below):

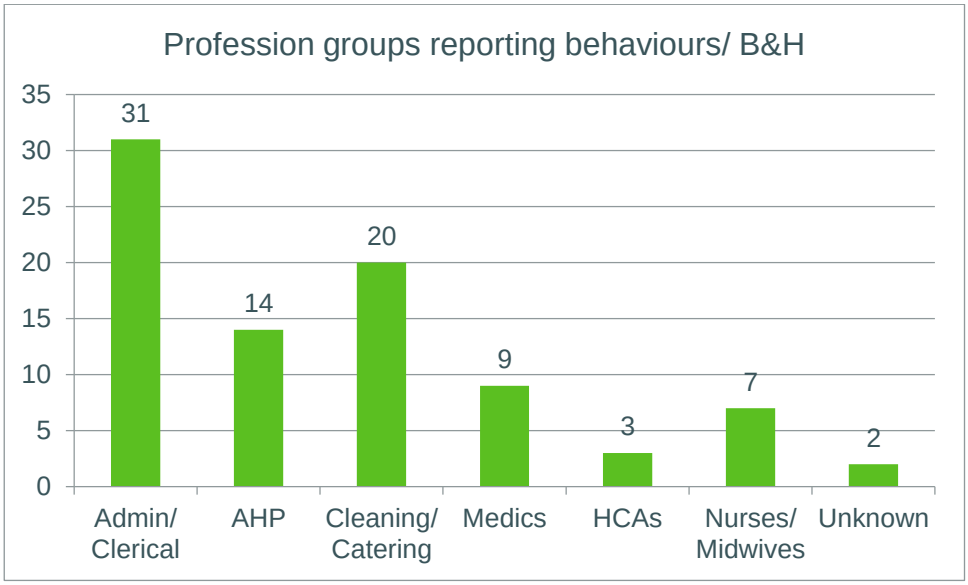


Concerns raised in relation to behaviours, bullying and harassment constitute for 58.4% of all concerns raised to the FTSUG between August 2020-21. Since the FTSUG commenced in post, 59% of concerns raised have been in relation to inappropriate behaviours, bullying and/ or harassment.



This is significantly above the national average whereby 30.1% of cases raised in 2020/21 which involved an element of bullying and harassment.

The professional groups raising concerns in relation to inappropriate behaviours, bullying and harassment between June 2020 and August 2021 are:



Concerns raised where there is an element of patient safety/ quality of care constitutes for 15.2% of the cases raised to the FTSUG between August 2020-21.

Comparing this data nationally, in 2020/21, 18% of cases involved an element of patient safety/quality. This was a five-percentage point decrease from 2019/20.

4.5 Anonymous cases

Workers speaking up anonymously may be an indicator that speaking up arrangements or culture need improvement. For instance, workers may choose to speak up anonymously because they are concerned about detriment for speaking up.

3.2% of concerns raised between August 20-21 to the FTSUG were raised anonymously and escalated to the appropriate management team. This is compared to 12% of cases nationally. This may suggest that staff feel safe in raising their concerns to the FTSUG.

This figure is not reflective of the number of individuals who would prefer to be anonymous when the FTSUG escalates a concern to either Workforce or Management.

4.6 Active caseload

There are currently 16 speak cases that remain open, of which the FTSUG is supporting/ involved in.

5. Feedback

The NGO advises that feedback should be obtained when a case is closed, even when the person speaking up may be unhappy with the outcome of their case. Each individual should be offered the opportunity to provide feedback, even if they spoke up about the same issue, together or separately.
Individuals who raise concerns are kept informed of progress and concerns are only closed when the process has been completed to the individual's satisfaction, where the individual concludes the process, or where it is agreed that the FTSUG cannot help with the matter any further.

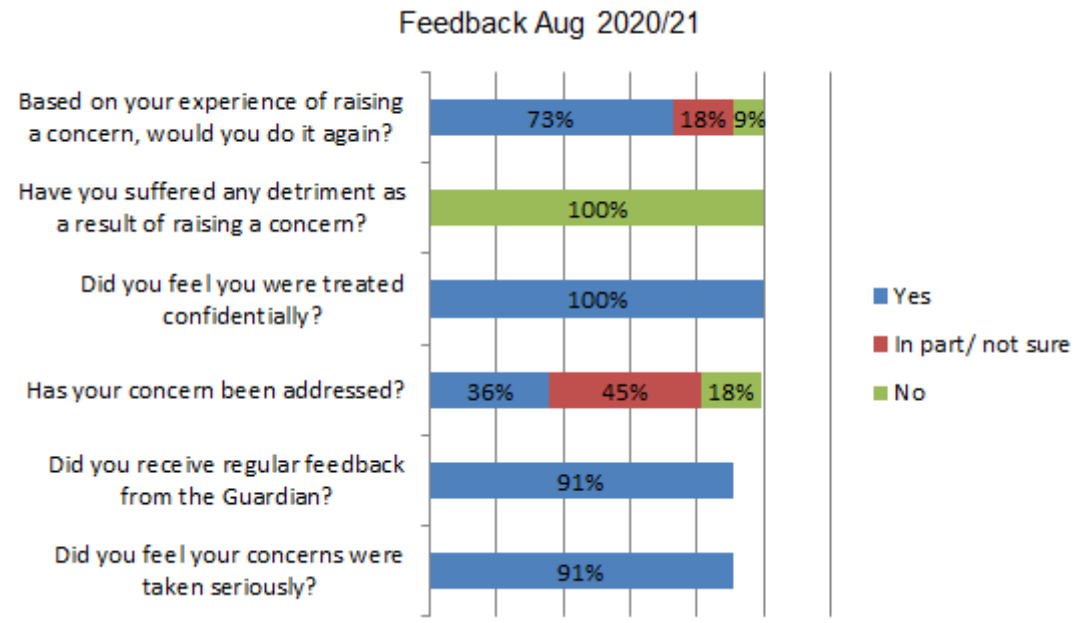
The NGO requires the FTSUG to ask "Given your experience, would you speak up again?" This data is then collected by the NGO quarterly.

Staff have the option of completing and returning the feedback form either electronically or by hand and/ or post. They can also complete the feedback anonymously if they wish as the focus is on learning and improvement, rather than who said what.

The Board are asked to note that response rates are low.

Consideration to needs to be given on how to gain feedback on the harder to reach staff groups who speak up who have limited access to computers at work. Where possible the FTSUG does post the feedback form if this is requested.

The chart below is for all the feedback forms received to date (11).



Of those who completed the feedback:

- 73% say that based on their experience would speak up again
- 100% say they have not received any unfair treatment since speaking up
- 100% say they were treated confidentially
- 36% say their concern was addressed, 45% felt unsure/ in part
- 91% say received regular feedback from the FTSUG
- 91% say their concern was taken seriously

There were no further details from the 45% that responded ‘in part’ to the question ‘has your concern been addressed’. Whilst this may appear alarming it is a subjective question and the Guardian can give assurance that no concern is closed until it has been addressed. Often individuals will have been expecting a particular outcome from raising a concern that doesn’t meet their expectation and this may be an explanation for this response.
Anonymised answers given to the question, “Is there anything else you would have liked the Guardian to have done?”:

- It appeared that I needed to do a lot of information gathering and involve HR for anything to be done and this meant I couldn't progress as my evidence would be lacking.

- Difficult to know what else could have been done as the problem was raised at the highest level within the organisation. An explanation has been provided and although rules may not have been broken, the matter does not seem ethically sound.

- The Guardian is an exceptionally professional, positive and insightful representative of the FTSUG process. I personally do not feel that I would have had the confidence to progress my concerns, or have felt comfortable in advising other colleagues of the process and point of contact if I had not truly believed in the Guardians integrity and honesty.

- Made the CEO listen to the concerns raised by numerous staff at a number of levels across sites and by supporting departments within the organisation. The issues are still very much alive though more cleverly administered.

- The Guardian provided the help I required and actually listened to my concerns, checking understanding and agreeing actions as a way forward then dealt with those actions very promptly. So I don’t really think the Guardian could have done more than this but I especially appreciated the offer to contact again in a few weeks’ time which I believe is probably above and beyond what I could reasonably expect.

- A couple of times the FTSUG said she would get back to me by a specific date/ time, but I had to contact her again for answers as she didn't get back by then. As I was really struggling at that time I feel it would have been better to under promise then over deliver on time frames. Also I feel when you are struggling to make decisions because of a situation at work, having so many options of how to take matters forward can be very confusing.

- No, the FTSUG was really helpful, kind and concerned about how I was feeling and followed up immediately with an email to support me with links and further advice, I can’t think of anything else she could have done.

As well as the formal questionnaire, the FTSUG receives a significant amount of informal feedback, some of which is captured below:

6. Freedom to Speak Up Index

Culture can seem a nebulous concept and difficult to pin down. It is often described as 'the way things are done around here'.

The Freedom to Speak Up (FTSU) Index is one of these indicators which can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident.

"Broadly speaking the index reveals a very strong correlation between trusts that are rated highest by the CQC and those that have the highest rated speaking up cultures," says Dr Henrietta Hughes.

"Trusts should see the index as an insight into the views of their workforce around the issue of speaking up," says Henrietta. "The aim of the report is to commend those trusts doing well and those that have shown significant improvement, while encouraging those that have room to improve to take the opportunity to address the issues that may be affecting their index scores. The FTSU Index is a new measure for assessing the speaking up culture in organisations. We encourage those at the top to support those with less positive results".
The four NHS Staff Survey questions are:

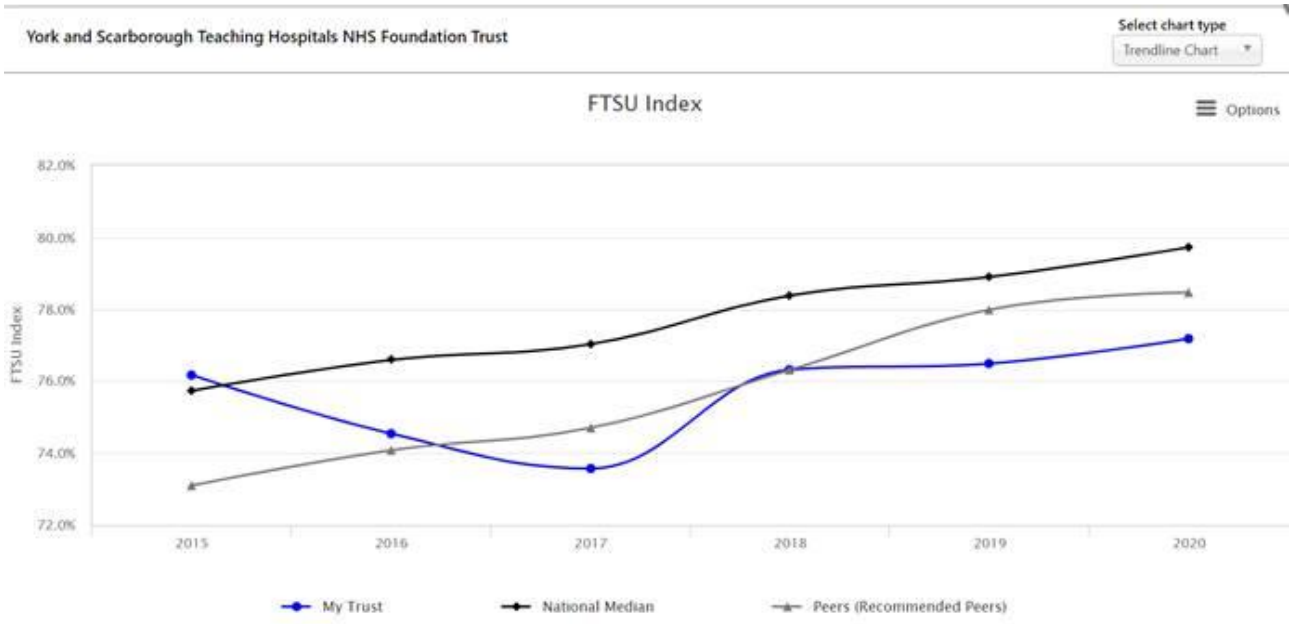
• % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
• % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
• % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
• % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

The FTSU index was calculated as the mean average of responses to the above four questions from the NHS annual staff survey.

The FTSU Index for York and Scarborough Teaching Hospitals is as below:

Year	Trust Index	Peer Median	National Median
2015	76.2%	73.0%	75.7%
2016	74.5%	74.0%	76.6%
2017	73.6%	74.7%	77.0%
2018	76.3%	76.3%	78.4%
2019	76.5%	78.0%	78.9%
2020	77.2%	78.5%	79.7%

FTSU Index for the North East and Yorkshire	
2016	76.7%
2017	76.6%
2018	78.5%
2019	78.9%
2020	79.5%



The Trust is below both the Peer median and National median for its FTSU index. The Trust is in quartile 1 (lowest 25%) for its FTSU index, however the index has improved by 2.4% over the last 3 years, suggesting there has been an improvement in speaking up culture.
The highest performing trust is Cambridgeshire Community Services NHS Trust with a FTSU index of 87.6% (for 2020).

The lowest performing trust is East of England Ambulance Service NHS Trust with a FTSU index of 66.65 (for 2020).

Since the introduction of Freedom to Speak Up Guardians in 2016 following the Francis Freedom to Speak Up Review, the FTSU Index has improved and risen 3.7 percentage points nationally from 75.5 per cent in 2015 to 79.2 per cent in 2020.

This year, a new question was included in the NHS Staff Survey, asking workers if they feel safe to speak up about anything that concerns them within their organisation. This question has not been included in the FTSU Index scores to enable comparability to previous years. However, the answers to this question show a very strong positive correlation with the FTSU Index.

The NGO welcomes the inclusion of this question, because Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job, whether that's an idea for improvement, ways of working or behaviour.

For those that participated in the NHS Staff Survey, 63.1% of respondents within York and Scarborough Teaching Hospitals agreed or strongly agreed that they would feel safe to speak up about anything that concerns them about their organisation. Nationally this score was 65.6%.

Inclusivity is at the heart of Freedom to Speak Up therefore I am asking you to listen to the silence; who is not represented in the survey responses?

7. Challenges to the role

The FTSUG was initially contracted to work 18.5 hours per week, however due to a high number of cases coming through to the FTSUG, which could be attributed either to the gap between FTSUG, or the Covid- 19 pandemic, or both, it was agreed with the Chief Executive that the FTSUG would trial working 22.5 hours per week, April 2021 until the end of September 2021.

It was also agreed that a member of the Executive administrative team would assist the Guardian with any general administrative duties, which was gratefully received.

It has now been agreed that the hours will remain at 22.5 hours per week due to case numbers remaining consistent. However, unfortunately the Guardian is no longer receiving consistent administrative support due to absence within the administrative team.

The FTSUG is predominantly only able to conduct the "reactive" side of the role, which is responding to, and supporting workers with their concerns within the time allocated.

It is the proactive side of the role, alongside other workstreams, such as the values work, Just Culture, national Civility and Respect work and Restorative practice, which will help improve the overall culture of the organisation, which then in turn may help workers feel psychologically safe to "speak up" within their teams/ manager, reducing the need for staff to raise their concerns to a FTSUG.

Some examples of the proactive side involves:

- "walking the floor" so the FTSUG has a visible presence within wards and departments and the different sites;
- Attending team meetings
- Holding developmental/ education sessions around raising concerns/ speaking up;
- Holding drop in sessions/ roadshows
- Engaging with hard to reach staff such as students/ agency/ locums

- General marketing/ communicating/ promoting the role and the agenda;
- Benchmarking ourselves against the key findings and recommendations for case reviews carried out by the NGO in order to promote a learning culture
- Promotion the Fairness Champion role and coordination of Fairness Champion "surgeries" so staff know how they can be supported and that we value them and their wellbeing.
- Collaboratively working with Workforce, Patient Safety, ODIL, Psychology, Occupational Health etc.

The FTSUG has been approached to assist with other workstreams that would assist with improving our culture and forming relationships, however this is not something that can be accommodated at this time within the contracted hours. Examples include, contributing to Schwartz rounds, and progressing Equality, Diversity and Inclusivity work.

The FTSUG has agreed to assist the York Teaching Hospital Facilities Management Group with its New Start Programme due to the historic issues within the organisation (i.e the Brid Report of 2017 and the ACAS Report 2020) but also the high numbers of concerns being reported within this area around inappropriate behaviours and bullying.

8. Fairness Champions

The role of the Fairness Champion is to promote the Trust Values, promote and role model fairness, diversity and inclusivity. Fairness Champions listen to staff, provide support and signpost accordingly. They contribute to creating a culture where staff feel safe and confident to raise concerns. They work alongside the FTSUG promoting, listening, supporting and providing an impartial view when supporting staff.

This is a voluntary role which staff are recruited into, on top of their substantive role(s).

There are currently 28 Fairness Champions across the organisation, which is a reduction since the last FTSU Board report in June 2019, when there was 37 Fairness Champions. Staff can request support from a Fairness Champion either by:

- Emailing the Fairness Champion mailbox (Fairness.Champions@york.nhs.uk). This is overseen and managed by 4 Fairness Champions on a rota basis;
- By referring to Staff Room/ Working Environment, to see who the Fairness Champions are and approaching them directly;
- Approaching a Fairness Champion they know, trust or who works locally to them.
- The FTSUG needs to review the role description to ensure that it is "fit for purpose" and also in line with the Trust's strategy and workforce needs.

The Fairness Champions also require refresher training, not only because of the amount of time it has been since they had any, but also to ensure it is in line with the NGO's standards and framework.

The FTSUG did hold initial separate meetings with a representative from ODIL, Workforce and the different Staff Networks regarding training for the Fairness Champions, however due to operational pressures, low staffing levels and time constraints this has unfortunately not been progressed.

The FTSUG would ideally like to complete this fundamental work before recruiting any more Fairness Champions so that the current group of Fairness Champions feel valued, respected, invested in and also more confident with the support they are providing to staff.

They will then be better placed to “buddy up” with new Fairness Champions to help develop and support them.

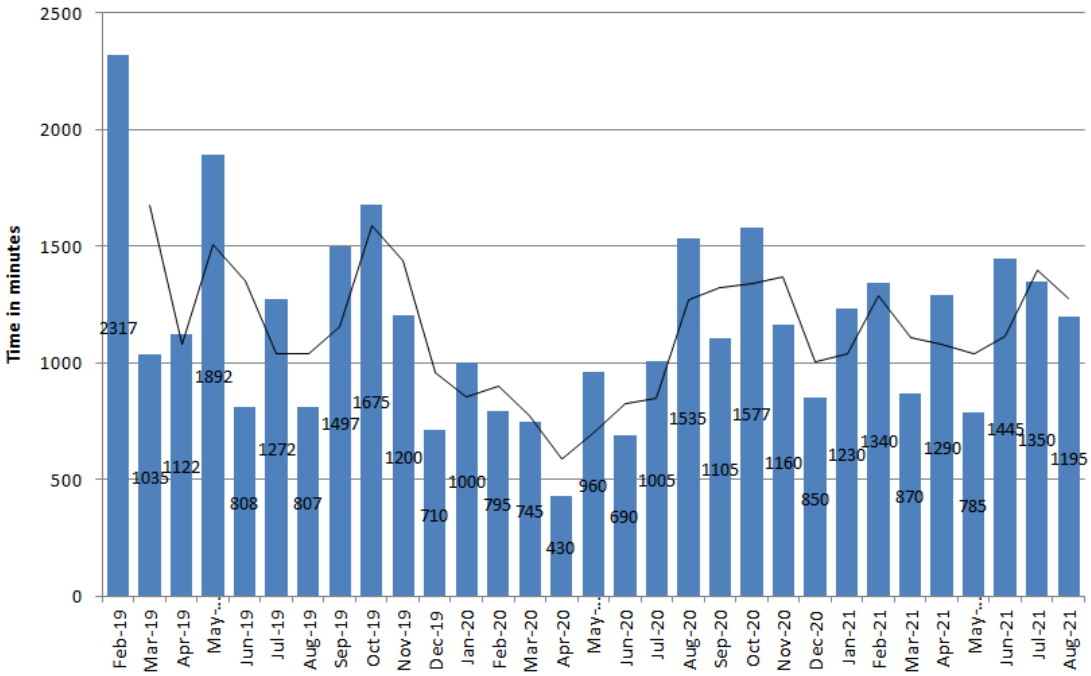
Currently the FTSUG is supporting 4 cases currently with Fairness Champions.

The FTSUG has introduced regular virtual Fairness Champion Peer Support meetings, which provides the FTSUG and the Fairness Champions with an opportunity to catch up, provide support, and share learning. Quarterly meetings have also been introduced whereby the Chief Executive is invited to attend in order to meet with the group, discuss current issues/ themes, and for the Chief Executive to demonstrate their support for the work they do.

The preference and the aim is to meet face to face as a group, as it is felt that this would be beneficial in terms of establishing and building relationships, however due to the current pandemic climate, and workload pressures, there are no current plans to do this.

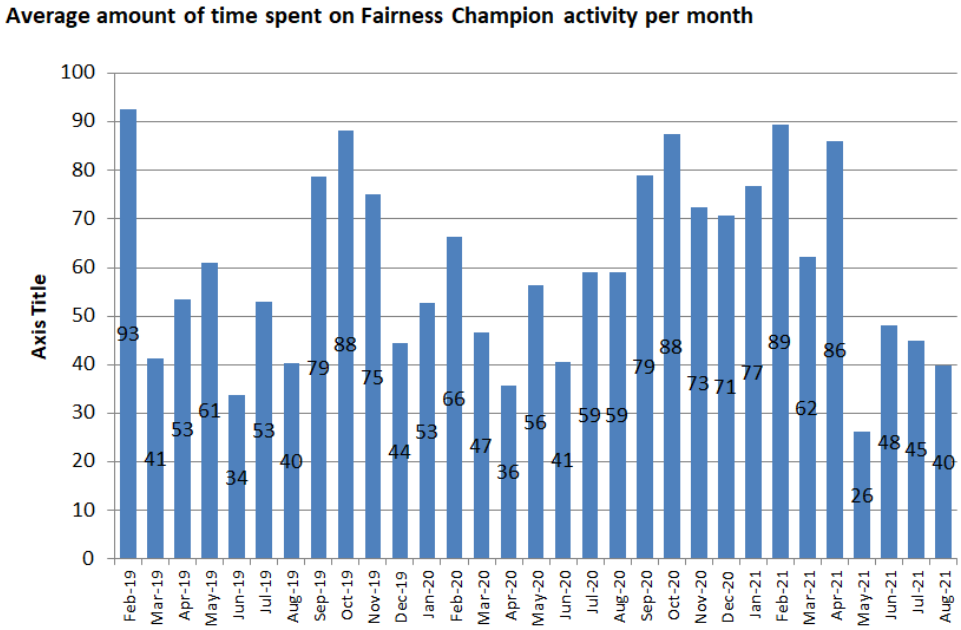
If you refer to the chart below, you will see that the Fairness Champions who respond to the monthly survey, are reporting the following time spent per month on Fairness Champion activites:

Time spent per month on FC activities (total for all Fairness Champions)



I am aware that not all Fairness Champions are submitting their time estimates therefore the data above may be under actual time spent. This also demonstrates the requirement and importance for refresher training so that the Fairness Champions understand the importance of reporting this data, in terms of learning and influence.

The average amount of time a Fairness Champion reports to spend on each case is 65 minutes.



Further work is required to promote the Fairness Champion role, however promotion done so far includes:

- A Fairness Champion attending team meetings virtually to talk about the role. There are plans to do this for the Internal Audit Team and within the Community;
- A new poster has been designed and distributed/ displayed throughout the Trust;
- A screensaver promoting the Fairness Champion role has been designed and added to the schedule via the Communications Team;
- A Fairness Champion postcard has been designed so that these can be left in staff areas i.e. staff rooms, calm rooms, and handed out by the staff/ Fairness Champions;
- The FTSUG has requested for the Fairness Champions to be included in the new Trust Values work, as this does sit within their role.
- Fairness Champions supporting virtual wellness support sessions for staff.

9. Internal Audit Report

Internal Audit works with management to improve the system of internal control which supports the Trust in meeting its objectives. This includes Internal Audit reviewing systems and processes identified as a risk to the organisation or those systems whose effective functioning is fundamental to the Trust's operation.

NHS Audit Yorkshire (our internal auditors) is currently in the process of reviewing the Raising Concerns and Whistleblowing systems and processes, which has been commissioned by the Chief Executive.

Once recommendations have been received, these will be shared with the Board.

10. National Speaking up eLearning roll out

The National Guardians Office (NGO) has launched the first two modules (Speak Up and Listen Up) of an e-learning package, developed in association with Health Education England, for all workers. The third module (Follow Up) developed for senior leaders will be launched in late 2021.

It is aimed at anyone who works in healthcare and explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

The first module 'Speak Up' is Core Training for all workers including volunteers, students and those in training, regardless of their contract terms. Workers' voices form a key pillar of the People Plan. This e-learning gives all workers the tools to speak up, particularly vulnerable groups who may feel they are unable to, like trainees, bank staff, or volunteers. The second module 'Listen Up' is aimed at all line and middle managers and is focussed on listening up and the barriers that can get in the way of speaking up. This e-learning aims to support organisations to build upon their speaking up culture.

A third module for senior leaders – including Executive, Non-Executive Directors and Governors is expected to be rolled out in the autumn of 2021.

This training is not part of the Trust's mandatory training programme.

This elearning package is available via the Trust's Learning Hub.

11. Regional and National Networking

The FTSUG is part of the Yorkshire and Humber FTSUG network and attends regular regional meetings, as well as Peer Support Meetings, and National Events, all conducted virtually. The FTSUG also receives one to one peer support from some of the local guardians from other trusts. These activities ensure that the FTSUG maintains a strong peer network, who provide both professional and emotional support, shared problem solving, shared learning, as well as ensuring the Trust and the FTSUG are working to best practice.

At the virtual regional meetings FTSUG's share their experiences and good practice. They have the opportunity to discuss reviews and recommendations supplied by the National Guardians Office. A member of the National Guardians Office (NGO) is generally present. The Regional meeting is a confidential, safe place to have group supervision and to discuss thoughts and concerns or experiences other guardians may wish to share.

12. Raising Concerns/ Whistleblowing Policy

Tom Grimes, Head of Advocacy and Learning in the People Directorate at NHSE/I is currently consulting with various national networks (such as Trade Unions, HR, Staff Networks etc), including FTSUGs, about their views on the current policy to aid the review. It is acknowledged that the policy needs to be brief, simple, and accessible.

The current policy has been circulated locally to the JNCC and the LNC for their views and comments, which the FTSUG will feedback to the Regional FTSU.

The new policy is to be expected in quarter 4 of 2021-22.

To view the current policy, click here

13. Strategic framework for Freedom to Speak Up

The NGO published its Strategic Framework for Freedom to Speak Up in July 2021, outlining the NGO's priorities for Freedom to Speak Up, aligning itself with the voice pillar of the NHS People Plan.

The strategy builds on the improvements that FTSU has made, ensuring that FTSU is implemented consistently, and sets out a framework to enable organisations to gain assurance that they are working towards a speak up, listen up, follow up culture.
There are 4 main pillars to the strategy:

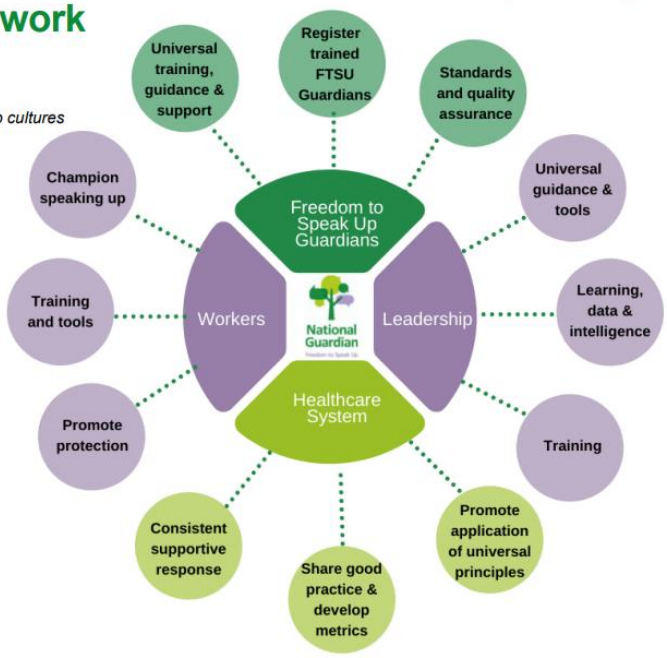
- Workers
- FTSUG
- Leadership
- Systems

To learn more about the NGO's FTSU Strategic Framework, please click here

The National Guardian Office's Freedom to Speak Up Strategic Framework

Working in partnership

to improve speak up listen up follow up cultures



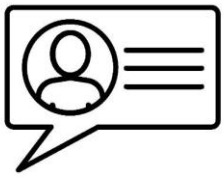
14. NGO's Annual Speaking Up Report 1 April 2020- 31 March 2021- The Year of the Pandemic

"The pandemic has made us all acutely aware of how much gratitude we owe to everyone who works in health, and how vital it is that they have the freedom to speak up safely about anything which has an impact on their ability to do their job."

Dr Henrietta Hughes OBE FRCGP
National Guardian for the NHS

Highlights from the report:

TOTAL CASES

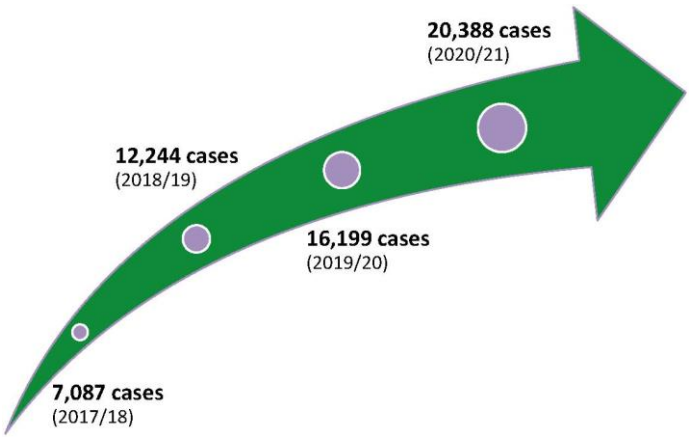


20,388 cases
were raised with
Freedom to Speak Up Guardians
In 2020/21

A 26-percentage point increase from 2019/20.

COVID-19 PANDEMIC

Workers spoke up about issues to do with the pandemic, including social distancing, personal protective equipment, support for workers isolating and shielding, and increased stress and exhaustion.



To read the full report, click here

15 Conclusion

The Trust FTSUG continues to be busy in comparison to similar sized Trusts across the country. Staff's behaviours and attitudes affect staff morale and directly affects the quality of care we provide and ultimately patient outcomes.

"Incivility affects more than just the recipient, it affects everyone."- Dr Chris Turner

There is extensive work to be done to improve both the culture in terms of civility and respect, and also in terms of staff feeling safe to speak up within their teams.

16 Recommendations

The Board are asked to:

- Consider the data in relation to behaviours, bulling and harassment;
- Consider the challenges of the role which impacts on the proactive work that could be done to help improve the overall culture, and then in turn worker health and wellbeing, worker experience, and patient outcomes;
- Consider its commitment to improving its FTSU index.

Minutes
Year End Group Audit Committee
10 June 2021

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Attendance:

Mrs J McAleese (JM), Non-executive Director (Chair); Dr L Boyd (LB), Non-executive Director; Mr S Morritt (SM), Chief Executive; Mr A Bertram (AB), Finance Director; Mrs S Hogan (SH), Deputy Head of Corporate Finance; Mr S Kitching (SK), Head of Corporate Finance & Resource Management; Mrs H Kemp-Taylor (HKT), Head of Internal Audit; Mr J Hodgson (JH), Internal Audit Manager; Mr D Beverley (DB), YTHFM Managing Director; Mrs C Johnson (CJ), Deputy Director of Governance and Patient Safety; Mr M Dalton (MD), Engagement Lead, Mazars; Mr M Outterside (MO), Senior Manager, Mazars; Ms J Hall (JHa), Interim Foundation Trust Secretary; Mrs T Astley (TA), Assistant to FT Secretary, minute taker

Apologies for Absence:

Mr S Moss (SM), Counter Fraud Manager; Ms M Hall (MH), Counter Fraud Specialist; Mr S Holmberg (SH), Non-executive Director

21/62 Chair's Introduction and Welcome

JM welcomed everyone and declared the meeting quorate. She thanked Dr Boyd for standing in due to the resignation of DW. She explained that the purpose of the meeting was to consider the year end suite of documents and to recommend to the Board tomorrow that these were approved.

JM noted that the meeting was being recorded for the sole purpose of taking the minutes. The recording would only be accessed and then destroyed once the minutes had been agreed. All participants gave their agreement to this.

21/63 Annual Governance Statement (AGS)

SM gave an overview of the AGS and highlighted the following: -

- To acknowledge the unprecedented nature of 2020/21 for the NHS and indeed for the nation, the challenges faced by the Trust, and the fact that the vast majority of normal business activities were suspended and many of those remain suspended across the NHS. The focus for the year for the organisation was to manage strategic risks in relation to the response and recovery of the Covid pandemic. The Board and committee structure continued throughout the year, albeit in a truncated form, and with shortened agendas. He wanted to give thanks to all those within the organisation who contributed to getting us through and helping the Trust build the recovery from the Covid pandemic.
- In terms of risk management, the Board had brought additional expertise into the organisation, had signed off on a revised Corporate Risk Register, a revised BAF, and a new risk management framework. In addition, a new Associate Director of

Corporate Governance would be joining the Trust and a specific Head of Risk role will sit within this team. An Executive Risk Committee had also been established, chaired by SM.

- During the year the Board took action to strengthen leadership across nursing quality, digital IT, and in areas where it was felt there was risk. He alluded to learning from incidents and the work being done to strengthen the incident management processes and the work ongoing to embed learning across the Trust.
- Despite Covid, there had been some notable successes during the year and SM gave an update on the lifting of 5 out of 7 of the regulatory breaches imposed by the CCQ and the lifting of the licence breaches imposed by NHSE/I. Alongside that, he informed that the Trust had moved to segment 2 from segment 3 within the NHSE/I Risk & Oversight framework.

SM explained that it had been a very challenging year, risks had been uncovered, but he felt confident that there was a plan in place to get the Trust to where the Board wants it to be.

JM asked External Audit/Internal Audit if the document reflected their perspective of the current situation in the Trust. HKT replied that from an Internal Audit perspective, there was a summary of the outcomes of their work that had been undertaken during the year and suggested that this should be added to the document and add more about the positive outcomes from the internal audits which form a key element of the Head of Internal Audit Opinion to give a more balanced view. SM agreed. MD added that they were happy that it complied with guidance, happy that it was consistent with their understanding, thought it was fair and balanced in nature, particularly when read alongside the Annual Report.

JM acknowledged there was still work to do and confirmed that SM was leading on the BAF, CRR and chairing the Risk Committee and also involving the GGI. These factors were really important to ensure that this work continued with the same level of enthusiasm and importance. SM confirmed that it will.

The Committee:

- **Approved the Annual Governance Statement, subject to the revisions suggested, and agreed to recommend approval of the document to the Board.**

21/64 Accounting Policies

AB reported slight changes to the policies. These featured in the Trust's accounts and were subject to the audit work carried out by Mazars.

AB referred to the Going Concern part and advised that this was the only place in the accounts where the Trust's new name was shown as the note related to the future. The rest of the accounts related to the old Trust name.

The Committee:

- **Approved the amended accounting policies and agreed to recommend their approval to the Board.**

21/65 Annual Accounts for adoption by the Board of Directors

AB gave an overview of the accounts and gave assurance that these had been thoroughly checked. He explained that the accounts had been prepared on a going concern basis which had been discussed and agreed at the recent Group Audit Committee meeting.

AB confirmed that some amendments were made after consultation with JM/Mazars and the Finance Team and gave an overview of those amendments. He also alluded to other information in the accounts that he wanted to highlight to the Committee.

AB stated that the accounts were a true and fair reflection of the Trust's position and he strongly recommended that these be presented to the Board for approval.

JM thanked AB and his team for producing a really high-quality set of accounts.

The Committee:

- **Approved the accounts and agreed to recommend to the Board that they also approve them.**

21/66 Letter of Representation

MD commented that there was nothing to draw to the attention of the Committee as it was a standard letter of representation. AB added that he had no issue whatsoever in recommending to the Board to sign this but wanted to draw attention to the last section "unadjusted misstatements" which can be removed as there were none. All the disclosure issues recommended by External Audit have been changed.

The Committee:

- **Approved the Letter of Representation and agreed to recommend to the Board that it be signed on behalf of the Board.**

21/67 ISA 260 Report incl. Enhanced Opinion

MD supported the comment around the high-quality set of accounts and will be issuing a positive and clean ISA 260 report and Opinion, other than the limitation of scope in relation to inventory balances. He referred to the headlines in the Executive Summary and gave a summary of the content of the report. There were no significant matters discussed with management that he needed to bring to the Committee's attention, and no significant difficulties encountered during the audit. There were no control deficiencies that he needed to bring to the Committee's attention, and, whilst the audit remained in progress, he was very much on track to issue the Opinion in advance of next Tuesday's deadline.

MD thanked the Trust and the Finance Team for the assistance provided throughout the audit during their first year as the Trust's auditors. It ran very smoothly. JM concurred with his comments. AB added his gratitude.

The Committee:

- **Received the report and took assurance from the content therein.**

21/68 Internal Audit Report Summaries

JH gave a summary of the limited assurance report and highlighted the following audits: -

- Well Led – outcome was a limited assurance. A lot of work had been undertaken or was on track. There was still work to do and 3 recommendations had been implemented and 1 was underway.
- CQC Action Plan – outcome was a significant assurance. The Committee acknowledged that there was still further work to be done.
- BAF – outcome was a significance assurance. Additional evidence given to show the work already undertaken and the improvements made during the past 4-5 weeks.
- Risk Management – outcome was a significance assurance. Additional evidence given to show the work already undertaken and the improvements made during the past 4-5 weeks.
- WTD – limited assurance. However, substantial work has been done and Internal Audit was looking to re-audit in due course.
- Ceiling of Care – discussions had taken place with the Medical Director. CJ provided additional evidence and the Committee noted that things were moving in the right direction.

JH gave a summary of the outstanding recommendations and informed that 31 had been implemented, 6 had been partially implemented and 8 had not yet been implemented. It was very good progress.

JM asked about governance in the Care Groups. CJ replied that Bobby Anwar, Risk Manager, had done a lot of work with the Care Groups and had made a complex topic simple to understand for the staff. He was having sessions with staff to upskill them on managing their risk registers and it was continually improving. He was now looking at how the key risks from the Care Groups could be presented at QPaS.

JM wanted to acknowledge the tremendous amount of work that had taken place during the past few weeks by a whole range of people and was grateful to JH/HKT and her team for their support.

The Committee noted the acknowledgement from Internal Audit that these key audits will not be left until the end of the year in future years.

The Committee:

- **Noted with pleasure the Outstanding Actions report along with the other reports.**

21/69 Internal Audit Annual Report & Head of Internal Audit Opinion (HIAO)

HKT stated that her report contained the IA Annual Report, Head of Internal Audit Opinion for the Trust and an Assurance Statement for the LLP. She commented that it had been a challenging year. They had completed a significant number of days in terms of the audit plan and the programme of work and had focused on areas of key risks, and have been able to give a very meaningful HIAO this year.

From the IA Annual Report, HKT highlighted the KPIs and was very pleased that all 4 had been met and only 2 out of 36 management responses had missed the 15-day deadline, which was an achievement this year considering the impact of the pandemic.

HKT moved on to the HIAO and explained the purpose was to contribute to the Trust's assurances of the effectiveness of the internal control system and in respect of the AGS. The basis of the Opinion was the design and operation of the assurance framework and supporting processes, including risk management which had been discussed at length. The Opinion took into account the range of individual opinions from risk-based audit assignments, the Trust's response to recommendations and the extent to which they had been implemented. The context this year had been difficult because of Covid 19 and because the Trust had been at level 3 all year. A note had been added stating that IA had worked in accordance with public section internal audit standards all year. The overall outcome was significant assurance. There was a good system of governance, internal control and risk management in place. In terms of BAF and risk management, there was considerable narrative that told the journey of reaching the end result. The Trust had kept its oversight of the Covid 19 related risks and, whilst there was still work to do to strengthen the assurance framework document and processes and the risk management systems, there had been significant work undertaken and planned. The Chief Executive was providing personal leadership to this. Internal Audit would be reviewing the situation during 2021/22 and not at the end of the year.

HKT spoke about the 30 significant assurance opinions received by the Trust and commented that it was good testament to the Trust. There were 7 limited assurances and 2 low assurances relating to the LLP. There were 139 out of 194 recommendations implemented with 25 recommendations outstanding. JH added the two low assurance reports for the LLP had been re-audited during the year and the result was a significant assurance for both.

HKT spoke about the narrative for the AGS which mostly related to the limited assurance/low assurance outcomes. Those had been discussed at the Audit Committee previously. There were no specific control weaknesses to draw to the Committee's attention. She thanked everyone for their support, especially Simon and Andy for achieving a positive outcome. IA would be tracking progress throughout the year to ensure the Trust was sustaining its improvements.

JM asked if HKT was happy that her HIAO had been appropriately reflected in the AGS, subject to the amendment to highlight some of the positives. HKT said she was happy that the AGS covered the key points, the significant assurance, and the control weaknesses and believed that by adding the positive outcomes it would give a more balanced view.

The Committee:

- **Was happy to receive the IA Annual Report and Head of Internal Audit Opinion.**

21/70 Annual Report

JH stated that the report was prepared in line with the Annual Reporting Manual published earlier in the year. She thanked all those who contributed to the report, and thanked TA for putting it together. She asked that the Committee approve the report and recommend to the Board for approval tomorrow. On Monday she would be working with SH to get it uploaded onto the portal for submission to NHSI. She asked that people contact her promptly if they had noticed any errors. JM commented that she had proof read it, and the Comms Team have read it, as well as the Chair and the Chief Executive.

The Committee:

- **Approved the Annual Report and recommended the approval of the document to the Board.**

21/71 Quality Account

CJ gave an overview of her report and said it was an honest account of where the Trust had areas for development but also showed the improvement in areas where a lot of work had been undertaken to give a balanced view of the current situation. Next year the Quality Account would be part of the Annual Report.

JM commented that Data Quality Group would be discussing at one of their future sessions the validity and accuracy of the data that was contained in the Quality Account as so much of it was mandated. CJ explained that ordinarily External Audit would audit the data contained but that was stood down by the Centre, as it was last year. Ordinarily it would have been scrutinised around the core indicators so the Committee would have had that level of assurance. In addition, the Governors' indicator was usually audited externally but that did not happen this year. The Quality Account had to be submitted by 30 June. JM asked for the Quality Account to be put on the next Quality Committee's agenda. CJ confirmed she would make sure it was on. The Committee thanked CJ for the work she had done on the Quality Account.

The Committee:

- **Approved the Quality Account and, subject to a further review from the Quality Committee, was happy to recommend approval of the document to the Board.**

21/72 Directors' Certificate for the Summarisation of Schedules (FTC)

AB confirmed that the summarised schedules were an exact summary of the Trust's accounts. The documents would be signed before submitting next week. MD confirmed that they would be certifying the consistency of the documents and would update the Committee through their follow up letter in due course. JH agreed to circulate the schedules to the Committee members for transparency.

21/73 Informing the Audit Risk Assessment

JM confirmed that she had completed this and it had been submitted to External Audit. It would be circulated to Committee members after the meeting.

Post meeting: SK confirmed that he had circulated the document to Committee members straight after the meeting ended.

21/74 Third Party Assurance Reports (NEP & ESR)

No questions were asked.

The Committee:

- **Noted the report.**

21/75 Any Other Business

No further business.

21/76 Date and time of next meeting

The next meeting of the Group Audit Committee will be held on 16 September 2021, 9.00 – 13.00, via Webex.

Action Log

No.	Meeting Date	Action	Owner	Due Date	Completed
21/16	09.03.21	Develop the Audit Committee's visibility and accessibility to other teams within the organisation. Discuss at the Time Out meeting in July.	HKT/SK /AB	~~July~~ Sept 2021	
21/41	11.05.21	Collate organisation chart of all committees in the Trust, and their reporting lines, and present at next meeting.	JHa/CJ	~~July~~ Sept 2021	

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Audit Committee 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

To receive the Audit Committee Annual Report 2020/21.

Executive Summary – Key Points

In line with best practice it is recommended that Audit Committees prepare an annual report to the Board of Directors and Council of Governors that sets out how the Committee has discharged its responsibilities and met its terms of reference. The attached report summarises the committees work during the year 2020/21.

Recommendation

The Audit Committee is asked to discuss and approve the report for upward reporting to the Board of Directors meeting in September.

Author: Jill Hall, Interim Foundation Trust Secretary

Director Sponsor: Jenny McAleese, Audit Committee Chair

Date: September 2021

Audit Committee Annual Report 2020/21

Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Board of Directors and the Council of Governors with a summary of the work of the Audit Committee during the period April 2020–March 2021, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

The Trust's Audit Committee meets at least five times per year and representatives from the external auditor, internal auditors and the counter fraud service attend these meetings.

The Trust has been through the most challenging year to date. The COVID 19 pandemic, which hit in March 2020 and continued throughout the year and into 2021, necessitated major changes to the configuration of Trust services and the way it supported delivery of these. Consequently, the audit of the year-end accounts and all associated meetings were conducted remotely.

Overview of the year 2020/21

Non-executive Directors make up the membership of the Audit Committee as follows:

- Mrs Jenny McAleese (JMcA) Chair from September 2017
- Mrs Jennie Adams (JA) from March 2018 (Chair of the Resources Committee until August 2020)
- Dr Lorraine Boyd (LB) from December 2019 (Chair of the Quality Committee until Nov 2020)
- David Watson from December 2020 (Chair of the Resources Committee from Nov 2020)
- Steve Holmberg from December 2020 (Chair of the Quality Committee from Nov 2020)

Table 1: Audit Committee Attendance

	Meeting Dates					
	05/05/20	**17/6/20 Year-end**	**07/07/20 Time Out**	**08/09/20**	**01/12/20**	**09/03/21**
JMcAleese (Chair)	✓	✓	✓	✓	✓	✓
J Adams	✓	✓	✓			
L Boyd	✓	✓	✓	✓		
David Watson					✓	✓
Steve Holmberg					✓	✓

The Audit Committee met on six occasions during 2020/21 and all meetings were quorate.

The Committee was supported at all of its meetings by:

- Finance Director
- Head of Corporate Finance and Resource Management
- Foundation Trust Secretary
- External Audit (Engagement Lead and Engagement Manager)
- Internal Audit (Head of Internal Audit, Internal Audit Manager, Senior Internal Auditor)
- Local Counter Fraud (Counter Fraud Manager, Counter Fraud Specialist, Anti-Crime Specialist)

Other staff were requested to attend the meeting for specific items:

- Chief Executive (for the Annual Governance Statement)
- Medical Director (for Mortality Reviews)
- Chief Operating Officer (for a report on Outpatient Clinic Utilisation)
- Deputy Director of Healthcare Governance (for Clinical Effectiveness Annual Report)
- Deputy Director of Patient Safety & Quality Improvement (for a Clinical Governance Update)
- Freedom to Speak Up Guardian (for the Freedom to Speak Up Annual Report)
- Interim Head of Risk (for corporate risk register and risk management framework)

Separately, private sessions were held with Internal Audit and External Audit prior to the year-end meeting. Internal Audit and External Audit are encouraged to discuss any concerns they may have with the Audit Committee on an ad hoc basis.

The External Auditors changed during the year and we said goodbye and thank you to Grant Thornton and welcomed representatives from Mazars in July 2020.

The Audit Committee's duties cover the following areas:

- Monitor the integrity of the activities and performance of the Trust and YTHFM and any formal announcement relating to the Group's financial performance;
- Monitor governance and internal control for the Group;
- Monitor the effectiveness of the internal audit function for the Group;
- Consider the appointment of the external auditors, providing support to the appointment made by the Council of Governors;
- Review and monitor external audit's independence and objectivity and the effectiveness of the audit process for the Group;
- Develop and implement policy on the employment of the external auditors to supply non-audit services;
- Review standing orders, financial instructions and the scheme of delegation;
- Review the schedule of losses and compensation;
- Review the annual fraud report;
- Provide assurance to the Board of Directors on a regular basis;
- Report annually to the Board of Directors on its work in support of the Annual Governance Statement.

Work of the Committee

The Committee currently organises its work under seven headings: Corporate Committee Work (Work *Groups)*, *Internal Audit, External Audit*, *Finance Issues and Governance Issues, Counter Fraud, York Teaching Hospital Facilities Management (YTHFM)*.

Each meeting considers the business that will enable the Committee to provide the assurance to the Board of Directors that the systems and processes in operation within the Trust are functioning effectively.

The Board's sub-committees play a role in managing the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). The Executive Committee plays a greater part in this and the BAF and CRR goes to every Executive Committee, Resources Assurance Committee and Quality Assurance Committee with the Audit Committee seeking assurance about the processes in place.

The Data Quality Group is a sub-group of the Group Audit Committee and reports directly to it. The group consists of some members of the Audit Committee and tests the quality of data used within the organisation. Its role is to examine and understand data quality issues relating to finance, human resources, risk and legal services and patient information systems. During 2020/21 the group met once due to the pandemic and the need for attendees to focus their efforts elsewhere. At the meeting the group received a presentation on SAFER data. The group is now up and running again with the first meeting of 2021/22 taking place in May 2021.

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire. The Chair of the Audit Committee and the Director of Finance sit on the Board of Audit Yorkshire, which meets quarterly.

The conclusions, including the assurance level and the corporate importance and corporate risk ratings, all findings and recommendations of finalised Internal Audit reports, are reviewed by the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually by the Audit Committee.

Internal Audit uses an inclusive risk-based approach to building its Internal Audit plans, with senior management identifying areas of risk or concerns which may then be included. Whilst this approach identifies current weaknesses and leads to activities which improve control, it almost invariably leads to an audit report giving an opinion of *"limited assurance"*. All Control Improvement Audits are reported to the Audit Committee. Internal Audit is asked to undertake additional audits and reviews following any concerns raised by senior management. The Audit Committee regularly reviewed the list of outstanding audit recommendations throughout the year and is pleased to report that these continue to fall.

A system whereby all internal audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported, including full details of all outstanding recommendations, to the Director

Team and the Audit Committee on a quarterly basis. The Chief Executive continues to meet with the Audit Sponsor of all limited assurance audit reports.

The Audit Committee reviewed the Internal Audit Plan for 2020/21
Internal Audit Effectiveness was reviewed by the Committee during 2020/21.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented the Annual Report detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

External Audit - External Audit services were provided by Grant Thornton for until July 2020. During 2019/20 the external audit contract was tendered and Mazars were appointed at the beginning of August 2020.

During the 2020/21 financial year the Audit Committee reviewed all External Audit's reports arising from their audit work in relation to the final accounts, the Annual Governance Statement and Value for Money review.

The External Auditors have attended the Audit Committee and regularly updated the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

The Audit Committee reviewed and approved the External Audit Engagement Letter in June 2020.

During 2020/21 the Audit Committee reviewed and, where appropriate, approved the following documents prior to submission to the Board of Directors:

- Assurance Framework and Corporate Risk Register in May, September, December 2020 and March 2021;
- Standing Orders, Standing Financial Instructions and Scheme of Delegation in December 2020;
- The Annual Governance Statement and the Head of Internal Audit Opinion prior to submission to the Board at the year-end meetings held in June 2021.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2020/21:

- Review and approval of Audit Committee Terms of Reference and work programme at the meeting held in July 2020.
- Ongoing review and revision of the Audit Committee's timetable.
- Support of the work in relation to the appropriate functioning of the Board Committees and ensuring that, where appropriate limited assurance Internal Audit Reports, further scrutiny by the appropriate Board Committee took place.
- Review of effectiveness leading to a verbal review at each meeting.

Meetings for the coming year

The Audit Committee has been encouraged by the work carried out during 2020/21 to strengthen the Trust's governance systems and to improve the lay-out and functioning of both the Corporate Risk Register and the Board Assurance Framework. It particular

welcomes the formation of the Risk Committee and the plans to work with the Good Governance Institute.

There remains work to do to ensure that strong governance is at the heart of the Care Groups, but the position is improving now that the Governance Facilitators have been appointed. Equally, whilst we have improved in terms of becoming a learning organisation, we are still not where we want to be. The plan is that the Quality Improvement agenda will help us make significant progress in this area.

In December 2020 the Audit Committee started to review the learning from the HPV Incident of 2019 and was not assured in this area. Consequently, it commissioned Helen Kemp-Taylor to carry out an investigation: that work has now been completed and Helen is due to report to Audit Committee in the Autumn.

Conclusion

The Audit Committee continues to be of significant importance in the context of increasing pressure on the NHS, both in terms of finance and operational performance. The Audit Committee ensures control processes and procedures are fit for purpose and continue to function effectively alongside the drive for ever more cost reductions.

The Committee is conscious of the need to give equal prominence to financial and clinical audit and has been pleased with the progress made this year. The Audit Committee continues to provide an overarching link between the Board Committees to ensure that audit work and risk is covered in the appropriate forum.

Members of the Committee are pleased to note the continued support for audit work from the organisation. This endorsement and support are both extremely important, as is the culture of openness and the desire always to learn and to improve.

This year I want to pay tribute the finance, internal and external audit teams and Jill Hall and Tracy Astley for working so hard in the most challenging of circumstances to ensure the production and audit of the Annual Accounts and the associated reports.

Finally, I thank the Board for the strong support it gives to the work of the Audit Committee.

Jenny McAleese, Chair of the Audit Committee
August 2021

York and Scarborough Teaching Hospitals NHS Foundation Trust

Board of Directors
30 September 2021
Resources Committee Annual Report on Effectiveness

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 present the Resources Assurance Committee Annual Report on its effectiveness.

Executive Summary – Key Points

The Resources Assurance Committee is a sub-committee of the Board of Directors, and as such provides regular reports to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Board of Directors with assurance on all aspects in relation to finance, workforce and organisational development, digital, transformation, sustainability and the LLP.

In line with best practice in other sectors, the Resources Assurance Committee also provides an Annual Report to the Board of Directors summarising its activities for the financial year 2020/21, setting out how it met its Terms of Reference. This is provided at Appendix 1.

Recommendation

The Resources Assurance Committee is asked to review and approve the Resources Assurance Committee Annual Report 2020/21.

Author: Jill Hall, Interim Trust Secretary

Director Sponsor: Lynne Mellor, Resources Assurance Committee Chair

Date: 21 September 2021

1. Introduction and Background

- Good practice states that the Trust Board should review the performance of its Committees annually to determine if they have been effective, and whether further development work is required.

- This Annual Report summarises the activities of the Trust Board's Resources Assurance Committee (the Committee) for the financial year 2020/21 setting out how it has met its Terms of Reference.

- The purpose of the Committee is laid down in its Terms of Reference. In summary, it is responsible for providing the Trust Board with assurance on all aspects in relation to finance, workforce, digital and the LLP.

Resources Assurance Committee Annual Report 2020/21

1. Foreword

We faced an unprecedented year in 2020-21 as the Covid-19 pandemic hit the NHS. On behalf of the Resources Assurance Committee, it is a heartfelt thanks to everyone who contributed to caring for the health and wellbeing of patients across the York and Scarborough Teaching Hospitals NHS Foundation Trust during this extraordinary year.

The Resources Assurance Committee has a wide-reaching remit covering key functions such as Finance, Workforce and Organisation Development, Digital and including its partnership - the Local Liability Partnership (LLP). This Resources Assurance Committee Annual Report outlines how its duties were discharged for the benefit of patients and staff across the Trust for the period April 2020 to March 2021.

During the year the Committee, in line with its remit, sought assurance to address key risks and challenges with some notable improvements:

- Covid for example, had a huge impact affecting the control and mitigation of risk. The LLP for instance assisted with the reconfiguration of the Trust sites to help with Covid patient isolation. During the period, travel to the Trust sites by patients and their families was limited due to tighter restrictions on infection and prevention control with the Covid virus. The Committee was pleased to note digital technology was deployed to assist 'virtual' outpatient appointments with the use of Telemedicine across all Clinical specialities, rising from 8k virtual outpatient appointments in 2019 to 19k in December 2020. Tablets were also made available to patients so that families and friends could contact relatives in hospital when visiting was restricted.
- For Trust staff the Committee throughout the year continually sought assurance that there was a focus given to caring for the mental and physical well-being of staff, particularly with the impact of Covid:
    - assurance was given that processes and systems were improved for staff with the introduction of for example stress reducing initiatives, staff resilience workshops, and improvements to staff Covid testing.
    - the Committee recognised the outstanding achievement of the fast and efficient rollout of the staff Covid vaccination programme where vaccination 'hubs' were established to not only vaccinate Trust staff but also staff external to the Trust from other NHS and supporting organisations from across the region.
    - the Committee noted a high staff absence rate throughout the year, fluctuating with Covid outbreaks. However, positive trends were noted in unfilled temporary nursing staff requests and a positive decline in vacancies in August lower than the Trust had seen for many years (except pockets such as ED and Acute medicine on the East coast). During the period the Committee welcomed staff retention stability rates remaining positive.
    - The Committee welcomed the introduction of the BAME network with reverse mentoring plans. In September it welcomed not only the growth in the apprenticeship programme, with the first cohort of students from Coventry, but also that the Trust was awarded the Ministry of Defence's

Employers Recognition Scheme Gold Award for the support of Britain's Armed Forces.

- Overall with Digital we started to see more 'green shoots' of improvement to the Trust's network and IT capability, such as the increase in network bandwidth at the start of the pandemic and throughout the year we saw the rollout of new laptops and applications such as Microsoft Office N365 application. In August the Committee welcomed the appointment of a Chief Digital Information Officer, with the second half of the year providing greater assurance as the Committee noted an uplift in understanding of the Trust's true digital maturity capability and gaps. The Committee recognises there is much to do in the Digital space. We continue to seek assurance in the short term on matters such as 'fixing the basics' including reducing significant risks such as a major IT failure or a cybersecurity attack. In the longer-term assurance is sought to have a fit-for-purpose Digital strategy, to underpin the Trust strategy.
- The financial regime was very different this fiscal due to Covid. Adequate Covid provisions were made, however the Committee continued to remain concerned about the small availability of capital funding, insufficient to cover the Trust's full needs for example with prioritisation calls needed for backlog maintenance and Digital. During April the Committee was pleased to see the Finance team awarded a key accreditation to support the delivery of quality services for patients by the NHS Leadership academy 'Future Focus Finance'.
- The Committee noted the LLP has made significant improvements over the last 12 months reflected in its improving KPIs and PLACE assessment scores, staff communication and governance including programmes of work addressing longer-term issues such as cultural change. The Committee continues to seek assurance that the LLP is making improvements and creating firm foundations to unleash the potential to grow its business strategically.

As we exited the 2021 fiscal, the Committee was assured that the Trust had improved key processes and systems to tackle risks particularly impacted by Covid, such as the rapid roll out of the vaccination programme and the provision of PPE to staff, as well as the ramp-up of digitally enabled capabilities, for example catering for staff remote working and patient Telemedicine.

Looking forward to 2021-22 we can see opportunities for improvement across all the Committee areas with the need for increased collaboration with our partners and stakeholders as the 'integrated care system' develops. We will continue to maintain our focus and commitment to assure ourselves that the Trust and the LLP are doing everything they can to meet the needs of patients, staff and support workers.

Kind regards

Lynne Mellor
Chair of Resources Assurance Committee,

July 2021

Introduction

This report has been prepared to provide primarily the Council of Governors and the Board of Directors with a summary of the work of The Resources Assurance Committee during the period April 2020 – March 2021, and in particular how it has discharged its responsibilities as set out in its Terms of Reference. In brief the scope of The Resources Assurance Committee seeks assurance from:

- Finance,
- Digital,
- Workforce and Organisation Development,
- Transformation
- Sustainability,
- Research and Development and
- the full remit of the Trust's independent Local Liability Partnership (the LLP) which includes Estates and Facilities.

Governance

The Resources Assurance Committee consists Non-Executive Directors (NEDs) and key NHS Trust officers. The Resources Assurance Committee met on 12 occasions during 2020/21, with all meetings moving successfully to an online format in keeping with government recommendations during the pandemic. All meetings were deemed to be quorate as they had at least two Non-Executive Directors and 1 Executive Directors in attendance.

Non-executive Directors make up the membership of The Resources Assurance Committee as follows:

- Jennie Adams (JA) (Chair to August 2020)
- Lynne Mellor (LM) (Chair September–October 2020)
- David Watson (DW) (Chair November 2020)
- Jim Dillon (JD)

Key officers attended the meeting to provide assurance to the Committee, including: -

- Andy Bertram (AB), Deputy Chief Executive / Finance Director
- Dylan Roberts (DR), Chief Digital and Information Officer
- Polly McMeekin (PMc), Director of Workforce & Organisational Development
- Delroy Beverley (DB), Managing Director of YTHFM LLP
- Linda Povins (LP), Foundation Trust Secretary
- Jill Hall (JH), Interim Trust Secretary
- Jo Best, Secretary for The Committee

And as required deputies attended during the period.

Table 1: Resources Assurance Committee Attendance

Attendance												
	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
JA Chair to Aug '20	√	√	√	√	√							
LM Chair Sept 20-Oct 20	√	√	√	√	√	√	√	√	√	√	√	√
DW Chair from Nov 20								√	√	√	√	√
JD	Ap	√	√	Ap	√	√	√	√	√	√	√	√
AB	√	√	√	√	√	√	√	√	√	√	√	√
DR					√	√	√	√	√	√	A	A
PMc	√	√	√	√	√	√	√	√	√	√	√	√
DB	√	√	√	√	√	√	√	√	√	√	√	√
LP to Dec 21	√	√	A	√	√	A	A	√	√			
JH from Mar 21												√
JB	A	A	√	√	√	A	A	√	√	√	√	√

Duties of the Committee

The Resource Committee's Terms of Reference outlines its key duties and includes a documented work programme. This work programme is a schedule of the key tasks to be undertaken by the Committee over the year. This is reviewed at least once annually.

Detailed minutes were taken of all Resource Assurance Committee meetings and were reported to the Board of Directors. The Chair escalates those matters (for action or for information) that The Resources Assurance Committee considers should be drawn to the attention of the Board or another one of the Trust's Committees

Following a review of the Committee's Terms of Reference, the key duties of The Resources Assurance Committee are as follows: -

- To gain assurance and provide challenge about the actions being taken to ensure the Trust has appropriate systems in place to maintain compliance with achievement of the financial plan, digital strategy, the required performance

standards around estates, and health and safety, fire and security and workforce and organisational development.

- To work in conjunction with the other Board Committees sharing information and agreeing the location for the discussion of certain topics.

- To regularly review the Corporate Risk Register and the Board Assurance Framework to gain assurance about the risks and mitigations around finance, digital, estates, and workforce and organisational development performance.

- To escalate any areas of concern identified to the Board of Directors for further discussion and resolution. Issues will on occasions be discussed in private by the Board of Directors on the advice of the Committee.

- The Committee will escalate items to the Board of Directors following each meeting and will submit minutes to the Board of Directors for information.

Reports

During the year the Committee explored in more detail some of the concerns and risks that faced the Trust, predominantly steered by the Covid-19 pandemic. To support this, it received additional information on the following topics:

- Board Assurance Framework and Corporate Risk Register
- YTHFM LLP
- Workforce and Organisation Development
- Finance including draft year-end financial outturn and financial regime for 2021/22
- Sustainability
- Digital
- Covid-19 pandemic
- Overseas visitors
- Staff survey
- Freedom to Speak Up (FTSU)
- Equality and diversity
- Getting It Right First Time (GIRFT) programme
- Data protection
- Research and Development
- Community Stadium

Overview of the Committee activity in 2020/21

The following provides a summary of the key committee activities during the past twelve months, seeking assurance where risks and issues were identified, and providing support as required. .

Local Liability Partnership (LLP)

The LLP manages the estates and facilities for the Trust including catering, domestic services, waste management, linen and laundry, car parking, grounds maintenance, security, medical device management, pest control, portering, energy and switchboard.

Staff

- In May the Committee welcomed the appointment of a new Managing Director to the LLP and subsequently noted the gradual improvement of KPIs with the introduction of improvement plans.
- The Committee noted the LLP commissioning of an independent body, ACAS to review people related issues. The comprehensive report from ACAS prompted the Committee to raise concerns when presented with the findings in August regarding historical and present-day behavioural and cultural people related issues. The Committee was assured that the recommendations were being addressed with the production of a comprehensive 'New start programme' to mitigate the risks and to start to tackle the highlighted issues, including the longer-term problems such as culture.
- During the period the Committee did continue to raise concerns around increased staff sickness in the LLP, particularly due to Covid. It continues to monitor progress, with some assurance given that processes were improving and were in alignment with Trust initiatives.

Estates and facilities

- In April the Committee was assured that the LLP worked hard to reconfigure spaces for patients and staff throughout the year to facilitate the operational plan for clinical care in dealing with the challenges from the pandemic. For example, the conversion of Anne Wright and Haldane at Scarborough General Hospital and York to single rooms improved isolation for patients.
- The Committee welcomed also in April the sustainable development plans developed for a 'Clean Growth' strategy for the Trust with the aim to deliver a 50% carbon reduction by 2032.
- The Committee highlighted the insufficient capital funding for back log maintenance, and the increase in risk to patients and staff. The Committee will continue to monitor this into next fiscal.

Governance

- The RC was assured that the LLP reviewed its overall governance structure slimming down the number meetings, attendees, frequency and measures.
- The Committee highlighted the need for better tracking of LLP's KPIs with the need to make improvements to the type, amount and monitoring: for example, in July 45 of the 120 KPIs were unmeasurable without the introduction of the new CAFM system. The progress with the CAFM system is still outstanding on the missing KPIs; as we exit the year the Committee will continue to seek assurance on this and other KPIs which are not meeting targets.
- Assurance was provided as the year progressed with a number of the KPIs improving, for example, food hygiene for York hospital improved however cleanliness remains an ongoing issue particularly for infection prevention control in Operating theatres and food waste. The Committee has requested more regular information on LLP KPIs in order to monitor whether progress is being made and sustained.
- Following the Covid 19 outbreak the committee requested a lessons' learnt paper which provided assurance that LLP was meeting the demands from the pandemic such as urgent requests for reconfiguration to the Trust's estate to meet the ever-changing Covid demands to providing oxygen supply for patients or travelling long distances to fulfil PPE needs.

Digital

The Committee has repeatedly stressed the significance of the role of 'Digital' within the Trust; seeking assurance that it is seen as a clear enabler to the Trusts' strategy and should be seen as integral to the Trust's overall business transformation. The Committee welcomed the appointment of a Chief Digital Information Officer in August. The Committee has post appointment, seen a marked improvement in Digital leadership, including the assessment of risk to the Trust and digital action such as the securing of more funding for Digital following the request for a benchmarking exercise.

Network and IT improvements

- The Committee has been assured that it has started to see important improvements to the Trust's network and IT capability, providing improved communications for patients and their families (such as the supply of tablets) and to allow for remote and more flexible working of staff during the pandemic. The Committee noted the increase in network bandwidth at the start of the pandemic, and the rollout of new laptops and applications such as Microsoft Office N365 application. The Digital team were congratulated for their delivery of Telemedicine capability with for example an increased usage of Telemedicine across the clinical specialities by September 2020, videoconferencing had increased from 150 hours pre-pandemic to 450 hours. The Committee noted and praised the Digital team, who worked with Clinicians to enable significant increase in outpatient appointments from 8k in 2019 to 19k appointments in December 2020.

Governance

- The Committee was assured that the Trust has started to get a better 'grip' of how it will monitor and control its Digital activity through the introduction of an improved programme of work and reporting structure with supporting resource. The Committee also requested that Digital KPIs were introduced for the first time to the Integrated Business report, with progress being monitored at every meeting.
- The Committee welcomed the introduction of 'Show and Tells' demonstrating digital improvements made throughout the year such as the 'outpatient restoration' improvements demonstrated in June, with new functionality which allows Clinicians to link together clinical activity across specialities. In October a demonstration of how artificial intelligence algorithms are being incorporated into patient records to reduce the risk of death in hospitals from mortality and sepsis, the Committee applauded this work and the recognition it was receiving working with external parties such as the Alan Turing institute.

However significant digital concerns were raised by the Committee including:

- the lack of available capital and revenue to meet the requirements needed to not only get the Trust to basic digital infrastructure levels but also to enable its future-proofing in areas such as best in class cloud services. In particular the Committee continues to seek assurance around the major risks in failure of IT equipment and cyber security. The Committee has encouraged funding to be sourced elsewhere; in April the Committee recommended the Digital Aspirant programme funding was sought and continued to seek assurance that funding was sought to bridge the gap from bodies such as NHSX, and the ICS. Moving into next year Committee continues to seek assurance adequate funding is provided for Digital recognising competing Trust demands.
- The size and skill set of the Digital team has also raised concerns with the Committee with the need to see a clear case for change to support the uplift of the Trusts Digital capabilities.
- The Committee seeks assurance that the Trust develops a refreshed Digital Strategy with a clear roadmap and architecture.

Finance & Efficiency

The NHS financial regime changed significantly, with a tighter control of funds from the centre to ensure Trusts had sufficient resources to meet the challenges posed by the pandemic. Efficiency schemes were also suspended due to the pandemic.

Governance

- The Committee sought and gained assurance that robust processes were in place to authorise, record and reclaim Covid expenses both capital and revenue. The Committee recommended that Finance undertake a review after year end of Covid spend across the Trust to ensure that any lessons learnt can be built into future plans to help mitigate risks in dealing Covid in 21/22.

- The committee raised concerns about the delays and challenges with the Community stadium rollout following an LLP update in February 2021 and asked for a Post Implementation review of the business case (Sept 2021 and March 2022) to determine lessons learnt.
- At the end of the fiscal the Committee asked for assurance on Covid spend to assure the committee that lessons learnt could be shared for the following year and ahead of any 'central' audit asks of Covid spend. The review is to include both opportunities for improvement and good practice.

Procurement

- In July the Committee was assured that revisions were made to the procurement policy and requested future versions to give a greater focus on sustainability.
- The Committee also monitored closely the procurement of PPE and plans for BREXIT. It was assured that the Trust improved its processes and facilities during the period to not only further source and house the growth in demand for PPE required to deal with the pandemic but also to meet any risks posed by BREXIT such as an adequate provision of medicine supplies.

GIRFT

- The committee also requested an evaluation of the GIRFT work taking place within the Trust in order to gain assurance that it is delivering measurable benefits. The Committee applauded the exemplar work on the Vascular Carotid Service. The Committee will continue to monitor this to ensure that the Trust focus remains on transformational pieces of work that deliver significant efficiency gains.

Funding

- Concerns were raised about the huge disparity between the capex 'wish list' and the capex available for 21/22 The Committee requested that alternative funding sources were reviewed to meet the 'gap' such as the sale of assets or how we generate more income to plough back into the business.
- The Committee was pleased to see the Finance team awarded a key accreditation to support the delivery of quality services for patients by the NHS Leadership academy 'Future Focus Finance'.

Workforce and Organisational Development

Following the outbreak of the Covid 19 pandemic the Committee raised concerns regarding staff physical and mental well-being:

- Staff Absence continued to be a challenge, fluctuating throughout the year (e.g., 5.7% in January, versus 4.4% in August) and in particular tracking with the peaks of the Covid pandemic. The Committee also noted fluctuations in vacancy rates with a positive decline in vacancies in August lower than the Trust had seen for many years (except pockets such as ED and Acute medicine on the East coast remaining high). During the period the Committee welcomed staff retention stability rates remaining positive moving from 88% in April 2020 to 90% by March 2021.

- The Committee was assured that throughout the year that a number of initiatives were employed to assist staff with the impact of the pandemic, such as
    - the introduction of Time in Post Incident (TiPi) supporting the identification of stress,
    - well-being training (e.g., 140 staff volunteered as reported in June to undertake mental health well-being training), resiliency workshops.
    - measures for the preventative spread of Covid and plans at the end of the year were outlined for extra staff such as clinical psychologists to be deployed.
    - early in the pandemic free car parking and packed lunches were provided for staff.
    - the Committee noted in May that the Trust also deployed a 'Clever Together' on line workshop to elicit staff views for Trust improvement, however the outcomes and action plans were delayed in the year with the pandemic.
    - the Director of HR also provided assurance in taking learning from other organisations such as lessons from industry for online working/management given 'remote/virtual' working was new to many in the Trust.
    - the Committee also recognised the outstanding achievement made by the Trust in the fast and efficient rollout of not only the normal flu vaccine for staff but also the staff Covid vaccine programme where vaccination 'hubs' were established to not only vaccinate Trust staff but also Covid vaccines were given to other NHS bodies and supporting organisations from across the region. The Committee noted with thanks that the success of the Covid vaccination programme was a true 'team effort' across the Trust, including the clinicians, administrators, LLP staff and volunteers.
- The People Plan was reviewed regularly by the Committee, the first review in September. The Committee will continue to seek progress on actions and greater clarity on plans into next fiscal.
- The Workforce Racial Equality and Diversity was high on the agenda with discussions on how this can be improved across the Trust including Board make-up. The setting up of a BAME network with champions across the Trust and the plan for reverse mentoring provided some assurance to the Committee of steps in the right direction for Trust improvements.

The Committee during the period also sought assurance on a number of staffing issues such as: -

- The staff survey results showed a lack of progress from 2019, e.g., Quality of Care and Safety culture, some actions had been planned to be addressed by the 'Clever Together' work, however this was delayed due to Covid.
- The Committee also raised concerns at the end of the period given 23.5% of staff experienced bullying, harassment or abuse from patients or service users in particular at work.
- The Committee monitored appraisal rates regularly raising concerns that completion rates were low - exacerbated by Covid issues. The Committee

was particularly pleased later in the year as the appraisal window closed with the rate of appraisal completions at 91.8%.

- Statutory & Mandatory Training for medical staff – The Committee was assured by the greater degree of granularity of monitoring and renewed efforts to improve compliance given the low compliance in August of 36.3% to a shift to 93.4% in March.
- The Committee applauded in September not only the growth in the apprenticeship programme with the first cohort of students from Coventry, but also that the Trust was awarded the Ministry of Defence's Employers Recognition Scheme Gold Award being given to the Trust, the highest national award in recognition for the support of Britain's Armed Forces.

A role of the Committee is to flag any risks to other Trust Committees and ask for resolution and/or escalation to the Board. For instance, in July the lack of progress from the staff survey on Quality and Safety culture was flagged to the Quality committee as well as the Board. In February the Committee requested the Quality committee to follow-up on the patient access to more tablets.

In Summary

The Resources Assurance Committee has a significant remit and covers a number of key functions for the Trust.

Looking back, the impact of the Covid pandemic has been evident throughout the year particularly in the consideration of the safety of patients and the health and well-being of staff. The Committee overall has discharged its duties in seeking assurance that the Trust is doing all it can to meet the needs of its patients and look after its staff.

Looking forward into 2021/2 the Committee has no doubt that linkages with the ICS will increase which are welcomed, until more of the impact is understood, the Committee would like assurance that:

- LLP: improvements continue to be made with the New Start programme particularly culture and behaviour. Key risks are mitigated such as staff sickness, KPI failings across for example theatre cleanliness, food waste and the monitoring of KPI gaps with CAFM. More funding is secured for backlog maintenance, as it continues to be a cause for concern. We also ask for assurance that the LLP has established firm foundations to unleash the potential to grow its business strategically and sustainably.
- Digital: the Essential Services Programme progresses to fix the 'basics' including addressing major risks around IT infrastructure and cyber security. The Committee also requests that a succinct Digital strategy with a clear roadmap is produced, aligned to the Trust strategy.
- Finance: avenues are explored to address the financial risk with increased financial spend likely next year for staffing, digital, and the LLP. (It is recognised that in the Board will have to prioritise emergent and existing strategic priorities both short and long term). It is also anticipated there will be a renewed focus on transformational efficiencies.

- Workforce and Organisational Development: steps continue to be taken to mitigate risks, particularly with the impact of the pandemic to the physical and mental well-being of the workforce. Vehicles such as the People plan will help in this assurance along with the implementation of actions from Clever Together and the learning gained this fiscal from new initiatives such as resilience focus groups. The Committee also requests greater frequency in R&D reporting, so we can be assured that benefits are being maximised for the Trust.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Quality Committee Annual Report on Effectiveness

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 present the Quality Assurance Committee Annual Report on its effectiveness.

Executive Summary – Key Points

The Quality Assurance Committee is a sub-committee of the Board of Directors, and as such provides regular reports to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Board of Directors with assurance on all aspects of quality including delivery, governance, risk management, regulatory standards of quality and safety, and operational performance.

In line with best practice in other sectors, the Quality Assurance Committee also provides an Annual Report to the Board of Directors summarising its activities for the financial year 2020/21, setting out how it met its Terms of Reference. This is provided at section 1 below.

Introduction and Background

- Good practice states that the Trust Board should review the performance of its Committees annually to determine if they have been effective, and whether further development work is required.

- This Annual Report summarises the activities of the Trust Board's Quality Assurance Committee (the Committee) for the financial year 202/21 setting out how it has met its Terms of Reference.

- The purpose of the Committee is laid down in its Terms of Reference. In summary, it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, risk management, regulatory standards of quality and safety and operational performance.

Recommendation

The Quality Assurance Committee is asked to review and approve the Quality Assurance Committee Annual Report 2020/21.

Author: Jill Hall, Interim Trust Secretary

Director Sponsor: Steve Holmberg, Quality Assurance Committee Chair

Date: 20 June 2021

Quality Assurance Committee Annual Report 2020/21

Introduction

This report has been prepared to provide the Council of Governors and the Board of Directors with a summary of the work of the Quality Assurance Committee during the period April 2020 – March 2021, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

Overview of the year 2020/21

Non-executive Directors make up the membership of the Quality Committee as follows:

- Dr Lorraine Boyd (LB) Chair to October 2020
- Mr Steven Holmberg (SH) Chair from November 2020
- Mrs Jenny McAleese (JMc)

Table 1: Quality Committee Attendance

	Meeting Dates											
	April 2020	**May 2020**	**Jun 2020**	**July 2020**	**Aug 2020**	**Sept 2020**	**Oct 2020**	**Nov 2020**	**Dec 2020**	**Jan 2021**	**Feb 2021**	**Mar 2021**
LB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
JMc	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

The Quality Committee met on 12 occasions during 2020/21 and all meetings were quorate.

Key officers attended the meeting to provide assurance to the Committee, including: -

- Chief Nurse
- Medical Director
- Chief Operating Officer
- Deputy Director of Healthcare Governance
- Head of Operational Performance
- Head of Information Services & Patient Access
- Deputy Director for Patient Safety
- Foundation Trust Secretary

The Committee received secretarial and administrative support from the PA to the Chief Operating Officer. There was a documented work programme which scheduled the key tasks to be undertaken by the Committee over the year. This is reviewed on an annual basis. Detailed minutes were taken of all Quality Committee meetings and were reported to the Board of Directors. The Chair also provides an escalated items log of those matters that the Quality Committee considers should be drawn to the attention of the Board.

2020/21 was an unprecedented year with the Covid-19 pandemic which saw the board and assurance committee governance arrangements change following guidance from NHSE/I in March 2020 to support Trusts to free up management capacity and resources.

In response the Quality Committee continued to meet monthly with a reduced membership and agenda. These arrangements were in place between April and July 2020.

The Chair of the Quality Committee also attends the Group Audit Committee.

Duties of the Committee

Following a review of the Committee's Terms of Reference, the key duties of the Quality Committee are as follows:

- To gain assurance and provide challenge about the actions being taken to ensure the Trust has appropriate systems in place to maintain compliance with achievement of the required quality and safety standards, performance improvement and transformational quality improvement.

- To work in conjunction with the other Board Committees sharing information and agreeing the location for the discussion of certain topics.

- To regularly review the Corporate Risk Register and the Board Assurance Framework to gain assurance about the risks and mitigations around quality and safety, performance improvement and transformational quality improvement.

- To escalate any areas of concern identified to the Board of Directors for further discussion and resolution. Issues will on occasions be discussed in private by the Board of Directors on the advice of the Committee.

- The Committee will escalate items to the Board of Directors following each meeting and will submit minutes from its meetings to the Board of Directors for information.

- To agree the Trust's quality priorities and receive the draft Quality Report and provide comment on the draft report.

Work of the Committee

1. Routine Reports

The Committee receives and reviews a number of annual, bi-annual and quarterly reports.

Annual:

- National In-patient Survey
- National ED Patient Survey – every other year
- Annual Report of DIPC
- Annual End of Life Care Report
- Annual Report on Safeguarding (Child and Adult)
- Annual Report in Information Governance
- Mental Health Activity Report

Bi-Annual:

- Maternity Report
- Serious Incident Themes Review

Quarterly:

- Falls Report
- Pressure Ulcers Report
- Mortality Report
- Patient Experience Report
- IPC Report
- Out of Hospital Care Report
- Minutes of Patient Safety Group
- Minutes of Clinical Effectiveness Group
- Perinatal Mortality Review Tool Report

Monthly:

- Performance Report
- Medical Director Report
- Corporate Risk Register and BAF
- Nurse Staffing Report
- Information dashboard on Patient Safety and Quality
- Infection Prevention & Control Updates
- Ockenden Compliance
- CQC Action Plan and Monitoring

2. Themes and focus for the Committee in 2020/21

Within the last twelve months a number of specific issues were identified within the scope of the Committee and some themes were identified. Lengthy discussions took place, encompassing key current risks around Infection Prevention and challenges of maintaining safe levels of nurse staffing.

The performance challenges were also discussed in this context and potential solutions and their wider impacts debated. In the face of these challenges maintaining Patient Safety remained paramount.

The Committee was assured by the contributions from all the Executive Directors and their teams to debate and evaluate the options. This enabled us to identify that, as these issues came together, our concerns were increasingly not just discussed in terms of quality and performance, but also the risk to safety. The need to more clearly capture and respond to potential harms was acknowledged along with the importance of linking, where appropriate, to the wider Trust challenges and the system financial challenges. This information would be invaluable as the Trust prioritises use of resources to ensure continued delivery of a safe service.

All Trusts became subject to Government advice regarding the coronavirus outbreak in March 2020, which saw the Trust making multiple adjustments to working practices including:

- Ensuring the safety of staff by finding out those most at risk, getting as many staff to work from home as possible and ensuring the right PPE was available;
- Establishing gold, silver, bronze and operational pandemic groups;
- Reconfigurations to clinical areas to introduce suspected and confirmed COVID 19 areas and achieving higher than normal discharge levels to ensure capacity;

Key areas of discussion have included the following:-

Covid-19 Pandemic

It is clear that the past year has been the most extraordinary and difficult for the NHS, its staff and its patients and has, of course, been dominated by the dreadful impact of Covid-19 – a pandemic with consequences that will certainly have repercussions for many years in terms of direct illness and mortality but also mental health, missed diagnoses of early cancer and other important conditions and extended waits for investigation and treatment. During the first wave, the Committee received assurance relating to availability of PPE, treatment of Covid-19 patients, staff wellbeing and the management of patients with non-Covid conditions including their access to emergency care and safety on extended waiting lists. The same issues remained relevant during the second phase but the situation was more complex with the requirement to continue to treat as many non-Covid conditions as possible. A Risk & Oversight Committee was established to provide focussed oversight during the worst phases of the pandemic and this had significant membership from the Quality Committee with both Executive and Non-Executive contributions. With hindsight, there were areas of the Trust response that demonstrated vulnerability in relation to managing a pandemic (PPE, nosocomial infection, loss of capacity due to social distancing, limited testing capacity) but these were reflected across the NHS and overall, the Committee was assured that the performance of the Trust protected patients and staff as much as possible. During the second wave, there was an additional focus in the Trust to prepare for recovery from the pandemic and the management of patients who had either had delayed referral for treatment or were placed on ever lengthening waiting lists. The Committee received assurance regarding an enormous amount of work carried out on clinical risk stratification and data that demonstrated that cancer care performance was largely maintained but acknowledged that risks remained around increased delays for non-urgent treatments and diagnostic procedures.

CQC

The Trust began the year having several pieces of regulatory action in place from the CQC. The Committee regularly received updates and assurance on the work to remedy the concerns underpinning the regulatory action. The Committee was pleased to learn that the hard work carried out resulted in the withdrawal of all but two of these that related to concerns about the management of mental health patients in emergency care and on-going concerns reflect lack of long-term assurance of working across partner organisations. Over the year, the focus of the Committee moved more to considering wider improvement actions that would impact on the Trust's CQC ratings at a future inspection. A self-assessment against current CQC standards, suggested that the Trust would receive an overall rating of Requires Improvement and was very helpful in directing workstreams to remedying gaps in governance and other standards. Some of these are discussed further on in this report.

Clinical Governance

During 2019, there was a clinical reorganisation into 6 Care Groups. A major focus of the Committee has been to encourage and receive assurance that enhanced clinical governance processes are being developed and utilised to improve the safety and quality of patient care. Key themes are:

- To promote visibility of concerns and risks in front-line clinical areas through the organisation to the Quality Committee and Trust Board (golden thread)

- To promote the dissemination of effective learning from internal data incidents e.g. SIs and external information around best practice e.g. NICE, GIRFT, CQC inspection etc.

These priorities are reflected in the development of a QI programme that has been discussed regularly in the Committee. The progression of this work has undoubtedly been slowed by the pandemic but the Committee has received assurance of progress towards more effective clinical governance. As part of this process, data has come to light that has identified significant backlogs in clinical effectiveness actions and the implementation of SI action plans. The Committee recognised that becoming aware of these problems represents progress in that previously they might not be systematically identified. The Committee was assured that updated processes and ways of working will ensure, as far as possible, that best practice can be disseminated and that important matters will 'not slip between the cracks'

Staffing

The Committee has reviewed information from a number of sources including CQC inspections, Staff and Patient surveys and data from the IBR that has raised concerns about staffing levels in clinical areas. Considerable progress had been made in relation to nurse staffing to address specific concerns raised by CQC but the Committee was pleased to receive a paper providing a systematic review of nurse staffing in the Trust. Although the paper did identify a significant short-fall when benchmarked against other Trusts, the Committee was assured that this concern had now been effectively investigated and, following escalation to Trust Board, a prioritised action plan has been developed and agreed. The Committee is aware from Medical Director reports that shortfalls exist in certain key areas of medical staffing but has encouraged a more detailed review to understand medical staffing requirements across the whole Trust. Beyond nursing and medical staffing, the Committee has been advised that problems in relation to some diagnostic procedures, especially ultrasound, relate in part to staff shortages. The Committee, however, received assurance that there were plans both to clinically risk assess patients waiting and to develop innovative ways to mitigate staff shortages.

Ockenden Report

Standards of care in maternity units have been of concern across the NHS arising from a number of highly critical reports from under-performing units. The Ockenden Report has set out standards that must be met by all maternity units and the Committee has welcomed this as an objective document that the Trust can follow in order to ensure that our maternity services are safe. As part of Ockenden implementation, a non-executive director (Dr Lorraine Boyd) has been appointed to provide assurance to the Committee and Trust Board on progress to Ockenden compliance. Thus far, staffing levels both of midwives and sonographers have been highlighted as the most urgent areas for action to achieve Ockenden standards.

Other Issues

Beyond these areas of focus, the Committee has continued to monitor and receive assurance across a wide range of issues relating to safety, quality and performance. Infection prevention and control (other than Covid) performance is regularly reviewed at Committee. Rates of Clostridium difficile continue to cause concern although considerable progress has been made against 19/20; the fabric of certain areas of our hospitals is seen as a significant concern and the Committee has asked for remedial actions to be undertaken in this regard. MSSA infections, particularly those associated with iv lines, have been another area of concern and the Committee has been pleased to receive

assurance that plans have been implemented to reduce harm in this area. Reducing harm from falls and pressure ulcers have been on-going areas of attention for the Committee

Conclusion

During the course of 2020/21 the Quality Committee has sought and gained assurance across the Board Assurance Framework, with a main focus on BAF 1-3 and 5-7
Our work has encompassed patient safety, patient experience, clinical effectiveness and performance, seeking to understand how we are maximising the use of our available resources to minimise patient harms and maintain best possible patient experience.

Quality improvement is an important driver of the work of the Trust and key to this is the encouragement of learning and sharing when things have gone well and not so well and collaborating with and learning from partners and external sources.

There have been some significant performance challenges in this past year and, it has been important to recognise and follow the progress of the intensive and far reaching transformation work streams being undertaken to improve the situation.

The onset of the Coronavirus 19 pandemic at the beginning of 2020 has had an impact that will continue to influence the work of the Trust in the coming years. In this context the Quality Committee will continue to seek assurance that patient safety and experience remains a constant guiding principal as we deal with the challenges of the pandemic and the reset and restoration of normal services.

I would like to thank the members of the Committee and their teams and the Board of Directors for their support during the year.

I would also like to thank the Care Groups for their contributions and look forward to continuing to develop strong Ward to Board assurance in the coming year.

Steve Holmberg, Chair of the Quality Committee
June 2021

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
30 September 2021
Risk Management 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 purpose of this paper is to provide the board with an update on the Corporate Risk Register (CRR).

Executive Summary – Key Points

Since rebaselining the CRR in June, 4 out of 13 risks have deteriorated in score whilst the others remained stable. A programme of risk deep-dives has commenced to provide additional focus and assurance on how risks are being managed and challenge assumptions made in the risk registers. A deep-dive on Cyber was presented to the July Risk Committee with a focus on 'Insufficient Staff' in September. The IPC risk is scored 16 and a deep-dive will be presented to the October meeting.

Recommendation

The board is asked to note the contents of the report.

Author: Bobby Anwar, Interim Head of Risk

Director Sponsor: Heather McNair, Chief Nurse

Date: 22nd September 2021

Introduction & Background

4 out of 13 risks have deteriorated in score since the last update in June. Covid forecasts, workforce numbers and unplanned care demand contributed to an increase in score from 9 to 12 for 'Failure to deliver services in line with standards'. Workforce challenges contributed to an increase in score from 16 to 20 for 'Insufficient Staff' making it the joint highest scoring risk along with Cyber. A deep-dive on this risk is being presented to the September Risk Committee. Resource constraints within the Information Governance team also impeded progress with actions and resulted in scores for two of the Information Governance risks increasing from 12 to 16. A full review of Business Continuity action cards and preparation of a Business Impact Analysis for each Bronze command was completed by a target date of 31st August 2021. The score on the Business Continuity risk will be re-evaluated in light of improved controls and reflected in next quarter's report. Whilst the 'Cyber' score remained unchanged, approval of the ESP plan B and its implementation in the current financial year should help strengthen the Trust's capability to manage the risk.

A summary of the key movements on the CRR is outlined below:

Risk	Key Actions	Risk Score		Trend	Comments
		June	Sept		
Cyber Security	Approve and implement ESP plan B – April 22 ESP security and IG maturity roadmap underpinned by chosen (accredited) 3rd party partner(s) and aligned to NHS central guidelines (DSP Toolkit) - July 2022	20	20	⇔	ESP plan b has been approved and is being implemented in this financial year. This includes an upgrade of the CPD infrastructure and underlying operating system to a version protected from cyber-attacks so should reduce impact of the risk.
Insufficient Staff	Formulate Workforce Plan – Oct 21 Develop Winter Workforce Plan – Nov21 Implement Values and Behaviours (includes Just Culture) - Dec21 E-Job planning - Mar22 HCV Workforce Action Plan - Oct21 Deliver medical recruitment project - Dec21 International Nurse Recruitment - Mar22 Implement Medical E-Rostering system - Mar22	16	20	⇩	Risk score increased from 16 to 20. Likelihood increased from 4 to 5 due to increase in unplanned absence which spiked from 3.9% to 8%. This includes, but is not restricted to, sickness. A new control has been added around Winter Workforce Plan. All other actions remain on track. A new control has also been added around incentivising temporary staff recruitment.
Confidentiality, Availability & Integrity of Data	Identify Information Asset Owners across the Trust - March 2022 Develop an effective mechanism to track compliance with DP and the toolkit. The last review by Internal Audit resulted in a Low Assurance rating being provided on the Toolkit for 2021. Insufficient resource in the IG team has meant delays in delivering the actions. Paper to be prepared outlining resource requirements.	12	16	⇩	Risk score changed from 12 to 16. Impact remains same. Likelihood increased due to resource constraints and its impact on delivering IG strategy (actions) and implementation of controls. Also has an impact on raising awareness of IG across the Trust as resource in IG not available to do this. Paper to be prepared outlining resource requirements. There have been 2 reportable breaches to the ICO in the last quarter as well as a near miss.

Breach of Data Protection Principles	Develop an effective mechanism to track compliance with DP and the toolkit - TBC Full training plan to be developed and targeted for all staff - TBC	12	16	⇩	Risk score changed from 12 to 16. Impact remains same. Likelihood increased due to resource constraints and its impact on delivering IG strategy (actions) and implementation of controls. Also has an impact on raising awareness of IG across the Trust as resource in IG not available to do this.
Failure to deliver services in line with standards	1. Recruitment and retention strategies - Ongoing 2. Building Better Care – Plan to be presented to Executive Committee - July 21 September update - Winter Plan was agreed at the Executive Committee on 1st September 2021. Building Better Care Executive Oversight meeting on 15th September and monthly thereafter. 3. A new Oversight & Assurance meeting to commence in September. September update: Oversight and Assurance meetings with Care Groups underway. CG3 and CG6 will be quarterly. CG1 and CG2 will be monthly. This is part of the Assurance process.	9	12	⇩	Score has increased from 9 to 12 due to the Covid numbers forecast which suggests the peak of Covid demand hasn't been seen. Also, workforce challenges and unplanned care demand have contributed to the change in score. Extra out of hours operational managers in both York and Scarborough will help strengthen operational management and engagement with the Emergency Care Intensive Care Support team to identify areas for improvement should also help management of the risk. To strengthen resilience, the command structure has been stepped up with daily Silver and Gold Command meetings now taking place.
Business Continuity	1. Review of BC action cards - Aug21 September update: Action cards have been reviewed by the target completion date. Certificates of Compliance in relation to the task have been provided to the Emergency Planning Manager. 4. Preparation of Board report for Accountable Emergency Officer confirming Trust compliance with the Emergency Preparedness Resilience and Response Core Standards – Oct 21. September update: This is a mandated annual assurance report and an update on the state of the outstanding work to be completed by Care Groups 1, 3, 4 and 5.	12	12	⇔	A significant piece of work has been completed to review action cards and produce Business Impact Analyses (BIA) for each Bronze Command. The action was completed by the target date of 31st August 2021. The risk score will be reviewed in light of the strengthened control position and an update will be provided in the Q4 risk report to Quality Committee. The risk rating will be reviewed in light of the progress made and an update provided in the next quarterly report.

⇩ Deteriorating ⇧ Improving ⇔ Stable

Recommendations

The board is asked to note the findings of this review.

Risk No.	Risk ID	BAF Ref	Risk Title	Description	Owner	Preventative	Detective	Directive	Actions	Gross Impact	Gross Likelihood	Gross Risk Rating	Net Impact	Net Likelihood	Net Risk Rating
			A high level summary of the risk	*A detailed description of the risk including the causes and consequences of the risk.*	*The person accountable for the risk*	*Controls that stop the risk occurring (**before** the event)*	*Controls that spot if the risk has occurred so corrective action can be taken (**after** the event)*	*Controls that sign-post what individuals should or should not do to mitigate the risk*	*The actions to be taken to mitigate the risk. These may include future control improvements or where gaps in controls are identified.*	*An assessment of the risk before the consideration of controls or assuming all controls have failed.*			*An assessment of the risk after the consideration of controls or assuming all controls are working effectively.*		
1	DIS1	PR2 PR5	Cyber security	Cyber attacks caused by a computer virus or malware, insufficient resources (financial and human), user behaviour, unauthorised access, phishing and unsecure data flows. This leads to patient harm, reputational impact, unavailability of systems, financial costs, inability to meet regulatory deadlines (NHSE/I, HMRC) and regulatory scrutiny/fines/censure (CQC/ICO).	DR	1. Compliance to standards i.e. DSP toolkit encompassing key aspects of Cyber Security (Patching, AV management, Education and Training)	1. Stakeholder steering group with Trust 2. IG and security measures and dashboard across operations (inclusive of toolkit)	1. Data Security and Protection Toolkit standards and principles (Joint Trust and NHS) 2. Joint DIS IG and Security Governance and Forums (Operational, Toolkit and ESP strategy) 3. Joint IG and Security strategy aligned to Essential Services programme informed by expert 3rd party (Co-Stratify) 4. Password protocols aligned to NCSC guidance.	1. Major awareness, communication and training model to develop and implement - Becky Bradley 2. Joint Security and IG action roadmap based on existing audits (internal and external), with governance structure - Becky Bradley 3. Develop focused IG and Security incident and major incident process - Becky Bradley 4. ESP security and IG maturity roadmap underpinned by chosen (accredited) 3rd party partner(s) and aligned to NHS central guidelines (DSP Toolkit) - Simon Hayes - July 2022 5. ESP Plan B includes the upgrade of the CPD infrastructure and underlying operating system to a version supported therefore protected from cyber attacks (April 2022). May reduce the impact of the risk. 6. Align to Trust Major Incident and Business Continuity Model	5	5	25	5	4	20
2	WFOD1	PR3	Insufficient staff	Failure to maintain adequate staff levels due to staff sickness, difficulties in recruiting (including RSCNs), inadequate establishments, national staff shortages, vacancy rates, Trust culture and unenforceable weekend working (non-emergency care). This leads to mismanagement of medical services, patient harm, financial costs, temporary staff recruitment costs, poor staff experience and therefore retention, reputational damage and delays in diagnostics and treatment.	PM	1. Risk assessments of vulnerable staff 2. Workforce models and planning 3. Targeting overseas qualified staff 4. Incentivised recruitment 5. Health & Wellbeing initiatives 6. Monitoring of staff retention levels 7. Incentivise temporary staffing	1. Silver Command established during Covid 2. Monitoring of staffing levels (temporary/permanent) 3. Oversight of rotas - e-Rostering 4. Oversight of Establishments	1. Sickness management policy 2. Health and Wellbeing Strategy 3. People Plan 4. Workforce & OD Strategy	1.Implement Values and Behaviours (includes Just Culture) - Dec21 - PM 2. Formulate Workforce Plan - Oct 21 3. E-Job planning - Mar22 4. HCV Workforce Action Plan - Oct21 5. Deliver medical recruitment project - Dec21 6. International Nurse Recruitment - Mar22 7. Implement Medical E-Rostering system - Mar22 8. Winter Workforce Plan - Nov21	4	5	20	4	5	20
3	CN1	PR1	Failure to manage contagious infection outbreaks	Failure to manage the spread of contagious infection outbreaks (including C.Difficile) caused by poor ventilation in in-patient wards, environmental issues, insufficient specialist and standard isolation capacity, reduction of bed base, a lack of adequate facilities at Scarborough Hospital and an inability to separate COVID and non-COVID patients in ICU. This leads to patient harm, the closure of wards, poor staff wellbeing and regulatory scrutiny/censure.	HM	1. Regular testing of patients and staff 2. Infection prevention precautions. 3. Personal Protective Equipment (PPE) 4. Cleaning process 5. Portable ventilation units 6. Quality Impact Assessments (QIAs)	1. Weekly monitoring of performance 2. Post Infection Reviews (PIR) 3. Monthly reporting to Board on infection rates.	1. Patient isolation procedures	1. CDI Improvement Plan - Ongoing 2. New build of York ED - 2022 3. New build of Scarborough ED - 2025 4. IPC Workplan (including handwashing and environmental audits) - Dec 21 5. Anti-microbial stewardships - Ongoing	5	5	25	4	4	16
4	DIS3	PR2	Confidentiality, Integrity and Availability of Data	Failure to protect the confidentiality, availability or integrity of data due to unsecure data transmissions, unauthorised access to systems/data, incorrect data, lack of training and awareness and poor record retention or storage protocols. This leads to patient harm, reputational damage, financial costs, customer compensation and complaints or regulatory fines/censure.	DR	1. IG team compliance walk arounds - paused due to Covid 2. USB ports blocked 3. Portable devices encrypted - mobiles and laptops	1.The identification, investigation and reporting of IG incidents 2. Reviews of data integrity by the Data Quality team.	1.IG policies and procedures 2. Annual staff training on IG 3. Staff guides/screensavers to remind staff of IG responsibilities	1. Incident Management Process requires improvement TBC 2. Full training plan to be developed and targeted for all staff - TBC 3. Identify Information Asset Owners across the Trust - Becky Bradley - March 2022 4. IG Policy / framework review - TBC Insufficient resource in the IG team has meant delays in delivering the actions. Paper to be prepared outlining resource requirements.	4	5	20	4	4	16

Risk No.	Risk ID	BAF Ref	Risk Title	Description	Owner	Preventative	Detective	Directive	Actions	Gross Impact	Gross Likelihood	Gross Risk Rating	Net Impact	Net Likelihood	Net Risk Rating
			A high level summary of the risk	*A detailed description of the risk including the causes and consequences of the risk.*	*The person accountable for the risk*	*Controls that stop the risk occurring (**before** the event)*	*Controls that spot if the risk has occurred so corrective action can be taken (**after** the event)*	*Controls that sign-post what individuals should or should not do to mitigate the risk*	*The actions to be taken to mitigate the risk. These may include future control improvements or where gaps in controls are identified.*	*An assessment of the risk before the consideration of controls or assuming all controls have failed.*			*An assessment of the risk after the consideration of controls or assuming all controls are working effectively.*		
5	DIS4	PR2	Breach of Data Protection Principles	Breach of Data Protection Principles caused by a lack of training and awareness around handling personal data, insufficient policies and procedures and a lack of oversight over data handling practices. This leads to patient harm, regulatory action/fines, financial impact, customer compensation and complaints and reputational damage.	DR	1. IG training for staff including compliance walk arounds (as above)	1. Review of data requests by the SAR team (only patient data - not sure about HR, CCTV or safeguarding data) 2. Review of data integrity by the Data Quality Team	1. Staff Guides/screensavers to remind staff of responsibilities 2. Review and sign-off of IG documentation 3. NHS Digital Security and Protection Toolkit - last review by IA resulted in Low Assurance on the Toolkit for 2021.	1. IG Policy / framework review - TBC 2. Develop an effective mechanism to track compliance with DP and the toolkit - TBC 3. Full training plan to be developed and targeted for all staff - TBC	4	5	20	4	4	16
6	DIS2	PR1 PR2 PR5	Major Technology Failure	A failure of the core technology estate (e.g. CPD or network infrastructure) caused by single points of weakness, loss of power/premises, insufficient funding in the infrastructure or poor data storage/sharing processes. This leads to patient harm, prolonged service disruption, poor quality of patient care, reputational damage, financial costs and regulatory scrutiny/censure.	DR	1. Pro-active management and maintenance of systems and solutions i.e. upgrades, patching	Major incident management process		1. Enhanced service management and operations including control, governance, major incident and problem management - Simon Hayes - March 2022 2. Deliver the Essential Services Programme (ESP) - year 1 deliverable (plan b as per board agreement July 21) - April 2022 3. Produce a proposal for the new DIS target operating model and associated organisation structure and recruitment of key skills - August 2021. ExCo asked for proposal to come back March 2022 due to funding uncertainty. 4. Pro-active management and maintenance of all critical systems and solutions - Q4/22 5. Solutions designed for service and security - Solutions architect recruited. Q4/22 6. Solutions underpinned (design, build, implement and manage) by SME 3rd parties - Q1/22 7. Table top exercise with EPM - Adrian Shakeshaft /Richard Chadwick - Q4/21	5	4	20	5	3	15
7	DIS5	PR5	Failure to manage change	Failure to effectively manage change due to a lack of oversight over key change programmes, insufficient budget, lack of policies/procedures for managing change or single points of failure e.g. insufficient project/programme resource. This leads to financial costs, patient harm, reputational damage or regulatory fines/censure.	DR	1. Senior management approval required on requests for change prior to submission. 2. Tracking / oversight of project portfolio by PMO.		1. New process for managing change.	1. Develop a Project & Portfolio Management function. 2. Recruit a Business Engagement Manager 3. Introduce standard/modern methods for change and innovation for DIS enabled work.	4	5	20	3	5	15
8	FIN1	PR7	Inability to meet Trust Estates Strategy	Failure to maintain and develop the Trust Estate, Plant & Equipment due to inadequate capital funding and inability to undertake planned maintenance. This impacts our ability to deliver clinical services and may result in reputational impact and regulatory scrutiny/censure.	AB	1. Agreed capital budgets 2. Estate Business Planning 3. Backlog maintenance programme 4. External planned maintenance programme by specialised contractors 5. Completion of national ERIC returns 6. Agreed revenue maintenance programme 7. Sign-off of maintenance works by authorised personnel	1. Contingency budgets 2. Clinical Environment Risk Group 3. Oversight of Trust Strategy by Resources Committee (Trust and LLP) 4. Monthly estate inspections 5. Annual PLACE inspections 6. Periodic full estate survey 7. Ad hoc leadership walkrounds	1. Estates Strategy 2. SOPs for maintenance programmes 3. Capital Programme Prioritisation Process (with board sign-off)	1. Explore other options to obtain additional capital funding - Ongoing 2. Prepare preliminary investment requirements to support major backlog maintenance work - Ongoing	5	5	25	4	3	12
9	WFOD2	PR4 PR5	Insufficient knowledge / skills	Failure to maintain adequate levels of professional accountability for all bank only workers caused by inadequate training, SoPs and disparate skill sets resulting in patient harm, non-compliance with training standards and regulatory scrutiny/censure.	PM	1. Oversight of training needs	1. Senior Nursing Oversight 2. Monitoring Bank Training Compliance	1. Core Skills Training Framework implemented.	1. Nursing and Midwifery Strategic Planning Group implemented in Dec '20 to oversee professional governance - Ongoing 2. Implementation of recommendations regarding Bank statutory/mandatory training compliance (excluding vaccination hub requirements) - Oct 21 3. Previously mandatory training will be available as 'recommended' for certain areas. Completion reports will continue to be available - Ongoing	3	5	15	3	4	12

Risk No.	Risk ID	BAF Ref	Risk Title	Description	Owner	Preventative	Detective	Directive	Actions	Gross Impact	Gross Likelihood	Gross Risk Rating	Net Impact	Net Likelihood	Net Risk Rating
			A high level summary of the risk	*A detailed description of the risk including the causes and consequences of the risk.*	*The person accountable for the risk*	*Controls that stop the risk occurring (**before** the event)*	*Controls that spot if the risk has occurred so corrective action can be taken (**after** the event)*	*Controls that sign-post what individuals should or should not do to mitigate the risk*	*The actions to be taken to mitigate the risk. These may include future control improvements or where gaps in controls are identified.*	*An assessment of the risk before the consideration of controls or assuming all controls have failed.*			*An assessment of the risk after the consideration of controls or assuming all controls are working effectively.*		
10	COO2	PR6	Business Continuity	Significant business disruption caused by single points of failure (power, utilities, staff, building and IT), insufficient BC arrangements, insufficient skills and capability, insufficient training. This results in patient harm, delays in patient care, reputational damage, regulatory scrutiny/censure and financial costs.	WS	1. Call cascade exercises (CONFIRMER system) 2. BC Working Group	1. Conduct after action reviews (lessons learnt) 2. Self-assessment against EPRR standards - reported to Board	1. Command and Control Framework 2. 3rd party support contracts stating BC arrangements 3. Documented BC plan 4. EPRR policy 5. Departmental Action Cards 6. Incident Response plan	1. Rehearse plans (BC/BIA) - Oct21 2. Formal BC training to BC leads - Dec21 3. Review of action cards - Aug21 - Complete 4. Preparation of Board report for Accountable Emergency Officer confirming Trust compliance with the Emergency Preparedness Resilience and Response Core Standards - Emergency Planning Manager - 29 Oct 21.	4	4	16	3	4	12
11	COO1	PR1 PR3	Failure to deliver services in line with standards	Failure to deliver timely and effective services in line with local, regional and national standards due to Covid 19, poor staffing levels, insufficient capacity and unable to manage demand. This leads to service constraints, patient harm, unsustainable operations, financial costs and regulatory scrutiny/censure.	WS	1. Business case management system for significant service change 2. Performance Management Framework 3. Scenario testing of surge plans 4. Operational Plans (including Covid operational plans) 5. Winter planning and resilience plans	1. Reporting of performance metrics through governance structure 2. Integrated Board Report 3. Dashboard reporting across KPIs and clinical services 4. Operational meetings to monitor and respond to operational requirements	1. Clinical Strategy 2. Training guides 3. Operational plans 4. WFOD strategy	1. Recruitment and retention strategies - Ongoing 2. Building Better Care - July 21 - 9/7 - The Building Better Care Programme is due to be discussed at the Executive Committee meeting on 21 July. 3. Oversight & Assurance meeting - September 21 - This replaces the OPAM and will be initiated on Monday 12 July. After 3 months it will be reviewed to assess whether it is operating effectively.	5	3	15	4	3	12
12	WFOD3	PR6	Failure to deliver learning outcomes	Failure to deliver learning outcomes due to a lack of teaching facilities, insufficient capacity for an increased HYMS cohort, limited availability of learning (tools) and insufficient funds for learning & development. This leads to patient harm, inability to attract, recruit and retain talent, limited CPD opportunities, financial costs, regulatory scrutiny and reputational damage.	PM	1. Planned use of Community Stadium for York 2. Continued review of teaching space across all sites 3. A potential replacement for LARC 4. Virtual training where possible	1. Monitoring and reporting of training compliance 2. External report from Health Education England 3. GMC survey 4. Staff survey		1. Implement an agile working programme - Ongoing 2. Implement space working group - Ongoing	4	3	12	3	3	9
13	MD1	PR1	Deteriorating Patients	Failure to correctly identify and manage deteriorating patients due to staff not escalating the risk, a key person dependency, inadequate treatment, discharge and admission plans and poor patient flows. This leads to serious patient harm/death, regulatory scrutiny/censure, financial costs and reputational damage.	JT	1. Critical Care Outreach Team	1. Oversight of system entries and segregation of duties 2. Datix safety alerts 3. NEWS monitoring 4. Annual audit by Intensive Care Unit (ICU) on deteriorating patients.	1. Individual escalation protocols 2. National Early Warning Scores (and associated pathways NEWS, MEWS and PAWs) 3. Staff training 4. SOPs/pathways for managing deteriorating patients 5. Deterioration Policy 6. Ceiling of Care Policy within clinical pathways		5	5	25	3	3	9