York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 24th November 2021
Time: 9:00am – 12:00noon

Classroom 1 & 2, MEC, 5th Floor Admin Block, York Hospital

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: Wednesday 24th November 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
14:45	Board of Directors – Development	Board of Directors
16:20	Close	

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 30 September 2021** To be agreed as an accurate record.	Chair	A	09	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Verbal	-	
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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
8.	**Board Assurance Framework** To note the report.	Chief Executive	C	25	09.45
Strategic Goal: To deliver safe and high quality patient care					
9.	**Quality Committee Escalation Report** Items for escalation to the Board:	Committee Chair			09.55
9.1	• To receive and note the minutes of the meeting held on 21 September 2021		D1	43	
9.2	• To receive and note the minutes of the meeting held on the 19 October 2021		D2	53	
9.3	• To receive and discuss the committee escalation log from 16 November 2021		D3	61	
10.	**Ockenden Report update:** To include Perinatal Clinical Quality Surveillance Report and Continuity of Carer Report	Chief Nurse	E	63	10.05
11.	**Care Quality Commission Update Report**	Chief Nurse	F	77	10.15
12.	**Medical Revalidation Annual Report**	Medical Director	G	95	10.25
13.	**Guardian of Safe Working Hours 2021-2022 Q2 report**	Medical Director	H	99	10:30
14.	**Emergency Preparedness Resilence and Response (EPRR) Core Standards Board Report** To receive and discuss the report.	Chief Operating Officer	I	119	10.40

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
Strategic Goal: To ensure financial sustainability					
	BREAK				10.50
15.	**H2 Planning – Elective Recovery and Income and Expenditure Plan** To include:	Director of Finance			11.00
14.1	• Operational Plan		J1	131	
14.2	• Financial Plan		J2	137	
14.3	• LLP Operational Financial Plan		J3	155	
16.	**Early release of Capital Expenditure on the Scarborough UEC Scheme**	Director of Finance	K	167	11.10
17.	**Annual Report of Sustainable Development Group**	Head of Sustainability	L	171	11.20
18.	**Resources Assurance Committee Escalation Report** Items for escalation to the Board:	Committee Chair			11.30
17.1	• To receive and note the minutes of the meetings held on 21 September 2021		M1	245	
17.2	• To receive and note the minutes of the meetings held on 19 October 2021		M2	259	
17.3	• To receive and discuss the committee escalation log from 18 November 2021		M3 (to follow)	-	
19.	**Integrated Business Report** To receive and discuss the performance report	Chief Operating Officer/Chief Nurse/Diector of Workforce & OD/Director of Finance	N	271	11.40
19.1	• Full Integrated Business Report				
Strategic Goal: To support an engaged, healthy and resilient workforce					

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
20.	**Workforce Race Equality Standards Action Plan (WRES) and Workforce Disability Equality Standards (WDES) Action Plan** To receive and discuss the report.	Director of Workforce	O	279	11:45
Governance					
21.	**Audit Committee Escalation Report**	Committee Chair	P	303	11.55
20.1	• To receive the minutes of the meeting held on 16 September 2021				
22.	**Corporate Risk Register** To note and discuss the corporate risk register.	Associate Director of Governance / Head of Risk	O	317	12:00
23.	**Reflections of the meeting**	All	Verbal	-	12.05
24.	**Any other business**	Chair	Verbal	-	
25.	**Items for Information**				
25.1	• Star Award Nomination Booklet – December				
26.	**Time and Date of next meeting** The next meeting held in public will be on 26 January 2021.				
27.	**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 1960.				
28.	**Close**				12.10

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes
Board of Directors Meeting (Public)
30 September 2021

Minutes of the Board of Directors meeting held on Thursday 30 September 2021 at the Community Stadium, York, commenced at 9:00am and concluded at 11:40am.

Members present:

Non-executive Directors
Ms S Symington (Chair); Dr L Boyd (LB); Mr S Holmberg (SH); Mrs L Mellor (LM); Mr J Dillon (JD), Prof M Morgan (MM)

Executive Directors
Mr S Morritt, Chief Executive; Mr A Bertram, Deputy Chief Executive/Finance Director; 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:
Mrs L Smith, Deputy Director of Planning and Performance (for Mrs W Scott, Chief Operating Officer)
Mr M Taylor, Associate Director of Corporate Governance
Miss C Gaynor, Executive Support Manager (for the minutes)
Miss L Gray (Executive Support Manager) for audio support

The Chair welcomed everyone to the meeting. It was noted that Mrs J McAleese, Non-executive Director was attending via Webex. It was also noted that the meeting was being livestreamed.

21/81 Apologies for absence

Apologies were received from Mrs W Scott, Chief Operating Officer; Mrs Lucy Brown, Director of Communications.

21/82 Declaration of Interests

There were no declarations of interest to note.

21/83 Minutes of the meeting held on 28 July 2021

Amendment - Minute 21/73 (Integrated Business Report) the first bullet should read ‘1488 patients were waiting longer that *52* weeks’.

On the basis of the above amendment, the Board approved the minutes of the meeting held on the 28 July 2021 were agreed as an accurate record of the meeting.

RESOLVED
With the amendment to minute 21/73, the Board approved the minutes of the meeting held on the 28 July 2021.

21/84 Matters arising from the minutes

No matters arising were discussed.

21/85 Patient Story

The Board received a pre-recorded patient story. The film featured a young man called Jack and his mother. Jack often requires blood tests and historically hated having the tests and often refused them. At 14 he would not go to the GP practice for the tests and was consequently referred to the Trust.

A bespoke bloods appointment was set up for him in Outpatients which was called the 'Men's Clinic' as Jack aspired to be a "grown up". He attended with his mother, had his favourite music played, and had the blood test completed without any waiting. He was given a certificate at the end of the appointment. Taking time and care to understand Jacks needs enabled him to successfully have the blood tests he needed to manage his care. Now 19 Jack continues to have his bloods taken in our phlebotomy clinic- with his favourite music, no waiting and the same phlebotomist!

During Jack's video he also talked about an admission for a tonsillectomy and the reasonable adjustments made for him. This highlighted the importance of the "what matters to me?" approach and how taking time to understand what was important to patients and their loved ones made a huge difference to Jacks experience.

The Chair asked that a letter of thanks be written to Jack and his mother on behalf of the Board for taking the time to make the video and talk about their experience.

21/86 Chief Executives Update

The Chief Executive referred to the Health in Coastal Communities report which 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. It was anticipated that this would become central to the work that will be done at Place level in the coastal areas of Humber Coast and Vale ICS.

The Chair raised the issue of Staff Wellbeing. She sought assurance on whether all of the Trust's health and wellbeing support initiatives were accessed in the way that was intended and also communicated as effectively as intended?

The Director of Workforce and Organisational Development detailed a number of Trust wellbeing initiatives, one of the most successful but not specific to the Trust was RAFT (Risk Assessment Following Trauma) which was a new initiative developed to support staff at risk of suffering from trauma due to their work. This was a peer-led process that sought to identify, assist, support and, if necessary, signpost people for further help when they may be at risk of psychological injury after experiencing a traumatic event at work. The Board noted that this was a method of Post-Traumatic Stress Disorder (PTSD) prevention and had been adopted and applied from the military. The RAFT initiative had helped the Trust to better understand the field of trauma. The workforce strategy involved the further development of the RAFT initiative by adapting it to apply in non-clinical areas.

Resolved:
The Board received and noted the report.

21/87 Board Assurance Framework

The Board of Directors received the report and noted its reference to the risk appetite workshop held with the Board in August 2021. The Chief Executive advised that the report reflected what was discussed in that session. He advised that discussions with Executive's were continuing. The Board were in agreement that the simplified risk descriptions were clearer.

LM asked when the Board were going to receive the completed templates. She identified gaps in controls and assurances. It was felt that it would be good to see these completed with some action points.

Resolved:
The Board of Directors noted the on-going progress of the Board Assurance Framework and the ongoing work with Executive Directors.

21/88 Quality Committee Escalation Report

Minutes of Quality Assurance Committee 20 July 2021

The Board noted the minutes of the Quality Assurance Committee 20 July 2021 meeting.

Quality & Resources Assurance Committee Escalation Reports 21 September 2021

LM introduced the report which set out a number of matters the Resources Assurance Committee had discussed at its meeting on 21 September, and sought to escalate to the Board.

LM referred to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) of which the committee felt the board should be aware.

SH introduced the report as Chair of the Quality Assurance Committee which detailed key topics discussed at the meeting in September which were consequently agreed to be escalated to the Board of Directors, this included:

- on-going medical staffing issues (staff shortage, senior review, statutory and mandatory training, cross-site integration)
- continued high levels of HAI especially outbreaks of C diff. MRSA infection noted in context of below-target screening
- Ockenden Report, Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report
- progress against CQC action plans
- difficulties in achieving multiple performance targets: emergency care, cancer waiting times, RTT

The Medical Director referred to the medical staffing issues and the cross site integration. He reported that, a key improvement for staffing was the surgical model where surgeons would cover both York and Scarborough. It is critically important that cross-site working (a

trust with 2 hospitals) was made clear at interview. The Director of Workforce and Organisational Development advised that workforce planning was integral to staffing discussions including the roll out medical rostering providing greater visibility.

Resolved:
The Board received and noted the escalation report.

21/89 Safer Staffing Report

The Chief Nurse presented the Safer Staffing report which provided information and assurance to the Board in relation to nursing and midwifery (safe) staffing levels for August 2021.
She reported that the average day fill rate for Registered Nurses was at 82% and night fill rate at 92%. be a comparative data available to provide a better picture for a future report.

The Board noted that the vacancy rate was 5.5% : Nurse net vacancy levels at York was reporting at below 4% and Scarborough & Bridlington at 9.6%.

The report described the impact of the pandemic on staff and the effect that was having along with ongoing pressures and challenges.

The Board recognised that the nursing staff is challenging although there are almost 90 additional nurses in 2021 compared with 2020. Sickness and absence around covid-19 was contributing significantly to the staffing stresses.

LM highlighted that there had been discussions at the Resources Assurance Committee around in international recruitment and the OSCE (the objective structured clinical examination). The Chief Nurse clarified that what had been observed was as although there was an increase in recruitment, the OSCE pass rate had declined.

The Chair emphasised the importance of getting the welcoming of recruits absolutely right so to capitalise Trust investment.

The board discussed staff resilience. but was there any addition to the workforce through the international recruitment.

MM enquired were there any further mitigation that the Trust could consider. The Chief Nurse advised the Board that additional health care assistants would help to reduce some of the pressure. Work was continuing with the operational team around whether the bed base could be reduced which would ultimately help in terms of nursing numbers but this was a challenge. In terms of mitigating for winter, the Trust had mapped every resource that it had in relation to registered nurses, specialist nurses etc. and had mapped them across specialities in order to identify nursing skills which could be employed.

Resolved:
The Board noted the report and did not agree any further actions or require any further information.

21/90 Ockenden Report Update

The Chief Nurse presented the Ockenden report which provided a one month oversight of perinatal clinical quality and a transparent and proactive approach to Maternity safety across the organisation.
The Board noted that the Trust was currently on track with Ockenden.

An external advisor was attending the Trust on the 30th September to advise on th continuity of carer pathway. 'Continuity of carer' describes the consistency in the midwife or clinical team that provide care for a woman and her baby throughout the three phases of her maternity journey (pregnancy, labour and postnatal period). The report outlined that the Trust was at 43.6% of women booked onto a continuity of carer pathway.

The Chief Nurse reported that there were concerns around the training compliance in particular for medical staff at the Scarborough site. The training compliance was monitored monthly through the Quality and Governance Team: medical staffing compliance had been escalated and action planning was in progress. The low compliance was symptomatic of sickness and staff absence. Assurance from the care groups was requested around this and they were invited to attend the Quality Assurance Committee in November/December to have a deep dive into some of the issues raised in the IBR report.

LM raised her concern around the impending winter pressures as well as the pandemic and wanted to understand what issues there were and the potential planning around those. The Chief Nurse advised that while the Scarborough site was better staffed, obstetric staffing numbers were a concern. Previously York based obstetrics had worked cross site: it was important to ensure that the resilience was there and also that cross site working was accepted and became the norm rather than the exception.

Resolved:
The Board of Directors reviewed and noted the detail of the monthly report.

21/91 Care Quality Commission (CQC) Update Report

The Chief Nurse presented the CQC update report which provided a summary of progress with the action plan for regulatory requirements and outlined the next steps in achieving excellence. She advised that there were 2 licence breaches to report, both of which were on Mental Health Assessment on both the York and the Scarborough site.

The Board noted that in order to have the licence breach lifted the Trust had to achieve consistent results above 85% in terms of its Mental Health Risk Assessment audit data. Inconsistencies mean that the trust would not be in a position to request the removal of the final outstanding section 31 conditions of registration.

The Chief Nurse reported that one high risk remained- the recruitment of a Paediatric Emergency Medicine Consultant for the Scarborough site which had been overdue since November 2020. The Board were assured that there were several mitigations in place and this was demonstrated through the risk register and acknowledged that non recruitment into this role could result in regulatory action from the CQC, namely a Section 31 notice.

The Chief Nurse advised that the bimonthly insight report was to be read with caution as some of the data could be out of date, but primarily it demonstrated 6 'much worse' (increase) indicators and 23 'worse' indicators (decreased) when compared nationally.

The Board noted that 3 of the 'worse'' indicators were now resolved and the remaining 3 had in fact worsened in recent months. Part of the next steps were continued 'safe' and

'well-led' deep dives across all Care Groups broken down into specialty level. Care groups would have an opportunity to present their safe findings at the Quality and Regulations Group in September 2021 followed but a summary paper to the Executive Committee in October 2021. It was hoped that the well-led work would be summarised and presented to the Executive Committee in November 2021. The Board noted that there may have been delays in the submissions due to the current operational pressures.

The Board discussed that an area of risk for the organisation was around whistleblowing alerts
The Chair suggested that this be discussed in more detail for the next private meeting of the Board of Directors.

Resolved:
The Board accepted the report as an updated position for the Trust in relation to CQC action plans (Section 29A, Section 31 and Must-Do actions).

21/92 Winter Resilience Plan

LS, deputising for the Chief Operating Officer, presented the report and noted that the plan had been developed through internal teams, care groups and also built on the experiences through the pandemic as well as lessons learnt from the implementation and review of the 2020-2021 Winter Resilience Plan. These interactions and learnings provided the basis for the 2021-2022 plan which had consequently been endorsed by the Executive Committee in September 2021. There were some expected principles that had to be followed (detailed on page 87) around surge and escalation, Paediatric Respiratory Infections, IPCC Management, Robust testing, Vaccination, Staff Support and Wellbeing, Clinical engagement and leadership and Communication plans.

The plan has been developed using a risk-based model which included the significant winter risks and mitigations. LS noted that one of the most concerning risks was the expected demand and the impact on staffing and workforce and ward based care.

This is a System Plan and LS advised that it was important to note that the challenges faced were not only the Trust's and were also felt across the system. LS advised that there would be some further triangulation work in the coming week to strengthen the plan.

MM queried external communications. LS clarified that the Trust was working with system partner organisations to deliver a system wide communication plan which focussed on preventative messages, infection control good practice, vaccinations and signposting alternatives to the Emergency Department. LS suggested that this would also include information around directing people to the right places, access to one to one health and these types of messages would be part of that broader system plan.

LM raised her concerns around economical threats such as supply chain issues, gas, petrol etc. what did that mean from a risk perspective and was this being measured or considered. LS noted this was not included in the plan, but referred the board to business continuity and logistics. It was agreed that the economic threats would be picked up retrospectively and referenced in the final plan.

The Director of Finance discussed the financial aspect of the plan and highlighted that the report noted that the plan was £1m within budget, given the Emergency Financial Regime and the Trust's running costs at the time. Despite the forecast, it was not yet clear what

level of funding the Trust was to receive in the year ahead. He explained that some resource for the resilience plan would come into the allocations.

The Director of Workforce and Organisational Development noted the Workforce Resilience Model Task and Finish Group. The objective of the group is to anticipate the risks to service delivery over the winter period and the measures identified to mitigate those risks.

The Chair asked that the Board agreed an internal communication at the beginning of November, through the Chief Executive, to feedback to the workforce the important messages coming into the Trust, the Winter Plan, assurance that the organisation was anticipating the pressures that winter would bring and assurance that the board were considering how best to support both staff and patients during the challenging months ahead.

Resolved:
The Board noted the significant and comprehensive planning that had been conducted to mitigate the multiple work strands that were implemented this winter. The Board also note the £1.153M expenditure identified to deliver specific Winter Schemes.

21/93 Capital Programme Update

The Finance Director noted that the report detailed the Trusts position at month 6 for the existing Trust capital programme. As part of the 6 month review all care groups and corporate directorates were asked to identify details of their most urgent and critical capital requirements for the remainder of the financial year and the report suggested a plan to deliver those requirements. The report was received and supported by the Executive Committee at its meeting on the 15th September and recommended that the Board approved as spend for the remainder of the year.

All Care Groups were asked to review what they had put forward for the business plan, specifically identifying what was urgent and critical. As part of the exercise, a full asset register was shared with the Care Groups, identifying all equipment by Care Group, including the age of the equipment, frequency of breakdowns, call outs etc.

The table on page 152 of the report summarised the latest position and confirmed £1.3m of true capital to be available. As well as having the cash resource to support this, it was important to have the NHS Capital Departmental Expenditure Limit (CDEL) cover and the approval in the capital programme. The Director of Finance highlighted that he sought approval from the Board for the suggested allocation of:

- £1.502m total for the capital programme
- £4.931m of equipment leasing requirements and implications of leases covered
- £0.955 of non-recurrent revenue expenditure
- £4.042m of suggested items that the Charitable Funds may wish to support in part.

It was noted that the £1.502m in the programme was a modest over commitment of available funding (£1.344) of £0.158m however this was considered as low risk as there would inevitably be slippage. Considering the suggested allocations, this allowed the Trust to proceed with £7.430m worth of capital.

Backlog maintenance will be managed in the resource available.

The Essential Services Programme and the IT and Digital Investment Programme, will provide some additional resource to what was hoped to be allocated externally.

The Director of Finance noted his disappointment to not be able to report positively on the outcomes of some engagement work with staff around the need for bigger and better changing facilities at the hospital sites. It was noted that the LLP was developing exploring opportunities, which while positive would cause inevitable pressures on next year's capital programme.

Resolved:
The Board noted the current position at the half-year point with regard to the Trust's Capital Programme. The prioritisation schedule was reviewed and the reported allocations were approved.

21/94 Resources Assurance Escalation Report

Minutes of Resources Assurance Committee 20 July 2021

The Board noted the minutes of the Resources Assurance Committee 20 July 2021 meeting.

Resources Assurance Committee Escalation Report 21 September 2021

LM introduced the report which set out a number of matters the Committee had discussed at its meeting on 21 September, and sought to escalate to the Board, in particular LM referred to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

-WRES and WDES

LM reported that the committee had requested that the WRES and WDES reports were presented to the Board with clear linkages to the culture and behaviours improvement plans with and communication plans within the Trust. There committee noted concerns around bullying, harassment and discrimination in both reports that linked strongly into organisational culture.

-Demonstration of some of the CPD system developments that integrate care across the system

LM advised that the committee received a "show and tell" demonstration which included; GP Connect, Ambulance Transfer of Care, Request for Expert Input and ePACCS (Elective Palliative Care Coordination Services). The committee noted excellent progress made in these areas. LM suggested that the Board would benefit from receiving the demonstration including actual clinicians and partners.

Resolved
The Board received and noted the escalation report.

21/95 Integrated Business Report

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

Elective Recovery Fund (ERF)
The Director of Finance reported that the Trust had secured its ERF in months 1, 2 and 3 but not in months 4 and 5 and it was expected to also not receive in month 6. This was primarily due to the moving of the benchmark becoming 95% of the 19/20 benchmark levels of activity. It was advised that would be a further ERF release for the 2nd part of the year to incentivise organisations and to provide cost cover for organisations who can do more.

Operational Performance

LS reported that 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, this remained an important priority.

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.

The Chief Nurse highlighted the difference in reporting between both the York and Scarborough sites, in particular noting the pressures on the Scarborough site.

21/96 Freedom to Speak-up Guardian Annual Report

The Chair welcomed Stefanie Greenwood (SG), Freedom to Speak-up Guardian to the meeting to present the annual report which updated the Board on the Freedom to Speak Up culture in the organisation by reviewing data, trends, themes and outcomes.

SG clarified the role of the guardian within the Trust and what this represented to the staff, encouraging them to speak up and ensured that other were no consequences that would be of detriment to them or patient care.

The Board noted that there had been 125 speak-up cases between August 2020 and August 2021 with the top groups of nursing, administration and LLP management.

59% of cases were around inappropriate behaviours of bullying and harassment, of which these groups included; admin and clerical, facilities management (LLP), Allied Health Professionals and medics.

LM highlighted the correlation between the WRES and WDES reports received by the Resources Assurance Committee around bullying and harassment. She reminded the Board that the Committee had asked for a related action plan, linking values and behaviours, organisational culture and communications.

The Director of Workforce and Organisational Development noted that it was helpful that the report provided a benchmark as to how the organisation compared nationally.
SG clarified that the Model Hospital contained relevant data and agreed to request this information and report back.

The Board acknowledged that staff were encouraged to speak up to their line manager before they speak with the guardian or champion. SG suggested that many staff were comfortable with this and noted that there was further work needed to understand why.

SH noted that the report asked the Board to consider the challenges of the FTSU role. He wanted to understand what the Board could do to further support the FTSU Guardian and how her work could be better included in key areas of work within the organisation such as the Values and Behaviours implementation.

The Board discussed and acknowledged the need for further resource in terms of the guardian role and also the fairness champions, who provided a tangible support network for staff. It was felt that additional resource would enable more proactive work, for example, working with staff networks and workforce. The Chief Executive assured the Board that there was active dialogue around the support for the guardian agenda, additional hours had already been agreed for the guardian role and there were discussions about refreshing the champions within the organisation.

Mrs McNair highlighted other areas of work such as patient experience that would benefit from triangulating with the FTSU Guardian. For example, she had recently seen a rise in complaints around administrative staff (primarily front line) from a patient perspective.

The Chair emphasised the importance of strong leadership which calls out poor behaviours and role models good behaviour.

Resolved:
The Board noted the report and considered the data in relation to behaviours, bullying and harassment and the challenged of the guardian role and its impact on the proactive work.

21/97 Group Audit Committee Escalation Report

The Board noted the minutes of the Group Audit Committee 10 June 2021 meeting.

Group Audit Committee Escalation Report 16 September 2021

The Chair presented the Group Audit Escalation Report from the meeting of the 16th September. She noted the following matters:

- Actions – noted outstanding actions arising from internal audits and the completion of the Board Assurance Framework
- Information - noted a counter-fraud Master Class for the Board to be arranged by the Associate Director of Corporate Governance.
- Information: noted the Data Security and Protection Toolkit: The Chief Digital Information Officer was invited to the Committee to update on progress and provide assurance on the Trusts performance.
- Information: The Board noted the rotational invitation of Executives to the Committee.
- Information: The Board noted that Mazars had presented their Annual Report to the Committee, the Finance Director advised that following receipt of the report from Mazars the Trust was able to lay its accounts before parliament.

- Risks – the Board noted that there were no new risks identified by the Committee.

Resolved:
The Board received and noted the escalation report. The Board also noted that upon receipt of the Mazars report, the Trust accounts had been laid before parliament.

Group Audit Committee 11 May 2021

The Board noted the minutes of the Group Audit Committee 11 May 2021 meeting.

21/98 Board Committee Effectiveness Annual Reports

Resources Assurance Committee

LM presented the annual report as the Chair of the committee. LM reflected across what had been an extraordinary year and highlighted a few key areas of the work the committee had achieved throughout the year:

- Recognition of the executives - who have worked hard and prepared reports for the Committee.
- The pandemic had a significant impact on the organisation did in respect of the control and mitigation of risks.
- Digital achievements and still a lot to do! But assurance that the basics were understood and issues identified with significant progress being made.
- There was still a need for some assurance on areas such as cyber security including the infrastructure, where issues were known and ensuring that the security plan was delivered.
- Assurance had also been received on mental health and wellbeing during the pandemic and the number of initiatives employed to assist staff with the impact of the pandemic.
- The setting up of a BAME network with champions across the Trust and the plan for reverse mentoring as well as the starter plans on staff induction.
- The significant achievement of the Ministry of Defence's Employers Recognition Scheme Gold Award. A credit to the Director of Workforce and Organisational Development and her team.
- The financial regime was very different due to the pandemic, there were adequate provisions made. The Finance team had been awarded a key accreditation to support the delivery of quality services for patients by the NHS Leadership academy 'Future Focus Finance'.
- The LLP had seen some significant improvements in the KPI's however there still remained a lot to do. Generally there was improvement across all areas of the LLP but assurance was still sought assurance against some areas that were of concern in terms of risk and mitigation.

Resolved:
The Board noted the Resources Assurance Committee Annual Report 2020/21.

Quality Assurance Committee

SH presented the annual report as Chair of the committee. SH highlighted the clinical governance work that the committee had developed in terms of encouraging and obtaining assurances around enhanced clinical governance processes. Key themes that were noted were:

- Promoting visibility of concerns and risks in front-line clinical areas through the organisation to the Quality Committee and Board
- Promoting 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.

SH highlighted that these priorities were reflected in the development of a QI programme that had been discussed regularly in the Committee. It was noted by the Board that the progression of this work had 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 had come to light that had identified significant backlogs in clinical effectiveness actions and the implementation of SI action plans. The Committee recognised that becoming aware of these problems represented progress.

Resolved:
The Board noted the Quality Assurance Committee Annual Report 2020/21.

21/99 Corporate Risk Register

Mr Taylor advised on the work the Risk Committee had progressed around cyber security, staffing and infection prevention control, and that a programme of risk deep-dives had commenced to provide assurance to the Board on how risks were managed and to challenge assumptions made in the risk registers.
Resolved:
The Board noted the report.

21/100 Reflections of the meeting

The chair apologised for the audio issues that were experienced throughout the meeting.

21/101 Time and Date of next meeting

The next meeting will be held on 24 November 2021, at the Community Stadium, York.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 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:

- Current operational pressures
- Vaccination programme
- 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: 24 November 2021

1. Current operational pressures

As is being reported in the media on a daily basis, the NHS is facing a sustained high level of pressure across every sector and there is growing concern about what might happen if this steps up further when we reach winter.

Our trust is no different, with several factors all contributing to the current pressures we face and severely compromising our ability to manage patient flow.

We are still admitting patients with COVID-19 (72 at the time of writing) and we have been managing our COVID-19 positive patients in three wards (two in York and one in Scarborough) which has an obvious impact on our admitting capacity.

Both emergency departments have seen activity returning to pre-pandemic levels. The scheme to increase capacity in York ED has also now begun. Once completed, the extra space will make a real difference but the challenges of managing a build within a working department at a time when the team is already under significant pressure should not be underestimated.

We are working hard to deliver our elective work and tackle the backlog of patients needing planned treatment. 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, alongside all the other issues described above, These current pressures on bed capacity inevitably place our elective work at risk.

The lack of capacity in social care is also having a significant impact on our hospitals. The sector is facing the same workforce and demand issues as the NHS, however we have a large numbers of patients who are medically fit for discharge but are delayed in hospital, contributing to delays in admitting patients from ED, and longer ambulance handover times.

All acute trusts received a letter from NHSE/I in late October calling for action on ambulance handover delays. The Association of Ambulance Chief Executives also published a report into the harm caused by these delays.

The letter, which has been shared with the board, requested all Trusts to ensure the actions from the Urgent and Emergency Care Recovery Plan were being mobilised.

Our Trust has had a sustained period of improved handover times during the COVID-19 pandemic, however our performance on handovers is now comparable to pre-pandemic performance.

We are engaged with local system partners and Yorkshire Ambulance Service in developing the Ambulance Handover Plan, which targets the actions set out in the letter. Our actions were discussed in detail at November's Quality Assurance Committee.

All of this is further compounded by well-documented workforce pressures, and this remains the biggest risk.

The current position is excellently summarised in the State of the Provider Sector report published by NHS Providers as part of its annual conference. The report is based on surveys with senior leaders in provider organisations, and can be read in full on NHS Providers' website: www.nhsproviders.org

2. Vaccination programme

As has been widely publicised, the Department of Health and Social Care (DHSC) has announced that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19. This is regardless of their employer, and includes secondary and primary care.

The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April deadline.

This government policy takes into account specific exemptions, including those who are medically exempt or under 18 years of age. This also includes those who do not have contact with patients or are a participant in a clinical trial investigating COVID-19 vaccination. I understand the policy applies to the first and second dose of the COVID-19 vaccination, but not to boosters or the flu vaccination at this stage.

The NHS has always been clear that individuals should get the COVID-19 vaccination to protect themselves, their loved ones and their patients and the overwhelming majority of our staff have already done so.

NHS England and NHS Improvement is working with NHS Employers, DHSC and wider stakeholders to develop detailed implementation guidance, which will confirm specifically which individuals are in the scope of this policy.
In the meantime, the Trust continues to encourage unvaccinated staff to take up the offer of the first and second doses. Our vaccine hubs have been back up and running for several weeks to deliver COVID-19 booster vaccines and flu vaccines. All trust staff are now eligible to book an appointment, and most who have come forward so far are opting to have both vaccines at the same time.

3. Humber, Coast and Vale ICS appointments

Finally, I want to congratulate our Chair Sue Symington o on her appointment as the first designate Integrated Care System (ICS) Chair for the Humber, Coast and Vale Health and Care Partnership.

As this is Sue's final board meeting with us, I want to note my personal gratitude and that of the board for Sue's service to this trust over the past six years.

I've had the pleasure of working closely with Sue over the last two years, to shape and steer the trust despite the challenging environment we are operating in. I have been struck by Sue's passion, voice of reason, personal and professional values and genuine care and empathy for our staff and patients alike.

I am certain that with Sue's vision, motivation and drive, she will successfully lead the ICS to ensure we offer outstanding patient care right across the partnership.

On a personal level I wish Sue all the best and look forward to continuing to work together through this exciting transformational change for the NHS.

Jenny McAleese will take over as chair for the interim period while we work to recruit a new chair for the trust, and interviews are due to take place in the new year.

At the time of writing we also anticipate that the appointment of the Designate ICS Chief Executive Officer will be announced imminently. The appointment of Chair and Chief Executive means that the process to recruit to other board positions can begin ahead of the ICS being formally established in law from April 2022.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
Board Assurance Framework

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

To note the current position of all of the risks on the BAF reportable to the Board of Directors.

Executive Summary – Key Points

The BAF has been evaluated across a balanced risk profile, risks updated as a result and amendments made to the Trust's BAF risks.

Development sessions have taken place with the Risk Committee and the Board of Directors over the reporting period with a view to reporting a full BAF to the public Board of Directors on 24 November.

Assurance escalation mechanisms have been amended to provide assurance for each risk on the BAF via each respective Sub-Committee to the Board of Directors.

Recommendation

The Board of Directors is asked to note the current status of the Board Assurance Framework.

Author: Mike Taylor, Associate Director of Corporate Governance

Director Sponsor: Simon Morritt, Chief Executive

Date: 15 November 2021

Board Assurance Framework (BAF)

1. Introduction and Background

The Board Assurance Framework (BAF) demonstrates the most pertinent strategic risks to achieving the Trust's strategy.

The BAF should be a live document demonstrating where assurances can be identified and what specific positive assurances the Trust has in managing each of its identified strategic risks on an ongoing basis.

Documenting a BAF robustly demonstrates that the Trust in managing its risks is aware of the controls and future actions that mitigate the likelihood of risks occurring and the impact of these should they occur. The assurances identified and evidence achieved against each of the risks managed, provide confidence to internal and external stakeholders that the Trust can deliver its objectives.

2. BAF development

The BAF has been reviewed by the Risk Committee in October when all risks were identified across the Trust's Foundation Trust peers risks and assessed against a balanced risk profile. This mapped the Trust's risks across; external and internal, known and unknown risks with a balanced risk profile's categories; core operations, organisation change, external core risk and emerging areas.

This identified and was agreed by the Executives to split formally the quality, safety and performance risks, to merge the workforce risks and to identify an Integrated Care System (ICS) risk. All other risks remained as previous with updated risk descriptions to reflect risk causes and consequences.

A BAF development session at the 4th November Board of Directors confirmed the risk profile from the Risk Committee and agreed the assurance escalation process from the sub-committees to the Board of Directors for the risks identified under their respective terms of reference. The BAF is presented at appendix 1.

3. BAF revised risks

The revised risks on the BAF are:

- Safety Standards - Access to patient diagnostic and treatment is delayed due to increased waiting times, insufficient bed capacity, poor patient pathways, unclear clinical guidance, inadequate buildings, premises and medical equipment, insufficient resource and failure of clinical staff to meet required professional standards. This leads to patients suffering unintended or avoidable harm, damage to the trust reputation, regulatory attention and financial costs.
- Workforce - Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand. Additionally, a lack of succession planning, limited career opportunities, operational pressures and inadequate buildings and premises. This leads to deterioration of staff wellbeing, high attrition rates, financial costs from interim arrangements, potential patient harm, reputational damage and regulatory attention.
- ICS - Trust unable to meet ICS expectations as an acute collaborative partner due to ongoing Trust operational pressures leading to challenges in delivering overall quality of care provision to patients and reputational harm in meeting system contribution targets required across the HCV region.

Risk No.	Risk Description	Net Risk Rating			Risk Owner	Target Risk Rating			Date to Achieve / Review Target Rating	Movement
	What is the specific risk to strategic objectives?	*I*	*L*	*IxL*		*I*	*L*	*IxL*		
PR1	Unable to deliver treatment and care to the required national standards	4	3	12	Heather McNair	2	3	6	Mar-22	
PR2	Access to patient diagnostic and treatment is delayed	4	3	12	Jim Taylor	4	3	12	Apr-22	New
PR3	Failure to deliver constitutional/regulatory performance and waiting time targets	4	3	12	Wendy Scott	3	3	9	Apr-22	
PR4	Inability to manage vacancy rates and develop existing staff	3	4	12	Polly McMeekin	2	4	8	Mar-23	New
PR5	Risk of inadequate funding to deliver the Trust and System Strategies	4	3	12	Andy Bertram	3	2	6	Nov-21	
PR6	Failure to deliver the minimum service standard for IT and keep data safe	4	4	16	Dylan Roberts	3	3	9	Apr-23	
PR7	Trust unable to meet ICS expectations as an acute collaborative partner.	2	3	6	Simon Morritt	2	3	6	Within Tolerance	New

2021-22 Board Assurance Framework

Risk ID	Risk Title	Risk Description	Risk Owner
Strategic Objective: Deliver safe, effective and high quality patient care			
PR1	Quality Standards	Unable to deliver treatment and care to the required national standards due to insufficient resource, professional competency of clinical staff, a lack of funding, inadequate buildings and premises, a lack of space and inadequate or aged medical equipment. This leads to patient harm, financial costs, reputational damage and regulatory attention.	HM
PR2	Safety Standards	Access to patient diagnostic and treatment is delayed due to increased waiting times, insufficient bed capacity, poor patient pathways, unclear clinical guidance, inadequate buildings, premises and medical equipment, insufficient resource and failure of clinical staff to meet required professional standards. This leads to patients suffering unintended or avoidable harm, damage to the trust reputation, regulatory attention and financial costs.	JT
PR3	Performance Targets	Failure to deliver constitutional/regulatory performance and waiting time targets due to Covid 19, increased waiting times, insufficient bed capacity and inefficient patient pathways. This leads to patient harm, reputational damage, regulatory attention and financial costs.	WR
Strategic Objective: To support an engaged, healthy and resilient workforce			
PR4	Workforce	Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand. Additionally, a lack of succession planning, limited career opportunities, operational pressures and inadequate buildings and premises. This leads to deterioration of staff wellbeing, high attrition rates, financial costs from interim arrangements, potential patient harm, reputational damage and regulatory attention.	PM
Strategic Objective: Contribute to the system's sustainability			
PR5	Inadequate Funding	Risk of inadequate funding to deliver the Trust and System Strategies comprising inadequate revenue funding to meet the ongoing running costs of service strategies, inadequate capital funding to meet infrastructure investment needs and inadequate cashflow to support operations.	AB
PR6	IT Service Standards	Failure to deliver the minimum service standard for IT and keep data safe due to inadequate policies and procedures, lack of IT/IG training, vulnerabilities in the trust's hardware and software and a failure to report information incidents in a timely manner. This leads to patient harm, regulatory attention (ICO), reputational damage and financial costs.	DR
PR7	ICS	Trust unable to meet ICS expectations as an acute collaborative partner due to ongoing Trust operational pressures leading to challenges in delivering overall quality of care provision to patients and reputational harm in meeting system contribution targets required across the HCV region.	SM

Strategic Objective: Deliver safe, effective and high quality patient care

Risk description	Unable to deliver treatment and care to the required national standards due to insufficient resource, professional competency of clinical staff, a lack of funding, inadequate buildings and premises, a lack of space and inadequate or aged medical equipment. This leads to patient harm, financial costs, reputational damage and regulatory attention.	**Risk Appetite Statement**	The quality of our services, measured by clinical outcome, patient safety, wellbeing and patient experience is at the heart of everything we do. We are committed to a culture of quality improvement and learning ensuring that quality of care and patient safety is above all else. We will put quality at risk only if, on balance the benefits are justifiable and the potential for mitigating actions are strong. We therefore have a MINIMAL appetite for risk in relation to the delivery of services that are clinically effective, safe, efficient and person centred.

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Quality**	
Impact	4	4	2	**Risk Appetite: Exceeding**		
Likelihood	4	3	3	**Date to achieve target score:**	**Risk Owner:**	**Heather McNair**
Overall risk rating	16	12	6		**Links to CRR:**	

Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Internal effectiveness reviews against national standards	None identified	-Clinical effectiveness team -Internal Audit	- Clinical Effectiveness reports - Internal Audit reports	None identified
Review of data from national surveys e.g. NICE, NSF	- Volume of data makes it difficult to focus on key issues - Data does not always flow through correct governance	-Healthcare Evaulation Data (HED) -Clinical Effectiveness Audits -NICE	- HED reports - National Survey results	None identified
Implementation of Clinical standards	None identified	-Board -Quality Committee	- IBR - Minutes and actions of papers (Board, Executive, Quality Committee)	None identified
Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Revalidation Report to Board	None identified
Oversight of performance	None identified	- Oversight & Assurance meetings and other governance forums	- Integrated Board Report - KPIs in Care Group dashboards - Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings.	None identified

Implement Workforce & OD Strategy	Poor diversity in leadership positions (gender pay, race equality)	- Board, Executive and Resources Committee.	- Board/Committee papers - Equality, diversity and inclusion data reporting	None identified
Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	- IBR - Executive Committee Agency Usage Report	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	-Limited visibility to investments required but not progressed.
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%)	-Training deferred/delayed due to operational pressures.
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- Risk stratified elective waiting lists.	- Diagnostic waiting lists to be risk stratified in July; outpatient list to follow.
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-Executive Committee and Board of Directors approved plan	None identified
Routine monitoring and reporting against capital programme	None identified	-Financial Services	-Agenda, papers, minutes and action logs for internal governance meetings (CPEG, Resources Committee, Executive Committee, Board of Directors) -Reports to external bodies (the ICS and NHSE/I)	None identified

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

Action description	Progress to date / Status	Lead action owner	Due Date
Implement medical eRostering	Commenced roll out for trainee doctors Aug 2021. Rolled out in Medicine in CG1 and 2.	Polly McMeekin	**Mar-22**
Develop Workforce Resilience Plan	Commenced August 2021 with Task and Finish Group	Polly McMeekin	**Nov-21**
Continuation of International Nurse Recruitment	Pipeline of circa 18 per month. BC approved to Mar 2022	Polly McMeekin	**Mar-22**
Six-month review of capital programme and final 2021/22 priority allocations.	Complete	A Bertram	**Sep-21**

Strategic Objective: Deliver safe, effective and high quality patient care

Risk description	Access to patient diagnostic and treatment is delayed due to increased waiting times, insufficient bed capacity, failure to ensure continuous improvements in patient pathways and clinical guidance, inefficiencies in buildings, premises and medical equipment, insufficient resource and failure of clinical staff to meet required professional standards. This leads to patients suffering unintended or avoidable harm, damage to the trust reputation, regulatory attention and financial costs.	**Risk Appetite Statement**	The quality of our services, measured by clinical outcome, patient safety, wellbeing and patient experience is at the heart of everything we do. We are committed to a culture of quality improvement and learning ensuring that quality of care and patient safety is above all else. We will put quality at risk only if, on balance the benefits are justifiable and the potential for mitigating actions are strong. We therefore have a MINIMAL appetite for risk in relation to the delivery of services that are, clinically effective, safe, efficient and person centred.

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Quality**	
Impact	4	4	4	**Risk Appetite:**		
Likelihood	4	3	3	**Date to achieve target score:**	**Risk Owner:**	**Jim Taylor**
Overall risk rating	16	12	12		**Links to CRR:**	

Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Clinical standards	None identified	-Board -Quality Committee	- IBR - Minutes and actions of papers (Board, Executive, Quality Committee)	None identified
Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Revalidation Report to Board	None identified
Conduct Incident Reporting and learning from Safety incidents	None identified	- Datix - Care Group Boards - Oversight & Assurance meetings - CPD	- Action plans following investigation of incidents - Datix incident reports - SI/Never Event reports presented to Quality Committee, QPaS, Care Group Boards and Oversight & Assurance meetings -Learning from deaths report to QPaS -6 monthly Cancer Harm report - Patient experience report - Medical Legal report -Escalations recorded on CPD	Overarching analysis and triangulation of all information

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

Action description	**Progress to date / Status**	**Lead action owner**	**Due Date**
Learnings from Serious Incidents (SIs) communicated to Care Groups	Reviewed SIs reported through Quality and Patient Safety Group, Quality Assurance Committee and Board of Directors. Learnings communicated to Care Groups. Reviewed process up to and including April 2022.	Jim Taylor	**Apr-22**

Strategic Objective: Deliver safe, effective and high quality patient care

Risk description	Failure to deliver constitutional/regulatory performance and waiting time targets due to Covid 19, increased waiting times, insufficient bed capacity and inefficient patient pathways. This leads to patient harm, reputational damage, regulatory attention and financial costs.	**Risk Appetite Statement**	The Trust is committed to delivering it's H2 activity plan and associated national and regional performance standards and improvement trajectories. Oversight of delivery via Care Groups is through the Trust governance and performance management framework. The Trust has an OPEN appetite for exploring all opportunities to deliver the requirements outlined in the plan.

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Quality**	
Impact	4	4	3	**Risk Appetite: Within Tolerance**		
Likelihood	4	3	3	**Date to review target score: April 2022**	**Risk Owner:**	**Wendy Scott**
Overall risk rating	16	12	9		**Links to CRR:**	**COO1**

Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Oversight of performance	None identified	- Oversight & Assurance meetings and other governance forums	- Integrated Board Report - KPIs in Care Group dashboards - Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings.	None identified
Implementation of surge plans	None identified	- Scenario testing of surge plans	- Results of scenario testing	None identified
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Implementation of winter plans and resilience plans	None identified	- Winter and resilience plans discussed at governance meetings (Executive, Board, Quality Committee)	- Minutes of Board, Executive, Quality meetings where winter and resilience plans are discussed.	
Development of the clinical strategy	None identified	-Trust intranet	- Clinical Strategy	- Clinical strategy is still in draft so control not yet assured.
Implementation of Building Better Care programme	Programme initiated but not fully embedded	- Programme structure established.	- Programme documentation	
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- 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	- Board	- 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
Deliver the H2 Plan on activity	Oversight provided through the Executive Committee as a formal subgroup of Board. Assurance provided through the Quality Assurance Committee.	Wendy Scott	**Apr-22**
Deliver the Building Better Care Programme	Oversight provided through the Executive Committee as a formal subgroup of Board. Assurance provided through the Quality Assurance Committee.	Wendy Scott	**Apr-22**

Strategic Objective: To support an engaged, healthy and resilient workforce					
Risk description	Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand. Additionally, a lack of succession planning, limited career opportunities, operational pressures and inadequate buildings and premises. This leads to deterioration of staff wellbeing, high attrition rates, financial costs from interim arrangements, potential patient harm, reputational damage and regulatory attention.			**Risk Appetite Statement**	Our Workforce and Organisational Development strategy identifies the current and anticipated future workforce challenges the Board needs to address, defines the kind of organisation and employer the Board aspires to be, and outlines our commitments and objectives to our people and, reciprocally, what the Board expects from its people. We have an OPEN risk appetite to ensure we attract the right people with the right skills and values.
Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Resources**
Impact	4	3	2	**Risk Appetite: Within Tolerance**	
Likelihood	4	4	4	**Date to review target score: March 2023**	**Risk Owner:** **Polly McMeekin**
Overall risk rating	16	12	8		**Links to CRR:** **WFOD1**

Controls	Gaps in Control	Sources of Assurance	Positive Assurance	Gaps in Assurance
Implement Workforce & OD Strategy	Poor diversity in leadership positions (gender pay, race equality)	- Board, Executive and Resources Committee.	- Board/Committee papers - Equality, diversity and inclusion data reporting	None identified
Delliver Board development sessions	None identified	-Board meetings	-Board papers (agenda, minutes)	None identified
Conduct Talent Management Framework	None identified	-Trust intranet	- Learning Hub - PREP	None identified
Design and Deliver Internal Leadership Programmes	None identified	-Trust intranet	- List of programmes on Learning Hub	None identified
Develop Succession plans	None identified	- Board, REMCOM, Executive Committee	-Board papers (agenda, minutes, action log) -REMCOM papers (agenda, minutes, action log)	None identified
Conduct NED development programme	None identified	- Gatenby Sanderson, external specialist recruiter	- Regular updates from Gatenby Sanderson	None identified
Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Board r(eporting on Equality, diversity and inclusion)	-Board papers (agenda, minutes, action log) -REMCOM papers (agenda, minutes, action log)	None identified
Implement Workforce models and planning	National contract limitations	-Director of Workforce & OD	-Board approved Workforce models and plans	None identified
Target overseas qualified staff	None identified	- Overseas nurse recruitment programme	- QIA for new nurse roles - CHPPD	None identified
Incentivise recruitment	None identified	-Reduced vacancy rates in IBR	-IBR	None identified

Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	- IBR - Executive Committee Agency Usage Report	None identified
Oversight of rotas - e-Rostering (nursing)	None identified	- Internal Audit	- Internal Audit reports on E-Rostering - CHPPD	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	Limited visibility to investments required but not progressed.
Monitor performance against the People Plan	None identified	-Resource Committee updates against the People Plan	-Minutes of the monthly Resource Committee	None identified
Implement Workforce & OD Strategy	None identified	- Reporting on performance against the Workforce & OD Strategy to Board, Executive and Resources Committee.	- Board/Committee papers - Equality, diversity and inclusion data reports	None identified
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%)	None identified
Communicate guidance for Managers for remote working	Space restrictions	- Trust intranet	- Agile Working Policy	None identified

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

Action description	Progress to date / Status	Lead action owner	Due Date
Implement medical eRostering	Commenced roll out for trainee doctors Aug 2021. Rolled out in Medicine in CG1 and 2.	Polly McMeekin	**Mar-22**
Implement Values and Behaviours	Commenced roll out during Summer 2021	Polly McMeekin	**Mar-22**
Develop Workforce Resilience Plan	Commenced August 2021 with Task and Finish Group	Polly McMeekin	**Nov-21**
Continuation of International Nurse Recruitment	Pipeline of circa 18 per month. BC approved to Mar 2022	Polly McMeekin	**Mar-22**
Progress procurement for Activity Planning	To commence procurement exercise	Polly McMeekin	**Sep-22**
Link output of annual talent management process with output of workforce plan	Appraisal window to close for non-medical staff Nov 21 and workforce planning to conclude Mar 22	Polly McMeekin	**Mar-22**
Implement Actions from Workforce Race Equality Standard	Action plan agreed with REN and now published	Polly McMeekin	**Sep-22**

Strategic Objective: Contribute to the system's 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 Statement**	We have a CAUTIOUS risk appetite in respect to adherence to standing financial instructions, financial controls and financial statutory duties. The Trust is committed to fulfilling its mandated responsibilities in terms of managing public funds for the purpose for which they were intended. This places tight controls around income and expenditure whilst at the same time ensuring public funds are used for evidence based purpose.

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Resources**	
Impact	5	4	3	**Risk Appetite: Exceeding**		
Likelihood	5	3	2	**Date to achieve target score: November 21**	**Risk Owner:**	**Andrew Bertram**
Overall risk rating	25	12	6		**Links to CRR:**	**FIN1**

Controls	Gaps in Control	Sources of Assurance	Positive Assurance	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 process - Internal Audit	-Business planning schedules. - Internal audit reports on effectiveness of controls around the Business Planning process.	None identified
Preparation and sign off of annual Income and Expenditure plan	None identified	-Executive Committee and Board of Directors.	-Approved I&E plan (Board, Executive, NHSE/I and ICS).	None identified
Routine monitoring and reporting against I&E plan	None identified	-Monthly updates to Care Group OAMs, Resources Committee, Financial Review Meetings, Executive Committee, Board of Directors, the ICS and NHSE/I.	-Monthly reports, agendas, minutes and actions for each of the governance forums as well as reports provided to external bodies (PFR monthly to NHSE/I) -IBR	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.	-Internal audit -Financial Management team	-Business Case Register -Internal audit reports on effectiveness of controls around the Business Planning process. -Reports produced by the Financial Management team on variance analysis.	None identified
Expenditure control; segregation of duties	None identified	-Finance systems	-System enforced approvals. -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. -Routine reporting of staff in post (i.e. paid) to budget holders. -IA review work	-Salary overpayment recovery policy. -Reports from Finance to budget holders on their staff in post -IA benchmarking review work	Limited visibility to issue
Income control; income contract variation process	Unforeseen and unplanned in-year reduction in income.	-Financial Management Team	Income Adjustment form register.	None identified
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-Executive Committee and Board of Directors approved plan	None identified

Routine monitoring and reporting against capital programme	None identified	-Financial Services	-Agenda, papers, minutes and action logs for internal governance meetings (CPEG, Resources Committee, Executive Committee, Board of Directors) -Reports to external bodies (the ICS and NHSE/I)	None identified
Overspend against approved scheme sums	None identified	-Financial Services	-Scheme sum variation process. -Scheme expenditure monitoring reports to CPEG.	None identified
Preparation and sign off of cash flow plan	None identified	-External Audit -Business Planning process	-External Audit report as part of Going Concern activity. -Plan approved by Executive Committee and Board of Directors and NHSE/I.	None identified
Routine monitoring against cash flow	None identified	-Board of Directors - Finance team	-Agenda, papers, minutes and action logs for internal governance meetings (Executive Committee, Resources Committee and Board of Directors). -(PFR monthly to NHSE/I) -IBR	Under the current emergency fincial regime there is no tracking of cash against plan at Executive Committee or Board of Directors but as normal arrangements return this will resume.
Cash flow management through debtors and creditors	None identified	-Financial Management Team -Government	-Monthly debtor and creditor dashboard to Finance Managers and Care Groups. -Trend data reported to Executive Committee, Resources Committee and Board of Directors. -IBR -Better Payment Practice Code (BPPC) - monthly report	None identified

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

Action description	Progress to date / Status	Lead action owner	Due Date
Planning guidance and funding allocations for H2 released 30 Sept. Trust now preparing H2 I&E plan.	H2 planning underway. 4 Nov 21 Board sign off.	A Bertram	**Nov-21**
H2 distribution of ICS central allocations (e.g. covid funding) to be agreed.	H2 planning underway. 4 Nov 21 Board sign off.	A Bertram	**Nov-21**
Confirm efficiency requirement and match to identified plans with a view to identifying any residual requirement.	H2 planning underway. 4 Nov 21 Board sign off.	A Bertram	**Nov-21**
Model H2 Elective Recovery Fund costs and income earning potential to maximise funded elective recovery activity.	H2 planning underway. 4 Nov 21 Board sign off.	A Bertram	**Nov-21**
Six-month review of capital programme and final 2021/22 priority allocations.	Complete	A Bertram	**Sep-21**
Review cash flow forecasting when H2 allocation details are released.	H2 planning underway. 4 Nov 21 Board sign off.	A Bertram	**Nov-21**

Strategic Objective: Contribute to the system's sustainability						
Risk description	Failure to deliver the minimum service standard for IT and keep data safe due to inadequate policies and procedures, lack of IT/IG training, vulnerabilities in the trust's hardware and software and a failure to report information incidents in a timely manner. This leads to patient harm, regulatory attention (ICO), reputational damage and financial costs.			**Risk Appetite Statement**	Innovation is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. We have a CAUTIOUS risk appetite in respect to IT / Information failures and will take a balanced approach to how we run the trust whilst acting in the best interests of our staff and patients.	
Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Resources**	
Impact	4	4	3	**Risk Appetite: Exceeding**		
Likelihood	5	4	3	**Date to achieve target score: April 2023**	**Risk Owner:**	**Dylan Roberts**
Overall risk rating	20	16	9		**Links to CRR:**	**DIS1, DIS3, DIS4**

Controls	Gaps in Control	Sources of Assurance	Positive Assurance	Gaps in Assurance
Implementation of Data Security and Protection Toolkit standards and principles	- Registration Authority Policy scoping being undertaken - Controls Library scoping to be undertaken when post filled - Data Security and Protection mandatory training 95% target with communication reminders undertaken - Patching exceptions log scoping underway	- Internal Audit	- Internal Audit report of IG compliance	None Identified
IG and Security Governance arrangements in place e.g. IG Executive	None identified	- Resources Committee - IG Executive Group	- Resources Committee minutes, papers, agenda, action log - IG Executive Group minutes, papers, agenda, action log	None Identified
Password protocols aligned to NCSC guidance	None identified	- IT systems	- System enforced control	None Identified
Trust Portable devices encrypted - mobiles and laptops	None identified	- IT Systems	- System enforced control e.g. bit locker encryption on Trust laptops	None Identified
Implementation of IG policies and procedures	None identified	- Staff intranet	- Approved IG policies -Statutory/mandatory IG training for all staff	None Identified
The identification, investigation, recording and reporting of IG incidents	None identified	- Information Governance Team	- IG breach reports	None Identified
Review and sign-off of IG documentation	None identified	-Information Governance Team	- IG team sign-off	None Identified

IT Service management standards / processes	Low maturity due to lack of training			None Identified

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

Action description	Progress to date / Status	Lead action owner	Due Date
Continue to review funding for ESP		Dylan Roberts	**Feb-22**
Implement the proposed DIS structure		Dylan Roberts	**Feb-22**
Deliver the DSP Toolkit plan		Dylan Roberts	**Nov-22**

Strategic Objective: Contribute to the system's sustainability						
Risk description	Trust unable to meet ICS expectations as an acute collaborative partner due to ongoing Trust operational pressures leading to challenges in delivering overall quality of care provision to patients and reputational harm in meeting system contribution targets required across the HCV region.				**Risk Appetite Statement**	The quality of our services, measured by clinical outcome, patient safety, wellbeing and patient experience is at the heart of everything we do. We are committed to a culture of quality improvement and learning ensuring that quality of care and patient safety is above all else. We will put quality at risk only if, on balance the benefits are justifiable and the potential for mitigating actions are strong. We therefore have a MINIMAL appetite for risk in relation to the delivery of services that are clinically effective, safe, efficient and person centred.
Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Lead Committee: Executive Committee**	
Impact	3	2	2	**Risk Appetite: Within Appetite**		
Likelihood	3	3	3	**Date to achieve target score:**	**Risk Owner:**	**Simon Morritt**
Overall risk rating	9	6	6		**Links to CRR:**	

Controls	Gaps in Control	Sources of Assurance	Positive Assurance	Gaps in Assurance
Integration with ICS on system wide planning	None identifed	Attendance of members of Trust Executive Team across HCV ICS governance structure	Chief Executive update reports on Board of Directors	None identified
Operational and Finance Plans 2021/22	None identified	Board of Directors approval processes and sub-committee assurances of delivery	Approval at Board of Directors and submission to NHSE&I for H1 and H2 plans	None identified
Trust involvement in the Collaborative of Acute Providers	None identified	Acute providers governance in decision making across 5 strategic themed transformation programmes; cancer, diagnostics, electives, maternity and paediatrics, urgent and emergency care	Trust Building Better Care Transformational Programme Engagement with HCV ICS - Managing Director of Collaboration of Providers engagement with Trust Executive Team	None identified
Trust CEO Provider representative on HCV Interim Executive Group	None identified	HCV Interim Executive Group meetings	Engagement with the HCV Interim Executive Group	None identified
Trust CEO Provider representative on North East and Yorkshire ICS transition oversight group	None identified	North East and Yorkshire ICS transition oversight group	Engagement with the North East and Yorkshire ICS transition oversight group	None identified

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

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

Ongoing collaborative strategy development at neighbourhood, place and system level delivering for Trust patients and wider HCV fo during 2022/23	Progress to be reviewed end of Q3 2021/22	Exec Team	**Apr-22**
Finance and activity planning for 2022/23 as part of HCV system delivery	Progress to be reviewed Q4 2021/22	Exec Team	**Apr-22**

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NHS

York and Scarborough Teaching Hospitals

NHS Foundation Trust

Minutes

Quality Assurance Committee
21 September 2021

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

/ Attendees: Donald Richardson (DR)

/ 1. Apologies for Absence: James Taylor (JT)

/ 2. Declaration of Interests

There were no declarations of interest.

/ 3. Minutes of the meeting held on 20 July 2021

BA was removed as absent as he is only required to attend quarterly meetings (Sept, Dec, March and June). Other than this, the minutes of the last meeting held on 20 July 2021 were agreed as a true and accurate record.

/ 4. Matters arising from the minutes

106 & 116 – DR confirmed work is underway to allow the senior review to be registered through patient boards on wards as investigations showed that documentary evidence of senior reviews was lacking. Digital Information Services (DIS) have also looked at ways to allow clinicians to log reviews via either ward rounds or a physical review on patient boards. DR confirmed that senior review data for surgery has begun to improve.

118 – CJ said the Task & Finish Group (set up as a subgroup of the Dementia Group) is looking at how data is extracted and used as well as raising awareness and focusing attention on teams with lower performance to ensure they are recording 4AT. They are also building reporting metrics. The Committee noted that when nursing documentation came off CPD and moved to paper records, staff were not always ticking the box on CPD. SH said the target needs to remain valid and that the Committee will continue to review the figures presented. CJ said there is work being done on the quality section of the IBR, which has uncovered a lack of clarity around where data is being sourced.

119 – WS said there is a brief update included in the COO report but agreed to run a session at Public Board to provide a more detailed picture of progress.

123 – CJ confirmed there are12 QI projects ongoing at present and that a paper will come to the October meeting to provide assurance on the work around SI themes and trends.

Action: WS to run a Public Board session on Building Better Care in November

Action: WS to invite CG1 and CG2 clinical leads and ACOO's (Mike Harkness, Jamie Todd, Stephen Lord, Gerry Robins and Ed Smith) to October meeting for insight on urgent and emergency care

Action: HM to invite CG5 maternity colleagues (Jo Mannion, Caroline Alexander and Sue Glendenning) to November meeting for insight on Ockenden

/ 5. Escalated Items

There were no items for escalation.

/ 6. IBR Overview to look at Patient Safety, Effectiveness and Patient & Carer Experience

SH expressed concern around YH 14-hour post take review performance. CJ confirmed a two week intensive support period that commenced this week for Care Group 1 to ensure all work expected of SAFER is being done e.g. staff are looking at board rounds and doing specific work on EDD (Expected Date of Discharge). CJ said there should be significant movement on 14-hour post take reviews plus other metrics as well as potential flow constraints. CJ said Gary Kitching is also supporting this support work and is undertaking a case note review of 50 case notes to review patient journey from admission to identify missed opportunities, reviews undertaken and any system constraints. WS agreed to update Michael Harkness on this ahead of his attendance at the next Committee.

CJ gave assurance that SGH 14-hour performance has started to improve as a result of the Always Aiming High Programme. The Committee noted this positive improvement but asked for more assurance that themes in deaths and SIs are not being repeated.

Action: CJ to provide update on work linked to 14-hour post take reviews and senior reviews

Patient Safety

/ 7. Medical Director's Report (incl. SI Trends and Incidents Quarterly Report)

The Committee noted the report focus on incidents and SIs and a positive trend in reporting. CJ said that since reporting of harms has been implemented the harms have started to increase but gave assurance that reporting figures in the data are correct because there are processes in place where all levels of harm are assessed and reviewed daily.

July figures were higher and the increased SIs account for some of this increase. There was also an increased number of staffing incidents and recurring themes in SIs, and the Committee noted concern around Ophthalmology incidents. CJ said she has met with NHSE/I to discuss these harms and our SI process going forward considering capacity issues and Covid. They have advised continuing 72 hour report monitoring for all

moderate and above harms plus a cluster review at the end of each quarter followed by a declared SI if needed.

#NOF is another area of concern and QI work has been implemented as a result of this. The Committee noted the positive improvements for time to surgery and the subsequent impact on mortality rate. A declared SI from earlier in the year is being investigated following an alert from the coroner (see p19) and CJ is now meeting fortnightly with the Medical Examiners to obtain greater scrutiny on deaths. This allows better coaching for teams re the importance of reporting and recognising safety incidents. The Committee acknowledged that we do not have an embedded safety culture yet.

The Committee noted concern around the number of incidents declared as SIs within Obstetrics and Gynaecology. CJ said there is a lot of work being done to understand the themes and gaps in assurance around maternity, including reviewing benchmarking across a number of different metrics. VTE prophylaxis has been flagged as a concern and we are strengthening audits to understand where we are not in line with national guidance. CJ said the audit data shows that we are doing risk assessments but not being clear around what intervention is being done as a result of the assessment.

There was a group discussion about overdue action plans and CJ said she now chairs an oversight and assurance group that oversees improvement action plans. This group also aligns with other groups such as Deteriorating Patients and Sepsis and should see a lot of overdue actions closed as a result. CJ said an assurance report is being written re Obstetrics and Gynaecology SIs, which will link in with the benchmarking work to look at gaps in assurance. The Committee agreed that key themes that could pose an organisational risk need to be flagged. SH said it was helpful to differentiate actions from learning and CJ said she would continue to do this around improvement plans and repeat themes. The Committee was assured by this.

The Committee noted that despite the maternity SIs, there is no evidence to suggest that our service is unsafe and LB said declaration of SIs is a good thing as it shows they are being investigated. It was agreed to include maternity SIs in the Ockenden update going forward.

Action: CJ to include paper detailing timelines for each project re overdue action plans and thematic analysis

/ 8. QPaS Update (Escalation and Assurance Report & Quality & Patient Safety Group Minutes – Blue Box)

The Committee agreed to move the Escalation and Assurance Report onto the monthly agenda and leave the minutes in the Blue Box.

/ 9.1 Reinstating Aseptic Non-Touch Technique (ANTT) as a mandatory subject

The Committee agreed that this was an Executive Committee decision so no further discussion was needed.

/ 9.2 Q1 Infection Prevention and Control Report

The report was received and no further discussion was required.

/ 9.3 Infection Prevention and Control Monthly Report (August 2021)

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

C. Diff remains a concern in SGH, especially on Chestnut Ward, which needs a refurbishment. We have the budget to do this but there are operational issues related to releasing and decanting the ward. The Committee discussed options and the most suitable one is to work on a bay by bay basis, which should take around 20 weeks. The Committee acknowledged the infection risk and agreed that this needs to be actioned soon. WS noted the significant pressures on flow and long waits in ED, and said because have another ward to decant into bay by bay is the only option. The Committee noted the significant issues with medical engagement on SGH site as well as poor ANTT practice (also a contributory factor of MRSA) and discussed whether more Executive presence is required at C. Diff and PIR meetings.

SH expressed concern that statutory mandatory training still has not improved. DR said the feedback was that too many individual clinicians were being mandated to do training that was not applicable to them so JT cut this back. Some governance and training sessions were also lost as a result of the pandemic. The Committee noted that care groups now have training oversight but raised concern that this distances the issue from Executive Committee and Board of Directors.

HM said that another C. Diff concern is that we do not use sporicidal wipes - this was likely a historic decision made as a cost reduction exercise. These are being reinstated where appropriate. There was a group discussion about whether there is enough governance around procurement decisions as well as a lack of clarity on the QIA process.

We have been undertaking audit controls in place for NHSE and they are happy with the assurance provided around Covid-19 measures introduced and being maintained. The new guidance around exemption for staff has helped with staffing numbers for those staff deemed as critical to service delivery.

The Committee noted concern around the lack of good ventilation. WS said the issue is that, due to the limited number of well-ventilated areas, we have to configure plans to ensure that Covid-19 or AGP patients are in the right areas, which may not be the best way of configuring bed capacity. WS anticipated challenges over winter due to limited side rooms, Covid-19 pressures plus flu and other winter viruses. HM said ventilation is something that the Trust needs to consider in order to appropriately manage cohorts of patients.

Water safety continues to be an issue, particularly at the Community Stadium. The Water Safety Committee is giving assurance that this is being monitored but it still requires close surveillance.

HM noted that Paul Rafferty (Deputy Chief Nurse) will leave the Trust this month and he has not been replaced due to a lack of shortlisted candidates. HM said there be a part-time secondment opportunity for an external candidate to provide senior leadership on the East Coast but that Tara Filby and Emma George will share the workload in the interim.

SH expressed concern at the two aspergillus cases and noted the potential risks when major groundwork is being undertaken.

Action: DR and JT to discuss mandatory training and how to encourage better engagement

Action: HM to confirm whether a QIA is done for clinical procurement changes and whether it is signed off at Executive level

Action: WS to invite CG3 leads (Amanda Vipond and Liz Hill) to December meeting to give insights on line team

Action: HM to look into aspergillus cases that led to two patient deaths and provide update/assurance to SH

/ 10. Ockenden Update (Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report)

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

Medical staff training compliance at SGH is poor. The Birth Rate Plus review suggests we are 21.5 WTE short – whilst we are meeting the midwife to birth ratio of 1:28 the national ratio measures in complexity of women. We cannot roll out any more teams on the YH site without further investment and work is ongoing with the LMS.

CNST standards have been released, which will be a challenge to achieve. We need to review Saving Babies Lives V2, particularly around radiographers and workforce, and consider the work plan and benchmark next steps. HM said we need a detailed paper from the care group around current position and what it means if we fail to meet standards again.

Work is ongoing around site integration but lacks staff engagement. WS said a paper is going to Executive Committee in October about obstetrics work and rotas and there will be a Board session on integration next week.

With regards to PMRT, the Committee noted that there were some cases that were not scanned to national guidance. Whilst it is unknown whether this would have made a difference it is still an organisational risk. LB pointed out the increase in still-births during the pandemic potentially due to a lack of face to face appointments, which is likely to have more focus in the coming months.

/ 11. Nurse Staffing

HM confirmed the vacancy rates – 3.87% (YH) and 9.63% (SGH) – which are improved but wards still feel understaffed due to absence. International recruitment is ongoing and there are c.100 new starters anticipated between now and the end of the year. There is a significant issue with retaining HCA staff.

There was a group discussion about the on-call rota and the Committee noted that the current situation is incredibly challenging, often resulting in ambulances queuing outside ED, a bed shortage and staffing issues. JM said she was conscious of the pressure being put on staff. HM said patient harms such as falls and pressure ulcers have increased and the Committee noted that the national language has changed from safe staffing to safest staffing.

WS said there have been some difficult decisions to make for SGH and it has been decided that it will be an emergency-only hospital with no day case activity to use beds and staff to alleviate the current pressures. Staffing will be a challenge in the move from day case to medical wards as there are no overnight staff. Covid-19 patients will be moved

to YH and the Children's Assessment Unit will be moved out of the front door to provide more space to Duke of Kent Ward. We are also considering cancelling elective day case activity, which has previously always been preserved – this is currently c.120 cases over the next two weeks, 18 of which are P2s. In August we had 48 12-hour breaches compared to 92 as of today in SGH, which is not tenable. There are both nursing and medical staff shortages and we need to create bed capacity to move patients through ED.

There was a Missed Opportunity Audit in SGH held by ECIST last week where a 24 hour period was selected and retrospectively audited every patient that came in by ambulance or walk-in and those involved discussed what was appropriate. 40% of patients brought in by YAS did not need an ED speciality and 82% that Vocare streamed to ED did not need to be seen. WS confirmed that she and Simon Morritt are meeting with Vocare to discuss this as well as a system leader conversation to discuss flagged issues, consider alternative pathways and ascertain what the system in the ICS can do to relieve pressure on ED. JM said she was assured that this was being picked up and that it explains why ED is so busy. WS said that two care homes in North Yorkshire have had to close due to staffing issues as well as St Cecilia's on the East Coast that provides our step-down red covid beds. WS said the issue is that there is nowhere to provide or commission capacity rather than discharge funding.

Action: WS and JT to discuss on-call rota and options for ensuring there is senior clinical oversight available at all times

Effectiveness

/ 12. Care Quality Commission Report

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

The safe deep dive is being finalised and the transitional regulatory framework deep dive was recently completed. CJ flagged the PEM consultant vacancy as a risk – JT is looking into options. This puts the organisation at risk of receiving a Section 31 condition notice if not addressed. The CQC insight report also shows concern around #NOF benchmarking. We are continuing to address actions within the CQC transitional regulatory framework but expect to receive a 'Requires Improvement' rating, especially around sepsis and mental health.

SH expressed concern that there has not been a lot of progression and CJ said actions are being finalised from the previous CQC report. There is work being done but performance needs to consistently improve in order to lift conditions. CJ said there will be a bigger action plan with QI plans attached to pursue the journey to excellence. There was a group discussion about whether a 'Good' rating is achievable and CJ said there are number of areas to address as well as the significant staffing challenges. The Committee acknowledged that this will be difficult to deliver.

CJ said that whistleblowing is a metric that the CQC will monitor, which triangulates with our staffing pressures following external whistleblowing from medical and nursing and alleged issues about practice on Ward 35.

/ 13. Q1 Effectiveness and Audit Report

CJ gave an overview of the report and highlighted the executive summary key points on p91. The Committee noted these and no further discussion was required.

Patient & Carer Experience

/ 14. Fairness Forum minutes and escalation

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

/ 15. Annual Complaints Report

The paper was received and Heather agreed to bring an update back to the December meeting following a team restructure. No further discussion was required.

Action: HM to provide update on Complaints Team restructure in December

Performance

/ 16. Chief Operating Officer Report including Performance Update & Restoration and Recovery Update

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

Emergency Care Position – the Committee noted the pressure on both sites and that both held an OPEL 4 status for multiple days, which is unprecedented. LS said this is not forecast to improve and we should expect a deteriorating position in terms of organisational pressure. Whilst there are actions in place, over winter we are expecting the same increased demand seen in August combined with reduced capacity due to both allowances for infectious diseases and staff reductions. We have had notification from partners that also foresee a deteriorating position across the Board such as the ability of YAS to response and social care ability to discharge patients out of hospital. The Committee noted that we have performed well on our elective position in Q1 but our action plan delivery is not enough to meet the ideal position.

There is pressure on the elective side of our cancer position as much of cancer operations are day case. There are risks with each decision being made but P2 remains the priority. Our 62 day target is 67.2% against the 85% national target, which is a challenging position, and we are not seeing some patients (primarily colorectal and lung) as soon as we would expect, primarily due to diagnostic delays.

In terms of our overall Trust plan we are still awaiting H2 planning guidance. There is a national expectation to restore activity levels – our ability to achieve this is limited given the operational pressures. There is a risk around funding the IS contract as we do not anticipate any further elective recovery funding – we have previously protected urgent care work on-site and long waiters have been treated off-site, which has worked well with the IS but we cannot guarantee access to support for an extended range of specialties. There are two different workstreams to consider – 1) managing urgent care and 2) financial/regulatory pressures. The national expectation is a 0 104-week waiting position by March (if not by Christmas), which will be extremely challenging.

WS confirmed that elective work was stepped down in YH last week as it freed up c.19 inpatient surgical beds but that it was reinstated this week. The Committee noted that Hull has been cancelling both elective and cancer work for some time and sent us a mutual aid request for cancer two weeks ago. Whilst we have day case capacity to deliver some

cancer services, there is a challenge around long waiters and our strategic position is to perform as much off-site activity as possible. Harrogate and NLAG have taken some of our endoscopy workload as we do not have the staff to open additional rooms, and NLAG have taken on some urology patients. Trusts are trying to offer aid wherever there is speciality capacity. The Committee noted the positive relationship with Ramsay and WS said that if there was any capital in the future, they were keen and willing to put an elective modular building on their site.

There was a discussion about appropriateness of patients using our services and WS said we are doing point of prevalence testing in ED but anticipate we already know the answers, primarily a lack of primary care access. LS said we are having constructive conversations through primary care networks re inappropriate referrals and reviewing cancer fast-track referrals, and that the CCG and PC's are actively working to try and support hospitals.

We have been asked to plan for another Covid wave (approx. 60% of the highest peak), which will further reduce our capacity but WS said this is not a problem unique to us.

/ 17. Integrated Business Report

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

Governance and Risk

/ 18. Review of Terms of Reference

This item was deferred to October.

/ 19. Board Assurance Framework

MT said work is underway around documenting risks, particularly assurances on controls to achieve Trust strategy. BA has been working with the Executive Directors on gross risk scores without controls and net scores with controls to understand our reliance on the controls used to define mitigating actions. There is work to be done on interdependency between risks on the BAF reported to Board and Sub-Committees, particularly as an example around adding a workforce element on performance and quality risks to get the CRR and BAF working together.

/ 20. Corporate Risk Register

BA confirmed a programme of deep dives has commenced through the monthly Risk Committee to review each risk on the CRR to challenge any assumptions made. IPC will be reviewed at the October Risk Committee and BA confirmed he would bring an update back in the next quarter. Going forward, BA will continue to report quarterly on the CRR to show any risk movements between periods but will also include updates on any relevant deep dives and include these on the BAF to ensure triangulation.

Action: BA to include update in December on IPC deep dive following presentation to October Risk Committee

/ 21. Consider other potential or new emerging risks

There were no potential or new emerging risks for discussion.

Item for discussion or escalation

/ 22. Consideration of items to be escalated to the Board or other committees

The Committee agreed the following items for escalation to the Board:

- On-going medical staffing issues (staff shortage, senior review, stat-mand training, cross-site integration)
- Continued high levels of HAI especially outbreaks of C diff. MRSA infection noted in context of below-target screening
- Ockenden Report - Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report
- Chief Nurse to note progress against CQC action plans
- Chief Operating Officer to note difficulties in achieving multiple performance targets: emergency care, cancer waiting times, RTT

JM, LB and SH extended their thanks to the Committee members and all staff for their work during unprecedented times.

/ 23. Any other business

There was no further business to discuss.

/ 24. Time and Date of next meeting

The next meeting will be held on 19 October 2021 at 1pm via WebEx.

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Minutes
Quality Assurance Committee
19 October 2021

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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

/ Attendees: Caroline Dunn (CD), Jamie Todd (JTo), Michael Harkness (MH), David Thomas (DT), Gerry Robins (GR), Ruth Dunlop (RD)

/ 1. Apologies for Absence: n/a

/ 2. Declaration of Interests

There were no declarations of interest.

/ 3. Minutes of the meeting held on 21 September 2021

P8 of the minutes - JM asked WS if there had been any developments around the private sector expressing interest in investing should any capital arise in the future. WS said they have agreed to fund a static MRI scanner at Clifton Park on the basis of guaranteed activity. WS said we have bid for some strategic capital (anticipated just under £5m) and there is a plan to pursue the option of a cold site in collaboration with Ramsay on the Clifton Park site. They have indicated that there may be an option to match funding investment on the basis of a long term investment with longevity around activity.

The minutes of the last meeting held on 21 September 2021 were agreed as a true and accurate record.

/ 4. Matters arising from the minutes

129 – JT confirmed that the care groups will take responsibility for training and have developed a process for this. SH asked when we will see evidence of compliance and JT said it would be difficult to commit to a date due to winter pressures and workforce challenges. JT asked the Committee to support agreement of an improvement trajectory moving towards the target. SH supported this but expressed concern from a regulatory standpoint that the Committee has not yet seen this trajectory while SIs and other harms are occurring.

130 – HM confirmed that QIAs are not signed off at executive level. Ian Willis has agreed to implement a process where clinical changes are signed off by clinicians with oversight at executive level before being actioned.

Action: JT to consider improvement trajectory for medical staff compliance with stat-mand training and provide update

/ 5. Escalated Items

There were no items for escalation.

/ 6. IBR Overview to look at Patient Safety, Effectiveness and Patient & Carer Experience

JT and HM confirmed any areas of concern were included in their respective reports.

There was a group discussion about the IBR indicators and concerns raised about progress. The Committee discussed the risk of escalating too many issues to Board. WS noted the tension between delivering performance standards, being fully compliant, delivering elective recovery plans and workforce restraints. WS said there are scheduled discussions at this week's Executive Committee around our risk tolerance and the point at which our position should trigger a different response from the Trust should it be deemed absolutely necessary. SH said a different approach is needed to look for assurance around mitigations that patient safety is protected despite missed targets e.g. cancer access times. The Committee agreed that assurance is needed around safeguarding patients. CJ gave assurance that this is being monitored e.g. 12 hour trolley waits and that quality metrics are being monitored as well as audits being done. Areas that are under-performing are also being escalated. HM said there is not full assurance that patients are receiving care in a timely manner and SH said the preference would be assurance on how care is being focused around patients. JT said we need to identify the risk and discuss, prioritise and manage it.

LS confirmed that the DIS team are working on a review of the IBR to minimise the risk of missing key points in the breadth of information.

/ 7. Board Assurance Framework

MT said there were discussions in the Risk Committee about quality, performance and safety around splitting out the risks and providing positive assurance. This will be discussed at Executive Committee and there should be a final version by the end of November.

Patient Safety

/ 8. CG1 and CG2 update on Urgent and Emergency Care

JTo, MH, DT and GR gave a presentation on system challenges and risks. The Committee noted the findings of the ECIST Missed Opportunities Audit for Scarborough – 40% of ambulance arrivals and 40% of walk-ins did not need an ED speciality input – as well as the Point Prevalence findings where most patients were advised to go to ED by either primary care or the NHS 111 service. The SGH Clinical Services Walkthrough recognised the SDEC service as positive development. Areas for improvement included a lower acuity

stream from ED, a better speciality in-reach from specialities as quickly as possible and better care home engagement.

MH noted that CG1 and CG2 house ED but are pivotal to both hospitals, and suggested a clinical senate to encourage integration. GR added that there is appetite to try new approaches on the East Coast in terms of the private sector.

The Committee thanked JTo, MH, DT and GR for their continued hard work in exceptionally trying times.

/ 9.1 Medical Director's Report (incl. SI Trends and update on 14-hour post take reviews and senior reviews)

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

14-hour post take reviews and senior reviews – the improvements required on CPD to better enable senior reviews will go live on 08 November. There has been increased reporting of moderate harms on Datix, which are not yet verified, and an increase in lower harm incidents.

Antibiotic usage is at a reasonable position with reduced total consumption and stable reduced consumption in high level antibiotics. The ARK project is restarting with early encouraging results but more work is needed.

A declared SI relating to Ward 32 is being escalated because of regulatory external interest (see P39 for a case summary) – the initial theme is of dehydration. JT identified some emerging themes within the completed SIs, one around radiology reporting and three relating to AKI and dehydration within the fractured neck of femur (#NOF) pathway. LB asked what assurances can be taken around the quality of our outsourced radiology reporting service. JT confirmed that we are considering commissioning a different provider and also reviewing all safety incidents related to this service. SH asked if clinicians are able to interact with radiologists and JT said that it is an OOH remote service so there is limited opportunity for this for cases that potentially raise questions.

Use of the Mental Health Act demonstrates increased activity in SGH, which confirms concerns that the service commissioned is not as effective as it is in York.

There was a discussion about Ward 32 and JM said it was good to see evidence of quick escalation and action taken, and asked HM how assured she was that the action taken has addressed the issue. HM said she could not give full assurance on this yet. The Heads of Nursing have been asked to replicate the action plan across all wards to get assurance around use of fluids – and nutrition to a lesser extent – and HM agreed to bring the audit results back once confirmed. The Committee discussed the basic fundamentals of care and the impact that tired staff and inadequate workforce numbers is having on these. JT said that part of the challenge is how to prioritise the staff we have, and added that we do not have the authority to turn away patients that present in ED even though they could have gone through other pathways. HM said that we are trying to plan for winter in a structured way and have asked specialist nurses to provide one day a week in a clinical

area. The Committee acknowledged that staff morale is low and feedback has been that some staff feel they are providing suboptimal care.

/ 9.2 Update on timelines for overdue action plans and thematic analysis

The Committee noted the report and CJ agreed to bring a further update once all driver diagrams have been completed. LB said she had met with Care Group 5 and felt assured following the conversation that there is significant work ongoing to tackle the overdue action plans.

/ 10. QPaS Escalation and Assurance Report

The Committee noted the report and acknowledged staffing issues as the main escalation by the Care Groups.

/ 11. Infection Prevention and Control Update

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

C. Diff remains a problem and there are currently 116 cases against the trajectory of 133, and 15 cases with the same 001 ribotype. Work on Chestnut Ward has been delayed due to a supply issue, and the operational team are trying to facilitate this on a bay by bay basis. The NHSE/I external team have visited SGH site. The report was received on 18 October and a York site visit is scheduled for the second week of November. They identified the environmental issues but acknowledged that we already recognise this. They also questioned the assurance around Synbiotix – the monitoring programme used for cleaning – as they felt after visiting a ward that had scored highly on the check that it was not clean enough. They reported that staff had commented on the relationship with the LLP, stating over-promising and under-delivering on the SGH site.

SH asked if reinfection is an issue and asked for assurance that IPC elements such as nursing, antibiotic usage and ward environments are aligned. HM said there is good engagement but the PIR process needs more work. There is not an issue with reinfection on the SGH site and antibiotic prescribing is reported as good. The main issue is that we either do not isolate patients fast enough or cannot due to the lack of side rooms, which means the spread of infection cannot be effectively managed. The Committee agreed to escalate this to Board as an ongoing patient safety issue.

Work is being done with informatics to check the data for elective screening for MRSA as it has been suggested that compliance needs to improve. If it is not a data quality issue, this needs to be revisited with Care Group 3.

HM confirmed that there was no direct correlation identified between the two patients that died with Aspergillus and the ongoing building work. The Building Projects team have confirmed that all procedures were followed correctly and there have been no further cases since September 2021. As a precaution, labs are now undertaking twice weekly galactomannan tests on patients.

Action: HM to bring NHSE/I IPC report back with our Trust response

/ 12. Ockenden Update (Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report)

SCH gave an overview of the report and said there have been significant developments in sonographer recruitment – we are hoping to scan at least all high-risk women before Christmas and all women within this CNST period.

Work on capacity and demand has been challenging but SCH said she was confident that we will be able to deliver the care bundle of Saving Babies Lives Version 2 (SBLV2) this year. We are looking at offering breech study days to increase staff confidence.

The Committee noted the significant staffing challenges and the impact this will also have on training compliance. SCH expressed concern around foetal monitoring training within the medical profession but confirmed that Jo Mannion (Care Group Director, CG6) is looking into this.

SCH said that the Trust is doing well on maternity transformation and the continuity of carer pathway for women, the number of women receiving intrapartum care has dropped due to continuity midwives being redeployed to escalation and labour ward cover at short notice.

HM confirmed that some digital capital has been nationally released specifically for maternity and that, within our LMS, we will have a joint maternity system for our hospital as a stand-alone LMS system for women.

/ 13. Nurse Staffing

HM said there was a discussion at NMT about whether the figures (YH - 3.87% / SGH - 9%) are correct as staff are reporting that it feels higher. No further discussion was required.

/ 14. Nursing Priorities Report

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

Effectiveness

/ 15. Care Quality Commission Report

CJ said the focus is shifting to planning for the future. There are some key indicators where we are appearing in a worse position than other Trusts, predominantly whistleblowing and ED.

Our position is currently split between ‘Requires Improvement’ and ‘Good’ and CJ said each care group has an improvement plan to address any gaps. We are now moving on

from the safe deep dive to the Well Led and effective domains with an aim to have the full totality of KLOEs with improvement plans going forward.

Patient & Carer Experience

/ 16. Fairness Forum minutes and escalation

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

Performance

/ 17. Chief Operating Officer Report including Performance Update & Restoration and Recovery Update

WS gave a brief update on elective care and our recovery plan position as well as national expectations of us for H2 planning – we have submitted our draft first plan and the final plan will be ready for submission on 08 November. This will also go to Board for discussion. WS asked the Committee to note that the risks relating to managing inpatients or those in ED are more visible however we are also managing the thousands of patients on our waiting lists that we are also expected to manage and risk assess. There is an expectation from the CQC and NHSE/I that elective waiting lists are also prioritised.

LS said the expectation of the H2 planning guidance is to clear 104 week waits by the end of March 2022. We are under scrutiny on a weekly basis until this is reduced to 0. There were 130 104 week waits declared at the end of September and we anticipate a rise in October. 52 week waits are required to stabilise as are waiting lists in the national planning guidance. The expectation is for us to discharge more patients into patient initiated follow-up (PIFU) – the target is 1.5% of all discharged patients. The target of 25% for non-F2F appointments has been retained but no longer links to ERF funding and is to be applied 'as clinically appropriate'.

The Elective Recovery Fund (ERF) was previously accessed through activity restoration but this has now changed to clock stops. We are being reviewed against our 19/20 figures with a set target of 89%. This target has been met a number of times retrospectively in H1 and we expect to do so again going forward but not on a monthly basis. Across the system we are hoping to be able to access approximately £5m from the ERF.

Cancer targets have remained static so the focus is on reducing the number of backlogged patients. The Committee noted that faster diagnosis standards are now an official constitutional measure.

Ambulance handovers have deteriorated over summer and there is a lot of ongoing work and monitoring around this. The target is to eliminate patients waiting for 12 hours in ED and the Committee noted our current outlier status.

The Committee acknowledged the significant challenges around delivering our elective programme, sustaining our emergency care position and treating all cancer patients within the timescales. LS added that we are not expected to offer any additional activity due to

our current workforce challenges. In terms of decision-making we can make some choices on how to manage these patients e.g. whether we offer a choice of site or allocate one. The Committee noted the challenges around a limited bed base through the winter period and that our trajectory to achieve 0 for 104 week waits is highly predicated on our ability to outsource a significant number of patients to the independent sector.

Activity levels have remained fairly static and the Committee was assured by confidence on activity delivery but also made aware that this will not resolve performance issues. There are currently debates at Board around our confidence level to deliver against the new performance trajectories. WS said we have been asked to provide mutual aid to HUFT and that we need to consider this from both an ICS and York Trust perspective. The Committee noted that the government has set a highly ambitious recovery programme policy and that this could potentially cause safety issues.

/ 18. Integrated Business Report

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

Governance and Risk

/ 19. Review of Terms of Reference

MT gave a progress update and said he had looked at the domains (quality, safety, experience, effectiveness and operations) as well as specific duties that refer to these to give clarity on what the Committee should focus on. The Committee noted that this is part of a review of all governance being undertaken and the work programme should be finalised for November.

Action: MT to bring finalised work programme to next meeting

/ 20. Consider other potential or new emerging risks

There were no potential or new emerging risks for discussion.

Item for discussion or escalation

/ 21. Consideration of items to be escalated to the Board or other committees

The Committee agreed the following items for escalation to the Board:

- SI reports show evidence of harms associated with failure to deliver basic care. Concern of linkage to medical/nursing staffing levels. Circumstances of a death on Ward 32 escalated to CQC and CCG

- Continued high levels of HAI especially outbreaks of C diff. at SGH. External review has highlighted failure/inability to isolate patients as significant contributory factor

- Ockenden Report - Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report. To note specifically harms associated possibly related to insufficient sonographer staffing

- To note progress against CQC action plans. Self-assessment rating continues as RI overall with pockets of 'Good'. Concern that vulnerabilities remain e.g. mental health care in ED, lack of PEMCon

- IBR and other metrics demonstrate increasing evidence that Quality targets are not being met and no realistic prospect of significant improvement over the next 1-2 quarters. Focus of assurance is shifted to patient safety particularly for patients with long ED stays and those with extended waiting times for treatment. Assurance also sought for the safety of care in ward areas given the pressure of increased non-elective demand and concerns over staffing numbers

/ 23. Any other business

SH asked the Committee if there was any preference over hybrid or virtual meetings as there is still limited room capacity due to social distancing. MT and SH agreed to make a decision on this.

/ 24. Time and Date of next meeting

The next meeting will be held on 16 November 2021 at 1pm via WebEx.

D3

NHS

York Teaching Hospital

NHS Foundation Trust

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

Committee/Group: Quality Committee	**Date: 16th November 2021**	**Chair: Steve Holmberg**

Agenda Item	**Issue and Lead Officer**	**Receiving Body, ie. Board or Committee**	**For Recommendation or Assurance to the receiving body**
8	COO – Continued pressure on hospital services resulting in inability to meet performance targets. Specific focus on ambulance handover times and actions to minimise delays	Board	Escalation
10	CN – Continued concern over IPC. C diff levels and other metrics such as MRSA screening remain a problem. Further information from external visit has highlighted a number of areas of concern particularly the impact of backlog maintenance, lack of side-rooms, HPV capacity and elements of staff engagement	Board	Escalation
12	CN – Ockenden Report. Perinatal Clinical Quality Surveillance Report & Continuity of Carer Report. Maternity SIs reviewed and to note themes around inadequate training, failure to adhere to protocols and poor communication.	Board	Escalation
11	CN – to note progress against CQC action plans. Heightened risk of reactive CQC visit due to factors such as high levels of whistleblowing, escalated SIs, levels of HAI and pressure area care. Overall Committee was not able to receive adequate assurance on safety of patient care and the requirement for urgent further action has been agreed to be discussed at Board	Board	Escalation
14	MD – to note compliance of mortuary facilities with new standards	Board	Escalation

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021 (September 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 September 2021:

- 1 PMRT notified and 2 completed
- 1 HSIB cases reported 1 HSIB review received
- 0 SI report received 0 SI declared
- 1 Incident 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
- MIS (CNST) standards for year 4 action planning
- Ockenden– awaiting RAG response from national team. Updated position detailed
- 38.3% 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: November 2021

1. Detail of Report and Assurance

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

1.2 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	1 1	1 2			
Cases referred to HSIB Finalised HSIB reports				1 0	0 0	0 0	1 0	2 0	1 1			
Number of incidents logged as 'moderate harm' or above				1	0	0	4	1	1			
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	See below	See below			
Minimum safe staffing Midwifery Obstetricians Unit closures:				See below 0	See below 2	See below 0	See below 4	See below 1	See below 4			
Service User Feedback				See below	See below	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	See below	See below			
HSIB/NHSR/CQC etc contacting the Trust directly with a concern or request for action				0	0	0	0	0	0			
Coroner Reg 28 made directly to the Trust				0	0	0	0	0	0			
CNST compliance (number of safety actions compliant with /10)				8	8	8	8	0	0			
Ockenden update (number of IEA complaint with /7)				0	0	0	0	0	0			

Continuity of Carer bookings				38%	39.5%	37%	43.6%	39.6	38.3			

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. Governance boards are now in place in the maternity areas to highlight safety concerns/themes, learning from incidents and investigations, training compliance and to highlight areas of good practice. The Quality Council has been re-energised with 4 more midwives completing the QI training, the next meeting is in November. The wellbeing team have run drop in sessions to support staff wellbeing and resilience and will hopefully be able to run more.

2. Context

2.1 PMRT

1 case notified and we anticipate review of this within 4 months, it 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 September. This will be shared in the next report.

Summary of case	Findings	Recommendations
Notified:	Awaiting PMM	

36+4 AN stillbirth. Known Edward's syndrome.		
Completed: Attended following 48 hours of reduced fetal movements. AN stillbirth confirmed at 35+1.	The patient, being a smoker, had a risk factor for a growth restricted baby, but did not receive serial ultrasound scans per National guidance. This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate This mother's risk status during labour was not assessed during the course of her labour	Local guidance was followed. Smoking cessation was offered but declined. Risk assessment not ticked, however management plan was in place. Theme already identified in prior PMRTs. Audit in progress. Email to be sent to staff. As above.
Completed: Intrapartum stillbirth following shoulder dystocia (also HSIB, as below)		The Trust to ensure mothers who have had an ineffective cycle of IOL have a senior obstetric review to inform their plan of care To feedback to the family and action plan

2.2.1 HSIB cases reported and/or received

Summary of case	Findings	Actions
Reported: Planned homebirth. Midwife attended as requested as labouring. Unable to auscultate fetal heart. Transferred in to labour ward and IUD confirmed.	Intrapartum stillbirth	Awaiting HSIB investigation
Received: Intrapartum stillbirth following shoulder dystocia	Intrapartum stillbirth	The Trust to ensure mothers who have had an ineffective cycle of IOL have a senior obstetric review to inform their plan

		of care To feedback to the family and action plan

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
Baby born in poor condition following Cat. 1 LSCS. Seizures and required passive cooling at neighbouring Trust.	Reported to HSIB 72 hour report completed	Following discussion with neighbouring Trust, criteria not met for HSIB reporting

2.4 Training Compliance

Training compliance will be monitored monthly via the Quality & Governance Team. The MDT Training Needs Analysis (TNA) meeting was 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. Medical staffing compliance has been escalated and action planning is in progress.
The figures in the table are all percentages.

Learning from I/C/C is learning from incidents, claims and complaints.

Scarborough	PROMPT	NLS	Fetal Monitoring	SBLv.2	Perinatal Mental Health	Bereavement	COVID19	Learning from I/C/C
Midwives	87	90	47	85	91	85	91	27
HCA/MSW	65	N/A	N/A	N/A	Not currently doing this training	94	72	N/A
Medical staff	37	N/A	32	75	Not currently doing this training	N/A	79	N/A
ODP	68	N/A	N/A	N/A	N/A	N/A	92	N/A
Anaesthetist	100	N/A	N/A	N/A	N/A	N/A	95	N/A

York	PROMPT	NLS	Fetal Monitoring	SBLv.2	Perinatal Mental Health	Bereavement	COVID19	Learning from I/C/C
Midwives	82	89	69	86	95	78	93	33
HCA/MSW	63	N/A	N/A	N/A	Not currently doing this training	89	96	N/A
Medical staff	47	N/A	60	57	Not currently doing this training	N/A	67	N/A
ODP	73	N/A	N/A	N/A	N/A	N/A	88	N/A
Anaesthetist	88	N/A	N/A	N/A	N/A	N/A	91	N/A

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: There continues to be significant challenge in achieving positive acuity scoring in clinical areas. This is due to staff absence (both covid and non-covid related sickness absence) and vacancy, particularly at the York site.

1:1 Care in Labour: York – 94.6**%** and Scarborough – 93.9**%.** All women should receive 1:1 care in labour. This is not currently being achieved cross-site every month. Workforce plans are being developed by the Head of Midwifery to address this.

Supernumerary Labour Ward Coordinator: York - 95**%** and Scarborough – 98.3**%.** 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 – this remains a challenge to embed.

York

Jan - Sept

1 to 1 care in Labour	CPD	100%		≤99.9%	n/a	96.6%	97.6%	96.7%	97.2%	100.0%	99.6%	98.6%	97.0%	94.6%
L/W Co-ordinator supernumary %	Shift Handover Sheets	100%		≤99.9%		97.0%	91.0%	92.0%	88.3%	93.5%	80.0%	80.6%	87.1%	95.0%

Scarborough

Jan - Sept

1 to 1 care in Labour	CPD	≥100%		≤99.9%		96.5%	97.5%	98.9%	97.9%	97.6%	94.8%	92.7%	100.0%	93.9%
L/W Co-ordinator supernumary %	Shift Handover Sheets	≥100%		≤99.9%		100.0%	100.0%	100.0%	95.0%	100.0%	98.3%	93.5%	100.0%	98.3%

Unit closure: There were 4 unit closures in September on the York site – staffing and acuity. None on Scarborough site.

Midwife Vacancy Rate: Band 5-8 RM York 15.6**%** and Scarborough 7.3**%**

Midwife: Birth Ratio: York **1:31** 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.

Scarborough

Scarborough had a slightly more settled month in September in terms of medical staffing, however there were some challenges from the middle and lower grade rota. An overview of the issues as below;

- Currently, 2 consultants are not undertaking on call duties due to occupational health recommendations.
- 1 substantive consultant is still on long term sick leave since July 2021
- Locum consultants were used to help fill the gaps on the rota as appropriate.
- There is a doctor on the lower grade rota who is less than full time, therefore her gaps are having to be managed on a weekly basis. Unfortunately we cannot recruit to bridge the gap, therefore we are using locums to cover.
- We have one middle grade on long term sick, however they are commencing their phased return in October.
- In August we recruited 2 x substantive consultants who will be starting in the New Year

York

Although not as challenging as Scarborough, York experienced some rota gaps throughout September on the middle grade rota. These gaps were managed by colleagues picking up ECP activity as well as utilising locum agency staff.

- Locum consultants were used to help fill the gaps on the rota as appropriate
- There are now 3 members of staff on the middle grade rota who are either on maternity leave or will be commencing maternity leave in this rotation year. We are currently looking at recruiting into these posts to fill the gaps.
- In August, we successfully recruited 2 additional consultants who will start with us substantively in the New Year.

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. Approach to complaint responses will be improved in terms of inviting all families in to discuss their concerns directly with the team. New 'learning from complaints' templates have been circulated and will support the development of feedback and action planning, via a 'you said, we did' approach.

Positive feedback received from service user:

In July 2019, I was 36 weeks pregnant, and I couldn't wait to meet my baby. Sadly that same week, my baby passed away. I delivered a little boy at Scarborough hospital in the snow drop suite. A sweet and kind midwife delivered my son, her name was Kim. Kim was there from the

moment she started her shift until she left, I don't think she even took a break. Kim was calm and patient with us, she helped us to decide on options we had when our little baby had been delivered. She never rushed us and always offered us more information if we needed it.
When I was discharged from hospital, she was so kind and kept in touch with us. She made sure we were ok and checked on my postpartum health. Kim again kept in touch with us and remembered us at anniversaries and special occasions. It helped us to feel cared for. We discussed the possibility of Kim being my midwife should I ever get pregnant again. I lived out of the area that her team covered so special permission was needed and the team would need to agree too. When I did fall pregnant again, Kim was my midwife again. It meant that her and the team were well informed about my situation. Kim saw me for almost all my visits, and the Jo from the Jasmine team saw me for the rest. Kim and the team were helpful in letting my husband come to my appointments and scans. It meant that I was calmer at my appointments and scans and never felt alone. This was really good for my anxiety and helped to lower my stress levels. Kim knew my pregnancy was scary for me and as it was high risk, after my previous loss, she was able to talk to me about services that would help my anxieties and worries. This meant I had extra support throughout my pregnancy and afterwards. By having the same team, my husband and I were able to voice our concerns and felt we were listened to. It meant that when I had concerns about my gestational diabetes or if I felt the scans were not enough and needed more, they were able to step in and help where needed. Kim helped me plan my induction and as we had been to hypnobirthing birthing classes we wanted to try and have a relaxed labour.
As with the covid restrictions we needed to ask for permission to have my husband at my induction, Kim helped to ensure that this happened. We also asked it would be possible to use the same suite that I have had previously given birth in, as it had calmed us and it felt right to give birth to my other child in the same room. When I was induced, Kim came in especially to deliver my baby. She again was so wonderful and helpful. We felt protected again and safe knowing she would be there to welcome our child into the world. I believe this was the reason my delivery was easy. I always knew I was in safe hands and as there was a low threshold for my delivery I knew she would be honest and guide us through any concerns and help us decide. When our little boy arrived, she handed him straight to me and there was not a dry eye in the room. Without Kim and the Jasmine team I don't think I would have felt comfortable in my pregnancy. I also believe that when the time comes again they will be there for me and my family.

Friends and Family (FFT) reported are not available for September. There has been a drive to increase the numbers of FFT cards being returned.

2.7 Safety Champions walk around feedback

MATNEO Safety forum feedback action plan			
Date/Site	**Safety Champion**	**Safety concern**	**Action**
22 Sept/ Scarb	Heather McNair	Walked around all areas – issued raised on SCBU re ventilators being form a different manufacturer (Dreager on the York site) which introduced risk when staff crossed site	SK to lead - update required

2.8 MIS (CNST) year 4 standards have been released. We are awaiting updates to the programme, currently under review, so deadlines/dates may change:

Safety Action	Compliance	Detail of each standard position
1	ON TARGET	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** Processes around PMRT strengthened to ensure compliance
2	NON COMPLIANT	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** Awaiting publication of compliance framework to support this safety action. Development of CPD required.
3	NON COMPLIANT	**Can you demonstrate that you have transitional care services in place to minimise separation of mothers and heir babies and to support the recommendations made in the Avoiding Term Admissions Into Neonatal units Programme?** Review of guidance and whether TC is in place fully, challenges around this to be identified. Quarterly board reporting required, working closely with paediatric colleagues to support this.
4	NON COMPLIANT	**Can you demonstrate an effective system of clinical workforce planning to the required standard?** Input from Obstetric colleagues required to action plan. Paper for CNST year 3 action planning around neonatal workforce re-submitted to ODN, as requested. This paper will require review for this year and submission by January 2022.
5	NON COMPLIANT	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?** Birthrate+ completed 2021, workforce paper developed. Challenges around midwife coordinator supernumerary status and 1 to 1 care in labour remain: actions to support collecting this data more effectively include attending labour ward handovers and discussing, email to all coordinators, changes to the recording sheets to make it clearer and highlighting it on governance boards. Awaiting confirmation from clinical network around actual definition of coordinator supernumerary status as being recorded differently at different trusts.
6	NON COMPLIANT	**Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** Some challenge remains around compliance with SBLv2, however progress has been made with a plan to go live in November with the new scanning schedule – there are plans for 45 extra scans at York and 30 extra in Scarborough.
7	ON TARGET	**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** Good links with MVP remain in place. Some assurance around current ToR for the following year required and ongoing co production evidence
8	ON TARGET	**Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?** **In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?** TNA and plan for 3 years training programme developed. Face to face

		training reinstated. Action planning around training compliance. MDT discussion around inclusion of MDT in PMH and safeguarding training sessions.
9	ON TARGET	**Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?** Pathways to update and circulate. Attendance at any matneo events required.
10	ON TARGET	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?** Improvements to process include provision of Duty Of Candour training and attendance at labour ward handovers of Q& G team

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. Progress in ongoing around compliance with SBL v2. Stated position was updated by HoM and Dep HoM September 2021 and detailed below. 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.** Update: There is a SOP written by the LMS for SI overview. Process in place to request external review of SIs via the LMS; Currently 1 in progress.
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. Update: Awaiting updated ToR from MVP chairs
3	PARTIAL COMPLIANCE	**Staff who work together must train together.** Actions: action planning in place around training compliance with ongoing MDT discussions to include PMH and safeguarding training onto Obstetric work plan. TNA and training planning completed in line with core competency frameworks. Ongoing audit of consultant led MDT ward rounds on labour ward. Update: Monthly audits in place, these are being updated and will be tabulated from the next report. Trust board commitment received to ringfence maternity training monies.
4	PARTIAL COMPLIANCE	**There must be robust pathways in place for managing women with complex pregnancies.** Update: Awaiting formation of maternal medicine networks. We have Obstetrician input into the regional working group.

5	PARTIAL COMPLIANCE	**Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.** Update: Ongoing audit of risk assessment compliance in place. Personalised care plans trialed in two areas, awaiting feedback from LMS prior to wider scale rollout. LMS wide digital system development is progressing with hopes to implement from April 2022; A digital midwife is expected to be appointed from interview in October. 30 sets of notes audited on York and Scarborough sites in September showed 100% women having 1st and 2nd assessments; however challenges remain around care planning, these audits will be tabulated from next month's report.
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.** Obstetric and midwifery fetal monitoring leads in place, awaiting JD for medical staff. Update: Appointment of fetal monitoring midwifery lead due in October
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 Update: formation of SOPS around personalised care planning required once rolled out. Update to website required.

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 has been submitted to the LMS and discussed with our national CoC lead during an assurance visit with the regional continuity leads in September 2021; updates to the developing action plan are underway as a result of this visit.

August 2021

Booked for CoC	Intrapartum CoC received
38.3% Black, Asian and mixed ethnicity backgrounds = 44% Postcode for top decile for deprivation = 84%	16.8% Scarborough = 43% York = 4% Black, Asian and mixed ethnicity backgrounds = 9% Postcode for top decile for deprivation = 41.6%

3. Next Steps

To continue to provide this report monthly.

4. Detailed Recommendation

For the board to acknowledge and discuss the data required.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 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 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.

Three actions are behind delivery (Appendix A); two of which have a plan in place to address compliance by the end of November 2021. One of the three 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. 2. All Section 31 actions from the Trust action plan have now been completed.

The bimonthly CQC insight report demonstrates 8 much worse indicators (increase) and 24 worse indicators (increase) 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. In addition there are 179 indicators which demonstrate the Trust are either comparable nationally or have remained the same in terms of previous performance. Finally, there are 7 indicators to suggest the Trust has performed better than previous years and/or better than the national picture.

Each Care Group reviewed and updated their Transitional Regulatory Response benchmarking assessments, and presented this to Quality & Regulations Group. A summary sheet was devised for each Care Group to utilise in relation to their findings. The summaries allowed care groups to share good practice, provide assurance and escalate items at Quality & Regulations Group, with a full summary provided to Quality Committee. Table 2 demonstrates the self-assessment outcomes across the Care Groups.

Care Group	Relevant Requirements	Inadequate	Requires Improvement	Good
Care Group 1	**21**	**0%**	**48%**	**52%**
Care Group 2	**17**	**0%**	**47%**	**53%**
Care Group 3	**10**	**0%**	**60%**	**40%**
Care Group 4	**18**	**0%**	**28%**	**72%**
Care Group 5	**19**	**0%**	**79%**	**21%**
Care Group 6	**26**	**0%**	**20%**	**80%**

Table 2: Transitional Regulatory Approach Deep Dive – August 2021.

Each Specialty carried out a "safe domain" self-assessment and presented this through their care group governance structure, before summarising to Quality & Regulations Group. Individual summaries were shared with Quality Committee. The summaries allowed care groups to share good practice, provide assurance and escalate items. Overall ratings have been provided in table 3, though it should be noted that despite having approximate ratings, a singular significant finding during a live inspection could lead to an overall rating of inadequate. Examples would include staffing and skill mix and delays in emergency departments.

Aggregated Location	Approximated Rating
Urgent & Emergency Care	Requires Improvement
Community Services (Adult)	Good
End of Life Care	Good
York – Medical Care (Including Care of the Elderly)	Requires Improvement
Scarborough – Medical Care (Including Care of the Elderly)	Good
Critical Care	Good
Surgery	Good
Maternity Services	Requires Improvement
Paediatrics (Including Neonates)	Requires Improvement
Sexual Health	Good
Outpatients	Good

Table 3: Approximated ratings based on self-assessments

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).
2. Recognise the completion of all Section 31 actions from the Trust action plan.
3. Acknowledge the increase in whistleblowing concerns received, and the associated risk of unannounced inspection. (Appendix B)
4. Recognise the approximate self-assessment ratings, whilst acknowledging a singular significant finding during a live inspection could lead to an overall rating of inadequate / Requires Improvement.

Author: Shaun McKenna – Head of Compliance & Effectiveness

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

Date: 13-11-2021

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

No engagement meetings have taken place since 31/08/202, with no further engagement meetings currently scheduled. The lack of engagement meetings has been highlighted to the CQC, who is working towards scheduling the meetings at their earliest convenience. The CQC engagement owner for the Trust is currently absent from work; an inspector from the North East is holding the portfolio until the substantive relationship owner returns.

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. Although York Hospital has demonstrated compliance above 85% for 3 consecutive months, the Trust will aim to stabilise compliance across both Emergency Departments before requesting removal of conditions to demonstrate that the organisation is “well-led”. An action plan to improve compliance is currently being developed by the Emergency Department Matron.

Results	**Scarborough Emergency Department**	**York Emergency Department**
May 2021	81%	58%
June 2021	70%	90%
July 2021	72%	88%
August 2021	73%	92%
September 2021	52%	86%

Table 1: Mental Health Risk Assessment Compliance

2.3 General Updates

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

- **Urgent & Emergency Care Survey 2020**

The CQC have released provider level results from the urgent & emergency care survey undertaken between November 2020 and March 2021. 494 people responded for York & Scarborough Teaching Hospitals NHS FT. The CQC have compared the results with other Trusts and determined that for all of the results, the Trust is “about the same” as other Trusts delivering urgent & emergency care services. The Trust is “better” than other Trusts for discussing transport arrangements for leaving A&E with patients.. Care Group 1 & Care Group 2 has devised action plans which have been presented at Patient Experience Group.

- **Recovery Challenges for NHS Hospital Services**

This month’s insight report includes a narrative in relation to recovery challenges for NHS hospital services. The summary explores how NHS hospitals are planning for peoples care, sharing learning from many different organisations. The information is based on views from May – June 2021 and considers how long waiting lists are being considered in a fair and equal way. Information shared with the Deputy Director of Planning & Performance to ascertain if there is any shared learning to be taken.

- **Safety, Equity and Engagement in Maternity Services**

This report, published by CQC, highlights continued concern about the variation in the quality and safety of England’s maternity services and calls for improvement to be prioritised to ensure safer care for all mothers and babies. The report has been shared with Maternity Services within the Trust for consideration and implementation. There are 4 recommendations for Trusts and Local Maternity Systems;

Leadership - In line with essential action 2 of the first Ockenden review, Boards must take effective ownership of the safety of maternity services. This includes ensuring that they have high quality, multidisciplinary leadership and positive learning cultures. They must seek assurance that staff feel free to raise concerns, that their concerns and adverse events lead to learning and improvement and that individual maternity staff competencies are assured.

Voices and Choices - In line with the Cumberlege review ‘First do no harm’; maternity services must ensure that **all** women and their families have information and support that allows them to make choices about their care. This includes listening to individual women and fully explaining choices, in an accessible way throughout the pregnancy journey. This includes, for example, working effectively with interpreters.

Engagement - As supported by the findings of 'Better Births' and 'First do no harm', local maternity systems need to improve how they engage with, learn from and listen to the needs of women, particularly women from Black and minority ethnic groups. They also need to make sure that targeted engagement work is appropriately resourced.

Data and Risk - Services and systems should use ethnicity data they collect to review safety outcomes for women from Black and minority ethnic groups, and take action in response to risk

factors. This includes working with Black and minority ethnic women to personalise care and reduce inequality of outcomes.

- **Community Support Requirements for People with a Learning Disability, a Mental Health Need and Autistic People**

The CQC have published a report with the aim of raising expectations of what can be achieved when appropriate planning takes place for people with a learning disability, a mental health need and autistic people. The report makes recommendations, some of which are relevant to acute trusts. The report has been shared with the Safeguarding Team and the Mental Health group for consideration and implementation.

- **Ted Baker Announces Plans to Retire Next Year**

Ted Baker has announces his intention to retire in March 2022, after almost 5 years as the Chief Inspector of Hospitals. The recruitment process for his replacement will begin shortly.

- **Patient FIRST (Updated)**

In October 2021, CQC have updated the Patient FIRST tool which was created with the help of clinicians who work in “good” and “outstanding” services. The tools has had a change of focus to include an emphasis on Board oversight, as well as measuring departments based on a system approach rather than in isolation. An associated improvement tool has been published, this has been shared with both emergency departments and plans are underway to ensure this is utilised to its full potential.

- **Government Amendment to the Health & Care Bill**

Dr Rosie Benneyworth released a statement in relation to the government amendment to the Health and Care Bill, which sets out new powers for CQC to have oversight of the Integrated Care Systems (ICS). The statement noted: "This amendment supports health and care systems to be held accountable and encourages the shift towards more integrated services and improved outcomes for people.”

- **State of Care**

This report, published by CQC, highlights people’s experiences of care, flexibility to respond to the pandemic, ongoing quality concerns, and challenges for systems. Ongoing quality concerns consist of:

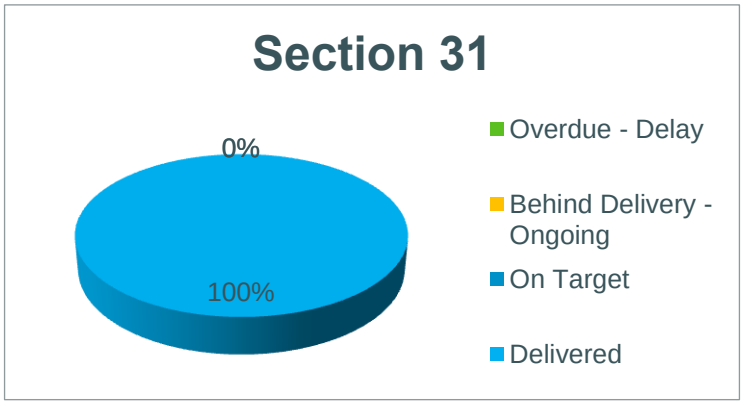
- Concerns that people continue to be put at risk in a small number of services where there are warning signs of closed cultures.
- Improvements in maternity care are far too slow, with continuing issues around staff not having the right skills or knowledge, poor working relationships, and not learning from when things go wrong. Other concerns include a lack of engagement with local women by maternity services and limited action taken by these services to improve equitable access.

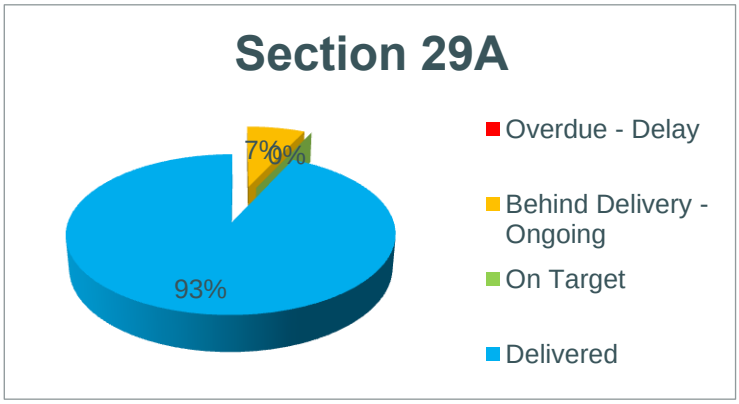
- While services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, they need to have a continued focus on people subject to a deprivation of liberty. CQC continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

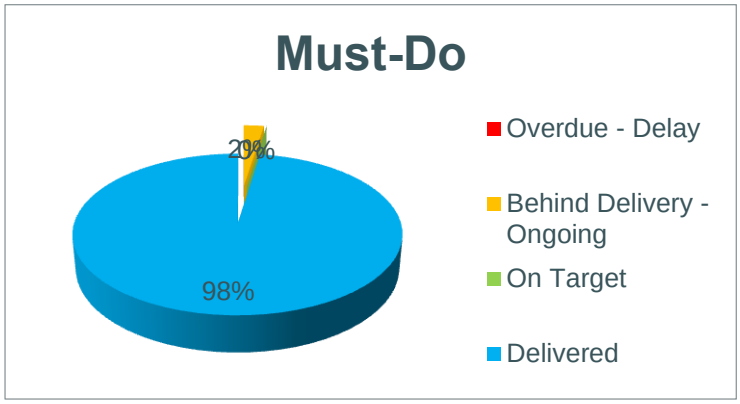
3. Regulatory Action Plan Update

3.1 Overview

	Overdue - Delay	Behind Delivery - Ongoing	On Target	Delivered
Section 31	0	0	0	20
Section 29A	0	2	0	27
Must-Do	0	1	0	40







3.2 Exception Report (Appendix A)

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 taken place with no eligible applicants received. In the latest recruitment round interest was expressed from an internal candidate. The subsequent recruitment premium request from the candidate was significantly increased and therefore could not be progressed. There is a risk that non recruitment into this role could result in regulatory action from the CQC, namely a Section 31 condition notice. The Medical Director is progressing conversations to promote the identification of an appropriate solution.

- 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. The Head of Compliance has met with the Associate Chief Nurse (Corporate) to discuss next steps. An improvement plan will be developed with stakeholder involvement and sign off.

Plan to be ready for implementation from November 2021 with clear governance pathways mapped throughout. Upon approval of the improvement plan, it is proposed that this action is closed and monitored through the identified governance route. 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. Evidence of ongoing engagement and progress is held within the evidence folders. A provisional go-live date has been scheduled for 22nd November 2021.

4. CQC Insight Report

4.1 Overview (CQC National Comparison)

Classification of Indicators	Number of Indicators – May 2021	Number of Indicators – July 2021	Number of Indicators – September 2021
Much Worse	5	6	8
Worse	25	23	24
About the Same	174	175	179
Better	7	5	5
Much Better	2	3	2

CQC Insight reports are released bimonthly and benchmark Trusts against previous internal performance and against national performance / quality indicators. The 8 “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. In addition there are 179 indicators which demonstrate the Trust are either comparable nationally or have remained the same in terms of previous performance. Finally, there are 7 indicators to suggest the Trust has performed better than previous years and/or better than the national picture.

- **Whistleblowing Alerts** (Appendix B)

Since the last update report, 14 whistleblowing alerts have been shared with the Trust following receipt by the CQC. A full summary of received whistleblowing alerts can be found in Appendix B. This is a significant increase in reporting and an associated risk is the prompting of an unannounced inspection. Responses are being submitted as requested, currently there is no indication as to how the Trust compares to other Trusts.

- **Patients spending less than 4 hours in major A&E (%)**

The data used for this metric was accurate as of August 2021 and demonstrate a decrease in performance from 79.2% in August 2020 to 50.3% in August 2021, compared to the national average of 66.2% and the overall aim of 95%.

- **Mortality outlier alert: Excision of colon and / or rectum**

The Trust was an outlier in this area for 2016-2019, however recent results demonstrate that the Trust is no longer an outlier in 2020. As such, the data has been shared with CQC with a request to update their reports.

- **Case mix adjusted mean HbA1c; blood glucose control**

The Trust has sufficient assurance through local data collection that this indicator is “much better”, however this will not show on the CQC report until the next national audit report is completed.

- **A&E Attendees spending more than 12 hours from decision to admit to admission**

The data used for this metric was accurate as of August 2021 and demonstrate a decrease in performance from 0 breaches in August 2020 to 43 in August 2021. We know from the IBR that this number has significantly increased in September 2021, and so the next report will also demonstrate a “much worse” position. Unfortunately CQC do not include a national comparator for this monitoring metric.

- **Patients spending less than 4 hours in any type of A&E (%)**

The data used for this metric was accurate as of August 2021 and demonstrate a decrease in performance from 86.7% in August 2020 to 71.7% in August 2021, compared to the national average of 74.4% and the overall aim of 95%.

- **Active professional registration (nursing and midwifery) (%)**

The data used for this metric was accurate as of June 2021 and demonstrate a decrease in performance from 92.8% in June 2020 to 88.9% in June 2021, compared to the national average of 98.3%. A focussed piece of work undertaken by the HR team has enabled this position to become improved; said results should be evidence in the November 2021 Insight Report.

- **Participation in the ICCQIP - Neonatal critical care services**

The Infection in Critical Care Quality Improvement Programme (ICCQIP) is a collaboration of professional organisations representing adult, paediatric and neonatal intensive care, microbiology, and infection control, supported by Public Health England (PHE). The group has developed a national surveillance programme designed to provide information about infections in Critical Care Units (CCUs) in England, with a particular focus on anti-microbial resistant infections. The Head of Children’s Nursing has established the Trust is expected to participate in this audit and as such is registering the Trust to provide the data. This should show as compliant in the November 2021 report.

5. Transitional Regulatory Approach Deep Dive

5.1 Introduction and Background

In response to challenges and risk arising from the coronavirus pandemic, the Care Quality Commission (CQC) developed a transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service. The transitional approach includes:

- A strengthened approach to monitoring based on specific existing key lines of enquiry (KLOEs), to enable continuous monitoring of risk in a service.
- The use of technology and local relationships to have better direct contact with people who are using services, their families and staff in services.
- Targeted inspection activity, where the CQC have concerns.

The CQC requested that the Trust completed a Transitional Regulatory Framework self-assessment, which was completed and submitted in January 2021. In line with the schedule of CQC deep-dives that the Trust has initiated, an updated self-assessment was presented from the Care Groups to Quality & Regulations Group.

5.2 Summary of Findings

Each Care Group reviewed and updated their benchmarking assessments, and presented this to Quality & Regulations Group. A summary sheet was devised for each Care Group to utilise in relation to their findings. The summaries allowed care groups to share good practice, provide assurance and escalate items at Quality & Regulations Group, with a full summary provided to Quality Committee. Table 2 demonstrates the self-assessment outcomes across the Care Groups.

Care Group	Relevant Requirements	Inadequate	Requires Improvement	Good
Care Group 1	**21**	**0%**	**48%**	**52%**
Care Group 2	**17**	**0%**	**47%**	**53%**
Care Group 3	**10**	**0%**	**60%**	**40%**
Care Group 4	**18**	**0%**	**28%**	**72%**
Care Group 5	**19**	**0%**	**79%**	**21%**
Care Group 6	**26**	**0%**	**20%**	**80%**

Table 2: Transitional Regulatory Approach Deep Dive – August 2021.

5.3 Escalated Items

Items escalated to the Quality & Regulations Group were shared with the relevant teams, where required, to ensure action could be taken to support improvements within the Care Group. Most escalations were addressed by the Care Groups advising an improvement plan would be created within the Care Groups.

5.4 Next Steps

Care groups will continue to use their benchmarking assessment as a "working document" within their quality governance structures. In addition, improvement plans will be reflective of the findings from the TRA Deep Dive. The Quality & Regulations Group will request updates on improvement plan progression on a quarterly basis, after completion of the 6 domain deep dives.

6. Safe Deep Dive

6.1 Introduction and Background

In line with the proposed plan of deep-dives into the CQC key lines of enquiry, each specialty area undertook a self-assessment using a pre-designed tool. An MDT approach was requested to ensure a holistic view of specialities rather than profession led deep-dives. Each specialty assessment fed into Care Group governance meetings and a subsequent Care Group summary was created. Care Groups presented their findings to Quality & Regulations Group in September 2021.

6.2 Summary of Findings

Each Specialty carried out a "safe domain" self-assessment and presented this through their care group governance structure, before summarising to Quality & Regulations Group. Individual summaries were shared with Quality Committee. The summaries allowed care groups to share good practice, provide assurance and escalate items. Overall ratings have been provided in table 3, though it should be noted that despite having approximate ratings, a singular significant finding during a live inspection could lead to an overall rating of inadequate. Examples would include staffing and skill mix and delays in emergency departments.

Aggregated Location	Approximated Rating
Urgent & Emergency Care	Requires Improvement
Community Services (Adult)	Good
End of Life Care	Good
York – Medical Care (Including Care of the Elderly)	Requires Improvement
Scarborough – Medical Care (Including Care of the Elderly)	Good
Critical Care	Good
Surgery	Good
Maternity Services	Requires Improvement
Paediatrics (Including Neonates)	Requires Improvement
Sexual Health	Good
Outpatients	Good

Table 3: Approximated ratings based on self-assessments

6.3 Escalated Items

Items escalated to the Quality & Regulations Group through summary sheets will be analysed and shared with appropriate working groups, where required, to ensure learning is shared across the Trust. Most escalations were addressed by the Care Groups advising an improvement plan would be created within the Care Groups. Nurse staffing levels was raised as a risk across the Trust, with a correlation of an increase in falls and pressure ulcers.

6.4 Next Steps

Care groups will continue to use their benchmarking assessment as a "working document" within their quality governance structures. In addition, improvement plans will be reflective of the findings from the Safe Deep Dive. The Quality & Regulations Group will request updates on improvement plan progression on a quarterly basis, after completion of the 6 domain deep dives. The summary sheets will be reviewed and actions mapped to pre-existing working groups where applicable, to ensure shared learning and Trust-wide action.

7. Next Steps

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 effective 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. The teams are working on this at specialty level.

8. Recommendations

Board of Directors are requested to consider the following recommendations:

- Accept this report as an updated position for the Trust in relation to CQC action plans (Section 29A, Section 31, & Must-Do actions).
- Recognise the completion of all Section 31 actions from the Trust action plan.
- Acknowledge the increase in whistleblowing concerns received, and the associated risk of unannounced inspection. (Appendix B)
- Recognise the approximate self-assessment ratings, whilst acknowledging a singular significant finding during a live inspection could lead to an overall rating of inadequate / Requires Improvement.

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	Medical Director	Nov-20	October 2021: Medical Director engaging in conversations to promote the identifcation of an appropriate solution		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	September 2021: Head of Compliance has met with the Associate Chief Nurse (Corporate) to discuss next steps. An improvement plan will be developed with stakeholder involvement and sign off. Plan to be ready for implementation from November 2021 with clear governance pathways mapped throughout. Upon approval of the improvement plan, it is proposed that this action is closed and monitored through the identified governance route.		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	

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
July 2020 ENQ1-9278166881	4	LLP - Concerns were raised around fire stopping processes and testing, legionella testing processes, treatment of staff, withheld training, and inappropriate delegation of tasks to staff without the skill or competence to undertake them. CQC notified the Trust about the whistleblowing alerts and requested responses given the potential implications on patient and staff safety.	Responses were submitted to the CQC alongside an action plan. CQC closed the alerts and have received no further submissions since October 2020. Assurance around fire stopping, legionella testing, training, and delegation was provided.	Closed
August 2020 ENQ1-9396795411	1	Concerns were raised around unsafe staffing levels and poor levels of basic care for patients. Assurance was requested for: - Intentional-Rounding - Reducing Trolley Waits - Staffing Numbers - Skill Mix - IPC Audits	A response with assurance was provided following specific questions from the CQC. The Trust incorporated intentional rounding into the hourly patient safety checklist in response to this alert, and compliance is audited.	Closed
March 2021 ENQ1-10543716841	2	York Acute Medicine - The initial whistleblowing alert focussed upon clinical leadership and subsequent vacancies in the acute physician workforce with the second alert focussing upon the vacancies in acute physician workforce and subsequent patient safety implications.	An initial response was submitted to CQC followed by a request for further information which was subsequently provided. CQC held a management review meeting and concluded the Trust were mitigating risks as much as possible and taking appropriate action, despite a high vacancy rate being evident. The whistleblowing alert will remain open until the next engagement meeting, where the position will be reviewed following a further submission from Care Group 1.	Open

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
July 2021 ENQ1-11313208191	3	2 were received from alleged anonymous staff members and 1 from an alleged anonymous patient in relation to Scarborough Emergency Department. The main themes included urgent care provision and associated systems and processes, nurse staffing and skill mix, and medical staffing and skill mix.	A response was submitted to the CQC and no further questions or information has been requested. Assurance was provided around staffing levels, and concerns were shared regarding the Trust backfilling vacancies in streaming for other organisation.	Closed
August 2021 ENQ1-11463977891	1	Staff member WB regarding an alleged delay in treatment for a cord compression during a transfer from Scarborough Hospital to York Hospital.	Datix investigation report submitted to CQC in October 2021, awaiting response from CQC.	Open
August 2021 ENQ1-11493898481	1	1 whistleblowing alert related to Ward 35 at York Hospital and alleges that patients were being woken up at 0530hrs to receive personal care to ease the pressures on day staff.	The Matron for the area has discussed with ward leaders and feels assured this practice is not being undertaken. An audit will be scheduled to assess personal hygiene care plans and the Corporate Nursing Team is undertaking a piece of work to promote individualised care planning. A verbal response has been provided; formal evidence is yet to be sent to the CQC.	Open
September 2021 ENQ1-11645926898	1	Concerns raised from an ex-employee regarding the following issues: - Poor Basic Care - Safety Concerns - Culture Concerns - Competency Sign-Off - Nutrition Concerns - Poor Communication	An investigation into these allegations has been undertaken and the response is to be collated for submission to the CQC.	Open

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
October 2021 ENQ1-11818914581	1	Anonymous concerns: - Staffing shortfalls (they understand this is a national issue) - Staff upset, frustrated and frequently missing meals - COVID swabbing is over 2 hours every weds and sat - Patient safety concerns: medications delayed, patients position not altered and falls risks not supervised appropriately - Poor documentation as staff are prioritising hands on Care Quality Commission Increase in complaints with regards to patient care	No response required from CQC. They have requested that the concerns are discussed in the next engagement meeting.	Closed
October 2021 ENQ1-11850123261 ENQ1-11854542432 ENQ1-11850238071	3	3 anonymous concerns which relate to: - Safety across the trust (particular mention to ED) - Unsafe staffing levels, pressure on staff, even with agency and bank - Ambulance are in overflow bays - No engagement from trust to make sure patients are discharged in a timely manner, staff shortages on wards effecting flow from ED 'having to look after people outside bays' - Constantly in escalation mode	No response required from CQC. They have requested that the concerns are discussed in the next engagement meeting.	Closed
October 2021 ENQ1-11707854725	7	CQC have received 7 concerns all relating to service closures with particular attention to the hyperacute stroke unit (HASU) at Scarborough hospital. The informants express concerns around poor	Response submitted with briefing papers, presentations, and a service review for the HCV. Concerns potentially raised due to delays in emergency ambulances to transfer patients. Awaiting response from CQC	Open

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
		accessibility and health inequalities.		
November 2021 ENQ1-11942252001	1	Information of concern related to unsafe staffing in maternity: ''levels of staffing appear so unsafe as to be putting women and babies lives in danger every day. When fully staffed, the labour ward has 4 midwives for 14 beds...beds that are often filled with increasingly high-risk patients who require one-to-one care. Additionally, the unit is never fully staffed any more, or even close. Consistently, shifts are run with 6 midwives staffing the 14 labour ward beds, 12 antenatal ward beds and 26 postnatal ward beds. On these shifts, the unit is often still open! To help with short-staffing, community midwives are expected to attend the unit on-call overnight. This often manifests in community midwives working a day shift 8.30am-4.30pm, going to the unit to help with staffing at 4.30pm, then not leaving until 7am the following day. The best midwife in the world would not be able to make safe choices for women and babies on a 24 hour shift.''	Investigation currently underway. Response to be submitted to CQC by 09/11/2021 12noon.	Open
November 2021 ENQ1-11952526288	1	Anonymous concern: Informed that physiotherapists have been offered to volunteer for shifts to cover nursing staff on the respiratory wards including the weekend and nights.	Response submitted relaying that physiotherapists were asked to support the nursing team in caring for patients requiring non-invasive ventilation. This is within their scope of practice, and requirements were made clear from the initial request. This has occurred on one shift so far, and the feedback from the physiotherapist was positive.	Open

Board of Directors
24 November 2021
Revalidation Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

To provide an update on the revalidation and appraisal programmes over the last year.

Executive Summary – Key Points

NHS E/I cancelled the 2019/210 Annual Organisational Audit (AOA), and have stood down the 20/21 one. For 20/21 they have requested an update on the appraisal year, and the impact of the amended appraisal model.

In response to the amended model, the platform used by the trust was updated, reducing the time required for doctors to input their appraisal information.

The amount of evidence required has been reduced considerably, with appraisals currently focusing on reflecting upon the pandemic, its effects, and any potential learning.

NHS England and the GMC took the decision to pause the appraisal programme in March 2020. At the same time, those due to revalidate in 2020 were deferred until 2021.

During this period, we allowed doctors to be appraised if they chose, but paused all reminders and formal action.

As a result of the pause to appraisals, the appraisal compliance rate reduced considerably over that period, as shown in Figure 2 below.

The expectation of NHS E/I for 2021/22 is that trust work to recover the appraisal rate.

Figure 1 shows the number of appraisals signed off during the pause period.

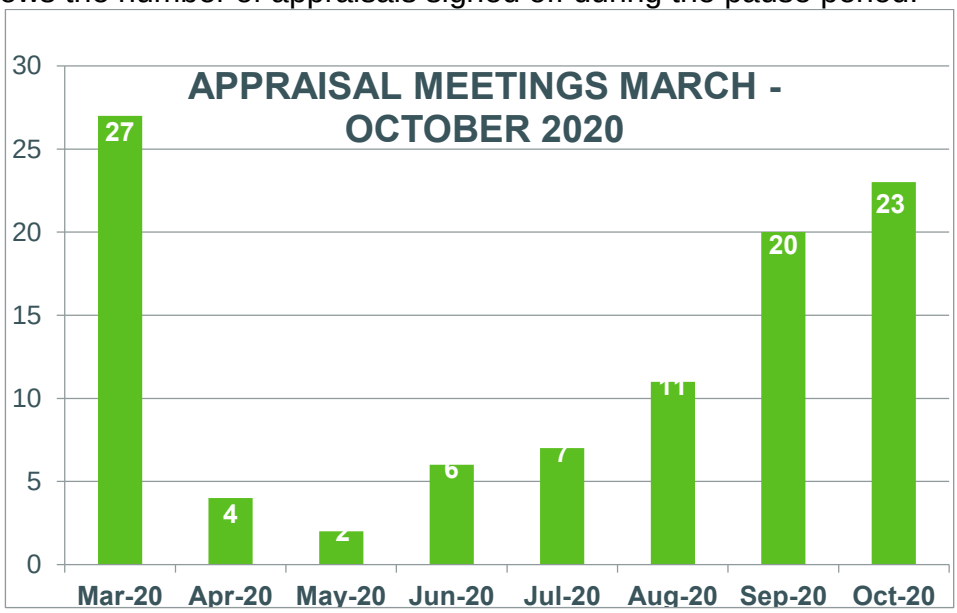


Figure 1

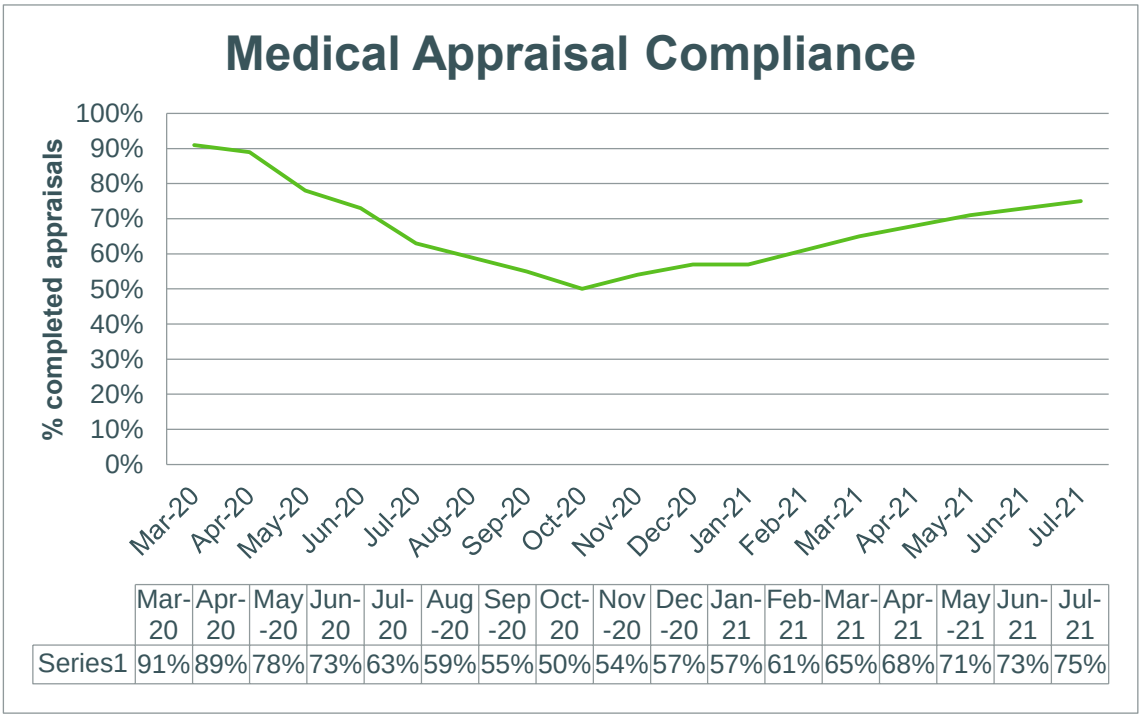
Changes to Appraisals

In response to the pressures created by the pandemic, NHS England produced a shortened appraisal form and guidance. The focus has been on minimal supporting information, and a supportive, reflective discussion regarding the personal and professional effects of the pandemic.

From October 2020 appraisals commenced on an annual basis. The trust has a number of doctors with missed appraisals. We are working with these doctors and their departments to ensure appraisals take place, and postponing any formal action which would usually be taken for late appraisals.

Care Group management teams are now being provided with monthly appraisal and job planning updates, allowing them to identify any areas which would benefit from assistance.

Figure 2 shows the appraisal rate during the period.



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Series1	91%	89%	78%	73%	63%	59%	55%	50%	54%	57%	57%	61%	65%	68%	71%	73%	75%

Figure 2

Appraiser Allocation
During the year we also introduced appraiser allocation, after consultation with appraisers and appraisees.

Several experienced appraisers have retired over the last year.
ODIL assisted Medical Staffing and our Senior Appraiser to write and deliver an online appraiser training course. A further eight appraisers have now been recruited and trained.

Online Appraisals
Before the pandemic, online appraisals were allowed, but very rarely used. Now people are getting used to it, we expect it to be used much more frequently. This helps us in being able to allocate appraisers cross-site more efficiently.

NHS England Action Plan
In January 2020 the trust was issue with an action plan:

Name of responsible officer	Mr James Taylor	
Area/concern/issue identified at Review Visit	**Action**	**Progress**
Reduced appraisal non-compliance % and high level of measure 3*	Trust to implement their allocation system in association with a review of the delivery of appraisal across the programme year.	Allocation system implemented
Reduced appraisal non-compliance % and high level of measure 3	Consider changes to appraisal policy, particularly non-engagement stage. Meeting to take place with Dr following first letter	Put on hold during pandemic
	Trust to establish a programme of medical appraiser networks to provide leadership to the cohort of appraisers	Network meetings started
Reduce the number of revalidation deferments * Measure 3 appraisals are those with no appraiser during the year, and with no agreed reason	Trust to instigate an action plan to review their management of Revalidation recommendations: Education of appraisers Re-issue of appraisal checklist Increase frequency of new starter workshops	All points addressed, however this year will see a high level of deferments due to appraisal delays, and difficulty obtaining patient feedback

We have re-started appraiser network meetings. The first two have been held online, and were well attended. This format will be used going forward.

Appraisal Compliance

Name of organisation: York and Scarborough Teaching	Number of appraisals	% of appraisals

Hospital NHS Foundation Trust		
Total number of doctors with a prescribed connection as at 31 March 2021	460	
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	289	63%
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	120	26%
Total number of agreed exceptions	51	11%

Our Statement of Compliance for 20/21includes the above overview of appraisal compliance.

Future Plans
The trust has for some time recognised that the current format of patient feedback (mandatory for revalidation in most cases) has limited value.

New GMC guidance allows us to think more broadly about capturing appropriate and valuable feedback.

We will therefore be looking at various options, including online/SMS feedback, and the possibility of recruiting volunteers to gain feedback from patients. This is being recognised as good practice in trusts that are now using similar processes.

Utilising volunteers could also allow the trust to offer work experience to young people considering healthcare careers. Opportunities for this are currently limited.

Recommendation

The board are asked to recognise and support the work of the revalidation team.

Author: Paul Whittle

Director Sponsor: James Taylor

Date: November 2021

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
Guardian of Safe Working Hours 2021-2022 Q2 report

/ Trust Strategic Goals

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

/ Recommendation

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

/ Purpose of the Report

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

/ Executive Summary – Key Points

1. The management of junior doctor rosters is moving to an electronic portal. The choice of provider means our platform for Exception Reporting moved to Allocate from DRS4 in August 2021. There is a difference in terminology and process that will impact content and comparison in reports this quarter.

2. After a year of relatively low reporting rates we have seen a steep rise in the second half of this quarter. The numbers are comparable with those seen after August changeover in the years preceding COVID.

3. As a consequence of the Exception Reports and subsequent exploration into contributing factors an FY1 doctor will be moved from general surgery to orthopaedics (Scarborough) on a trial basis in the next training year (2022/23). The move will be made permanent based on the quality of training and supervision received.

4. The absence of a dedicated location for handover in York has been raised as a patient safety risk. The challenge in delivering robust handover is also causing stress and dissatisfaction amongst staff who are constantly working around the problem.

/ 1. Introduction and background

This is the 2021/2022 Q2 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training.

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

The GoSWH holds the position of Chair of the JDF. Monthly meetings have been held via WebEx since October 2020. Doctors are encouraged to contact the Guardian outside of Forum meetings if necessary.

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

/ 2. Detail of report and assurance

/ 2.1 Exception reporting and guardian fines

As reported in the Q1 paper the Trust has changed software provider for Exception Reporting. The rules around the appropriate management of reports remain unchanged. However, the portal uses different terminology and processes. The variances impact on how information will be presented to the Board. There is a possibility reporting rates and speed of their closure has been affected.

New User Guides and videos have been created and uploaded onto StaffRoom to assist both junior doctors and supervisors. Key changes to highlight are:

1. Junior doctors can no longer select multiple breaches in a single report (e.g.: overtime and missed breaks). However, if the text contained within the report indicates this is the case then we are tracking them as such.

2. The breaches doctors can select from are phrased differently.

3. Supervisors no longer close a report but complete an "initial review". Once an initial review is submitted the junior doctor must agree/disagree with the outcome before the report is officially closed. The new pathway is attached as Appendix 1.

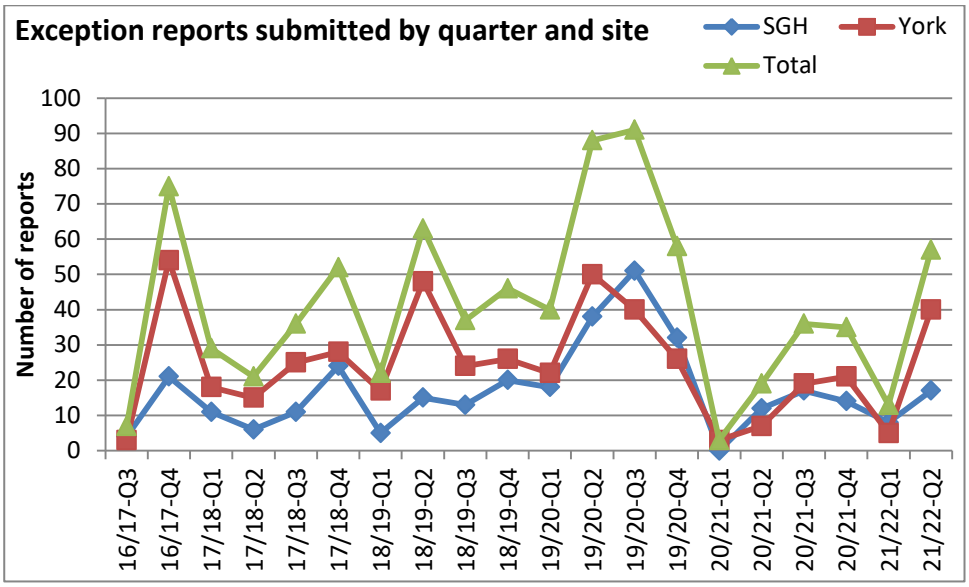
4. The Guardian team cannot manage reports on behalf of supervisors or in their absence. A workaround has been devised through the creation of a supervisor account under the name Dr Exception Reporting. The primary supervisor can be reassigned to this account which is accessible only to the Guardian team.

/ 2.1.1 Summary of fines for quarter 2

The balance of Guardian funds is currently £596. No fines have been applied in Quarter 2.

Although the balance of Guardian funds in cost centre 113003 is currently £596, £500 has been ring fenced for use towards the York Doctors Mess. **This means that the actual available balance is £96.**

/ 2.1.2 Exception reporting trends



There has been a fourfold increase in the number of Exception Reports submitted in Q2 compared to Q1. As demonstrated in the chart above this reflects the peak seen after Junior Doctor changeover in years pre-dating COVID-19. The trend may mark the end of the modest reporting rates that persisted since the pandemic began.

The 57 valid reports in Q2 came from 27 doctors.

A further 8 were cancelled after being submitted in error and have not been factored into the statistical calculations. Interestingly, the ‘error’ for some of these reports lay within the e-roster software. The Medical/Elderly FY1 ward shifts were listed as 08:30-20:30. Doctors were being told to arrive at 8am and understandably submitted Exception Reports highlighting this variance. Upon investigation it should have been on the e-roster as 08:00-20:30; timing reflected accurately in work schedule and pay. The issue has been resolved and we contacted affected juniors to reassure and update them.

The majority of reports continue to be submitted by Foundation Year 1 and 2 doctors. The breakdown in distribution is as follows:

- 44 (77%) came from Foundation level doctors in training
- 10 (18%) came from CT1-ST3 level doctors in training
- 3 (5%) came from CT3 equivalent Trust grade doctors.

Most reports continue to originate from doctors working in departments under the umbrella of General and Elderly Medicine. This is reflective of the inpatient bed base. The breakdown according to Care Group and department is detailed below. It is worth noting

that the specialty recorded reflects the doctor's primary base but not necessarily where they worked the shift in question. This is usually the case in reports related to out-of-hours shifts.

- 28 reports (49%) were received for **care group 1** at York Hospital (6 x educational):
  - 11 from general medicine (respiratory)
  - 9 from elderly
  - 3 from general medicine (renal)
  - 2 from general practice placements
  - 2 from acute medicine
  - 1 from general medicine (gastroenterology).

- 13 reports (23%) were received for **care group 2** at Scarborough Hospital:
  - 9 from general medicine (diabetes & endocrinology)
  - 2 from elderly
  - 2 from general medicine (cardiology).

- 13 reports (23%) were received for **care group 3** (1 x educational):
  - 5 from general surgery
  - 3 from anaesthetics
  - 3 from urology
  - 2 from vascular surgery.

- 1 educational report was received from **Care Group 5** (Obstetrics & Gynaecology) and the final two reports from **Care Group 6** (Trauma and Orthopaedics) (1x educational)

- No reports were received from **Care Group 4** for this period.

40.35% of exception reports were closed within 7 days. This is the lowest rate since records began. This is an effect of the Trusts new exception reporting system as described earlier. Reassuringly, the rate of reports actioned by supervisors within the 7 day target remains higher at 67%, although it still represents a drop.

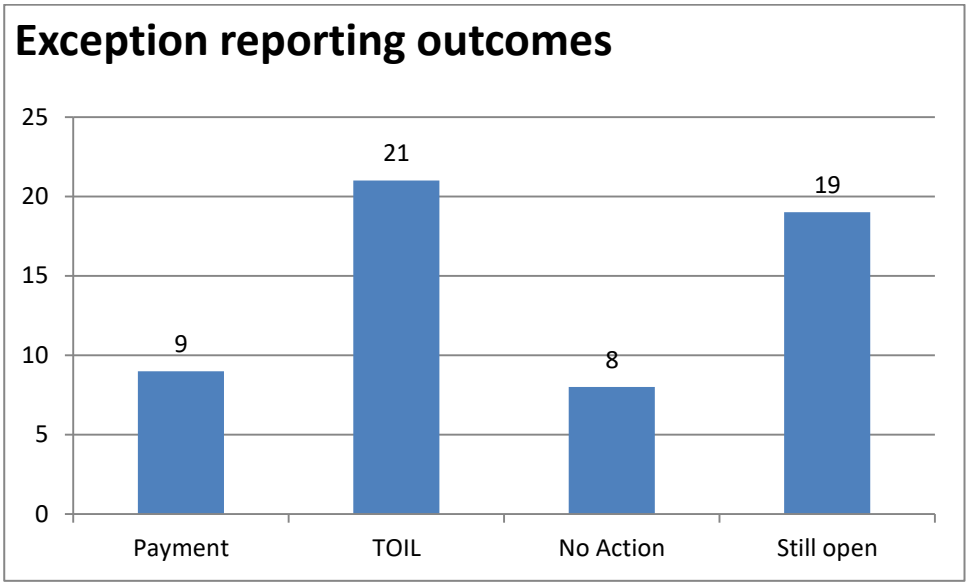
The majority of reports (48 / 84%) related to Hours and Rest issues, mainly claims for additional hours worked and missed rest breaks. The top recorded theme was 'perceived staff shortage' followed by 'unreasonable workload' and 'unavoidable delay'. The latter refers to events such as the need to liaise with families or attend to deteriorating patients at the end of a shift.

The remaining 9 reports are concerned with education and training issues. The Director of Medical Education receives all such reports. The majority pertain to inability for trainees to obtain their Self Development Time (SDT). SDT is relatively new and is a mandatory (but not contractual) component of training. It is the equivalent of SPA time for consultants. Some rosters in the Trust have SDT built in whilst others recognise the variability between teams and Junior Doctors are advised to agree bespoke patterns with their supervisors at the beginning of each placement.

There is ongoing discussion regionally (and potentially nationally) as to whether a failure to achieve SDT should be highlighted via Exception Reporting. The reason for this is a

difference in guidance from Health Education England and NHS Employers. Trusts vary from actively encouraging to discouraging reports for missed SDT.

Reporting SDT does not lead to the provision of time off in lieu (TOIL) or payment and is being used as a mode of monitoring. Locally we have not taken a stance either way and are focussed on ensuring junior doctors and supervisors are aware of SDT allowance and the need to agree a plan for its utilisation. Exception reports provide us with a further opportunity to inform and advise on the rules surrounding SDT.



Several reports remain open pending agreement from the reporting doctor. Unfortunately, in some cases this is a result of them now being absent through sickness.

/ 2.1.3 Trauma and Orthopaedics, Scarborough

Recent reports to the Board have highlighted the high volume of exception reports from doctors working in trauma and orthopaedics. Further investigation revealed a need for more staff rather than a change in roster design. As a result of escalation by the Guardian this has resulted in HEE trialling the move of one FY1 doctor from general surgery to orthopaedics in 2022/23. The post will be permanent based on the training and supervision received by the doctors.

There remains a need for a doctor to be recruited into the vacant Trust Grade position; this is ongoing.

/ 2.2 Junior Doctors' Forum

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

Vice-Chairs for the 2021/22 period have been appointed after doctors were given the opportunity to register an expression of interest in taking up the posts. Voting was not necessary as only one entry was received for each site:

- Dr Ceejay Ochukpue (Scarborough)
- Dr Muhaned El-Gheryani (York)

/ 2.2.1 Rostering

This is an area of ongoing discontent among junior doctors. They are aware of the staffing shortfall within the rostering team but morale is low and patience is wearing thin.

Electronic rostering has been launched for general & elderly medicine across York and Scarborough. Junior doctors report this being done with limited communication and no guidance on how to use the software. The Guardian team agreed to host user guides on the Forum intranet webpages. However, on reviewing the guides available from the provider they are too generic and unlikely to be of much benefit. Locally produced guides will be pursued.

There have been problems with doctors receiving timely access to the software when moving from specialties not currently on e-rostering or other hospitals. A delay in uploading rosters from December 2021 is affecting the ability for doctors to request annual leave. There are also reports of a recurrence in delays receiving a response to requests for leave and communication in general. All of these items have been raised with senior leaders in Medical Staffing and Rostering. The Guardian has recommended the development of a dedicated enquiry line that is staffed Monday – Friday, 08:00-17:00. This would allow simple queries to be dealt with immediately, more complex items to be triaged to the appropriate person, reduce constant disruption to the rest of the team and eventually improve relations with junior doctors.

/ 2.2.2 Handover location, York

A recurrent item raised at JDF in recent months has been the lack of a dedicated space for General & Elderly Medicine handover. Previously handover was held in the Operation Centre but this is now in permanent use. Doctors report significant variation in the quality of handover and the risk this poses for patient safety. The issue has been raised in other forums, in particular Hospital out of hours steering group and Local Negotiating Committee. The Guardian has liaised with senior clinicians and managers in the care group to support the identification of a suitable location. A list of all available spaces with details on technology (computer, mounted screens, telephones), capacity and location has been collated and supplied to them.

/ 2.2.3 Junior Doctor Awards

In the Q1 Board report we shared the names of all finalists. A small, cross site COVID secure event was held. The winners for 2021 are:

Compassionate Care:
Dr Ruairidh Kerrigan.

Educational/Clinical Supervisor:
Mr Matthew Harbottle.

Outstanding contribution to QI or research or teaching:
Dr Mohamad Kajouj.

Rising Star (joint top scores):
Dr Sarah Burn, Dr Adam Ferguson and Dr Thomas Holder.

Team Player:
Dr Kiandokht Rostami Monjezi.

/ 2.3 Annual Guardian Survey

The annual Guardian of Safe Working Hours survey opened on 10 June 2021 and closed on 19 July. Response rates were low providing limited scope for interpretation. A copy of the final report is contained as Appendix 2.

/ 2.4 Additional issues raised to Guardian

Junior Doctors are encouraged to contact the Guardian outside of Forum meetings if necessary. The low attendances at Forum meetings do not reflect this activity.
Recent activity includes supporting doctors in accessing decisions about leave – entitlement as Less Than Full Time doctors and the processing of requests, advising trainees on contractual regulations around rest and rostering, and signposting doctors to appropriate services.

/ 2.4.1 Emergency rest facilities

The 2016 contract stipulates that doctors who finish a long day or night shift and do not feel safe to drive home should be provided access to free accommodation or transport. The process for this within the Trust was established several years ago and elements are in need of review. The refurbished on call area in Scarborough Hospital is now complete and provides an in-house option. Discussions are ongoing into developing a process for managing these rooms in general, but in such a way that incorporates a method for them to be utilised by Junior Doctors in this predicament.

/ 2.5 Summary of rota gaps

Data on medical and dental staffing is only produced every two months so this data is the most recently available (at 31 August 2021):

	Covered by trainee/Trust Grade	**Vacant**
York	300 (90.09%)	33 (9.91%)
Scarborough	149 (88.17%)	17 (11.83%)

Training posts

	Filled	**Vacant**
York	77 (85.56%)	13 (14.44%)
Scarborough	47 (88.68%)	6 (11.32%)

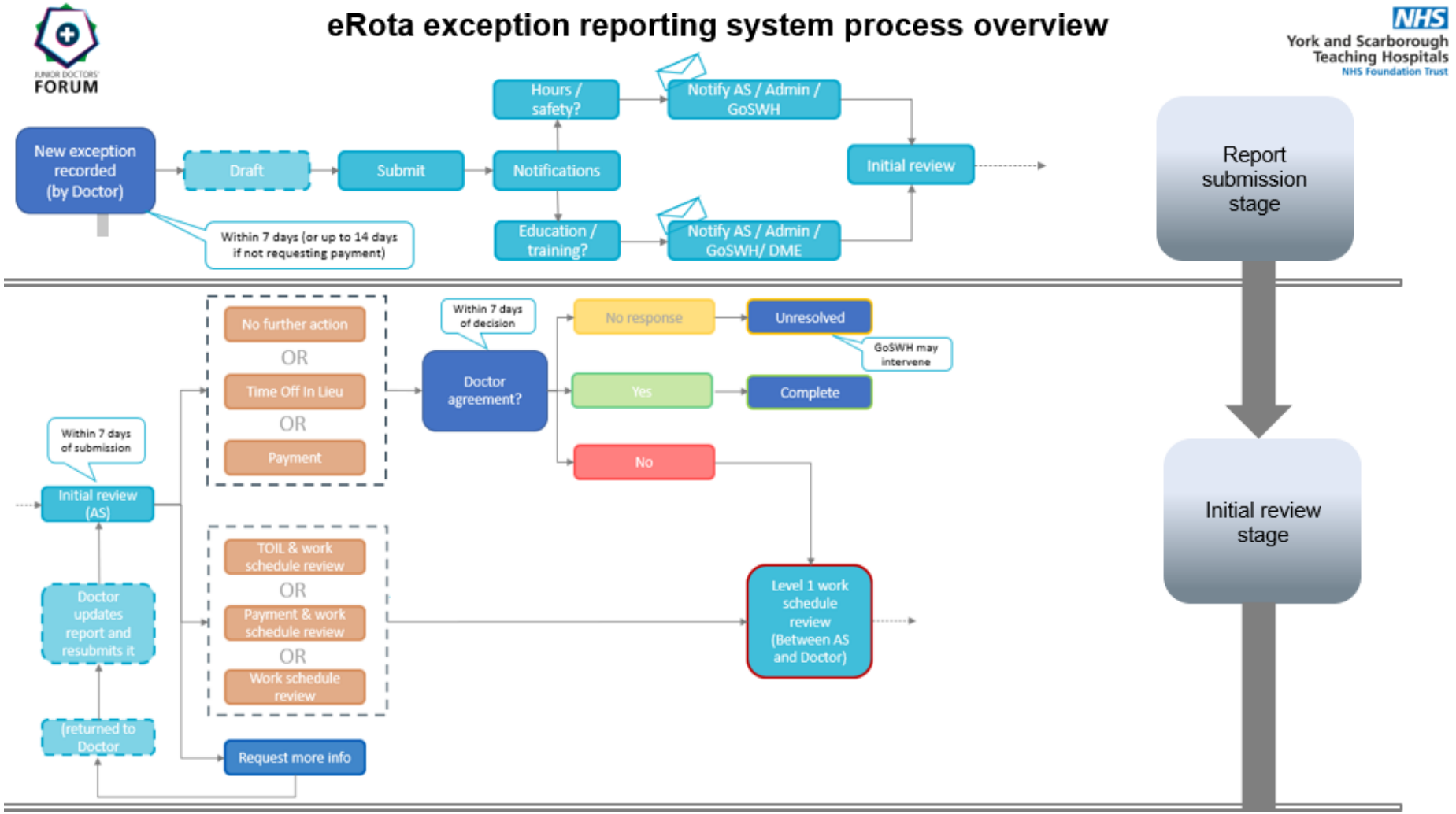
Non-training (non-consultant) posts

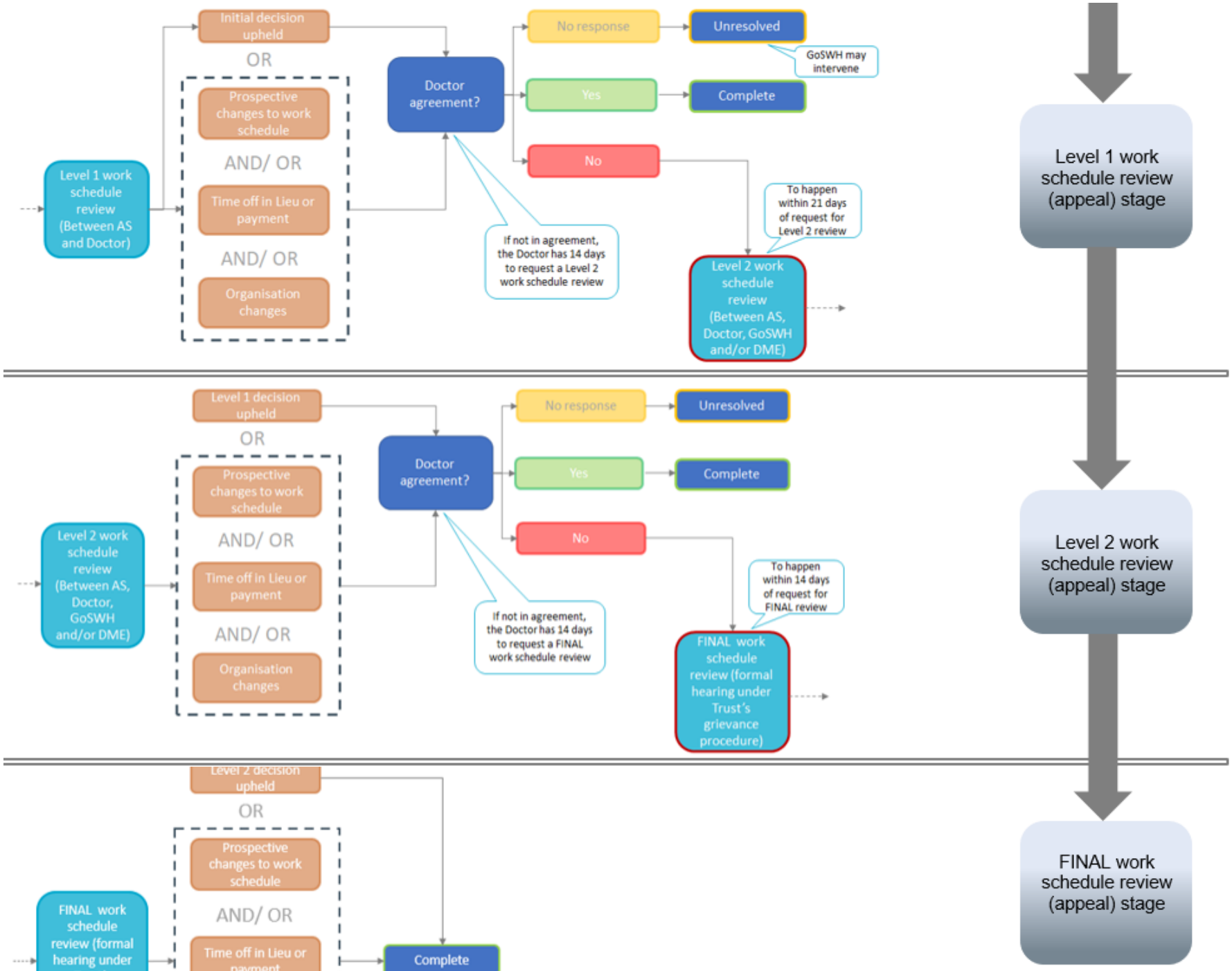
Author: Dr Ruwani Rupesinghe, Guardian of Safe Working Hours

Director Sponsor: Mr James Taylor, Medical Director

Date: 15 October 2021

Appendix 1


eRota exception reporting system process overview
JUNIOR DOCTORS' FORUM
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust
New exception recorded (by Doctor)
Draft
Submit
Notifications
Hours / safety?
Notify AS / Admin / GoSWH
Education / training?
Notify AS / Admin / GoSWH/ DME
Initial review
Within 7 days (or up to 14 days if not requesting payment)
Report submission stage
Within 7 days of submission
Initial review (AS)
No further action
OR
Time Off In Lieu
OR
Payment
Within 7 days of decision
Doctor agreement?
No response
Unresolved
GoSWH may intervene
Yes
Complete
No
TOIL & work schedule review
OR
Payment & work schedule review
OR
Work schedule review
Level 1 work schedule review (Between AS and Doctor)
Doctor updates report and resubmits it
(returned to Doctor
Request more info
Initial review stage



For any questions about the exception reporting process please contact:
Junior Doctor Contract Coordinator
771 2591 / 01723 342591

JUNIOR DOCTORS' FORUM

Appendix 2

Guardian of Safe Working Hours (GoSWH) Survey Results 2021

Introduction

In July 2017 the Guardian issued a survey to get feedback from Junior Doctor Forum (JDF) members and Local Negotiating Committee on the GoSWH role. In May 2018 the JDF decided the survey was a good opportunity to acquire more detailed intelligence on the experience of working within the organisation. The Royal College of Physicians shared the questionnaire they used to collect data for the "Being a Junior Doctor" publication. Elements of this have been incorporated into the survey since 2018 as a separate section for Junior Doctors only.

The survey was accessible online via Microsoft Forms or by contacting the Junior Doctor Co-ordinator for a copy to be sent via email or print. The survey was open between 10 June 2021 and 19 July 2021.

People were invited to complete the survey via email which was distributed to all junior doctors, consultants, and JDF members who were encouraged to share the information. The survey was advertised via the JDF Twitter account and poster displays in the Education Centres (Scarborough and York).

Only anonymised data was available to the GoSWH for analysis.

Response rate

Only 27 responses were received which represents a significant drop from a total of 41 in 2020. In 2020, the distribution was 28 junior doctors and 13 from other staff groups. This year only 12 of the 27 submissions are from junior doctors.

PART A: Guardian (results)

Awareness of the role and effectiveness:

Slightly more than 90% of respondents reported knowing what the purpose of the Guardian role is. This is static compared to previous years.

For the first time the survey asked responders to select what staff group they fell into. Standard NHS categories were used. The breakdown of results is as follows:

- 12 Medical and Dental (Junior Doctor in approved postgraduate medical education and SAS/Trust Grade/locally employed doctor/staff grade/trust grade)
- 10 Consultants

- 4 Administrative and Clerical
- 1 Estates and Ancillary.

74% of responders felt the Guardian at met their expectations. A proportion (18.5%) felt the statement was non-applicable to them.

One person disagreed and another strongly disagreed. The responder who 'strongly disagreed' did not leave any further details as to why this is the case. The responder who 'disagreed' stated *"I called once and the message that came across was "not my problem"*."
The following statement was left by a Junior Doctor who felt the statement was 'not applicable' to them: "*Never exception reported in my role. Always leave on time or can easily make back the time following discussion directly with colleagues so no need to exception report."*

93% (25) of responders agreed (11) or strongly agreed (14) that the Guardian had advocated on behalf of Junior Doctors. Of these 11 are Junior Doctors. The individuals who 'disagreed' and 'strongly disagreed' that their expectations had been met reported the same views in this question. No additional comments were received.

The majority of responders, 16 (60%), selected 'not applicable' to the statement "The Guardian of Safe Working Hours has treated my concerns seriously". 10 'agreed' or 'strongly agreed' that concerns are taken seriously. The individual who detailed the phone call referenced earlier understandably disagreed with this statement. 9 individuals expressed satisfaction that concerns are escalated appropriately. The remaining 18 individuals felt the statement was not applicable.

85% (23) responded favourably as to whether the "role is making a difference to the safe working environment of Junior Doctors". Of the 4 who don't feel this this to be true, 2 are Junior Doctors and 2 are Consultants. Both Junior Doctors 'disagreed' whilst both consultants 'strongly disagreed' with the statement. Of particular note is that two of the four provided positive feedback in other areas of the survey. The inference being that despite complementary views on intent there is scepticism over whether the role has any impact.

Independence, credibility and visibility:

93% (25) of responders believe the Guardian is independent from the Trust. A Consultant and Higher Specialty Trainee disagreed with this statement. Only the trainee left a comment which read, "I don't know". In 2020, 37 (90%) responders felt the Guardian was independent compared to 4 who didn't. Two Consultants and a Higher Specialty doctors do not believe the Guardian has credibility within the Trust. No comments were received.

85% (23) respondents believe the Guardian has been visible within the Trust. 2 Consultants and 2 Higher Specialty doctors did not agree with this statement. 8 out of 41 (19.5%) respondents in 2020 did not feel the Guardian had successfully engaged with Clinical and Educational Supervisors. This number has dropped to 4 out of 27 (14.8%). Importantly, 8 individuals in 2020 and 2021 deemed this question to be 'not applicable'. Of the 3 doctors who do not believe there has been successful engagement 2 are Consultants and one is a Higher Specialty doctor.

Appendix 2

PART B: Junior Doctor's only

Participants:

12 individuals were able to progress into Part B of the survey which is aimed solely at Junior Doctors working within the organisation. As the term 'Junior Doctor' encompasses a wide range of grades, individuals in formal national training programmes and permanent members of staff we asked responders to identify which category they best fit into.

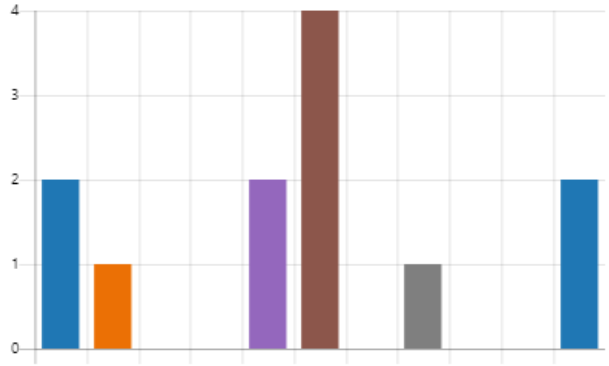
Individuals could select one of the following:

- Foundation Year 1
- Foundation Year 2
- Post-foundation but not currently in a training programme (currently in a clinical role)
- Post-foundation but not currently in a training programme (currently in a non-clinical role)
- Core medical trainee
- Higher specialty trainee (currently in a clinical role)
- Higher specialty trainee (currently in a non-clinical role)
- Specialty registrar not currently in a training programme (currently in a clinical role)
- Specialty registrar not currently in a training programme (currently in a non-clinical role)
- Other: (please state).

16. What is your current grade?

More Details

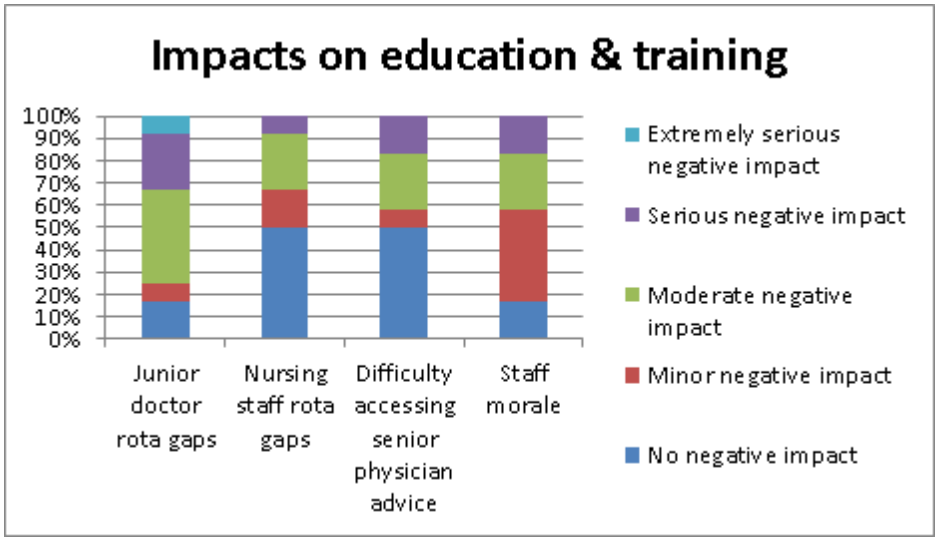
Foundation Year 1	2
Foundation Year 2	1
Post-foundation but not curre...	0
Post-foundation but not curre...	0
Core medical trainee / IM	2
Higher specialty trainee (curre...	4
Higher specialty trainee (curre...	0
Specialty registrar not currentl...	1
Specialty registrar not currentl...	0
N/A	0
Other	2

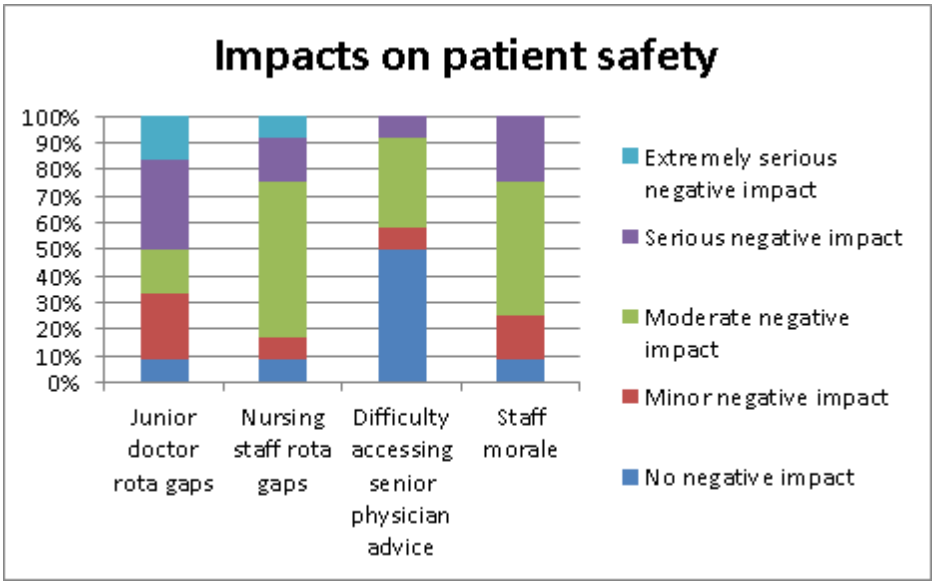


Training and patient safety:

Part 2, Questions 2 and 3 are aimed at gauging the impact rostering gaps, access to senior clinicians and morale are felt to be having on patient safety and Junior Doctor education/training.

Appendix 2





Junior doctor staffing varies, but on a bad shift where there are gaps in Registrar rotas and SHO rotas it can feel extremely busy and unsafe.

Juniors are often left alone with no senior input. Very stretched covering wards

Not enough junior doctors on medical wards often meaning ward rounds are rushed when there is no consultant on. Too many patients to review and jobs to complete.

Health and wellbeing:

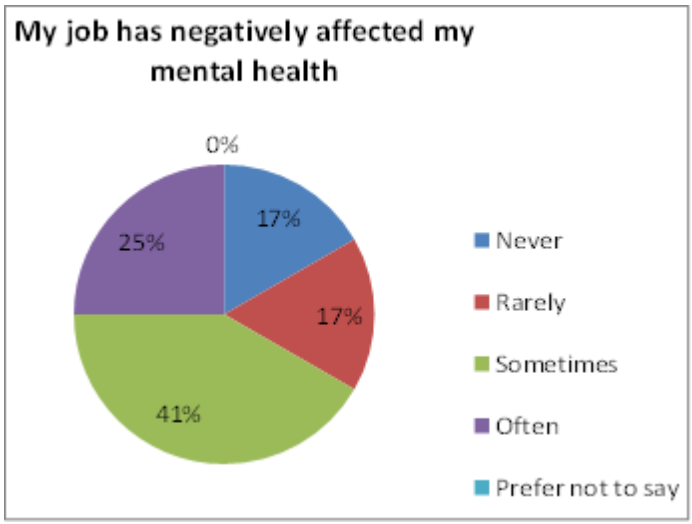
42% (5) of individuals reported working a shift <u>without</u> having a meal in the preceding month. This is comparable to 2020.

58% (7) reported working a shift <u>without</u> adequate hydration in the preceding month. This has been consistently over 50% since data collection began despite some variability.

…but almost always cutting breaks short just to deal with the volume of work. If I don't then I'll just end up staying longer at the end of a shift or handing more tasks over to the next doctor. I am happy to hand some tasks over, but obviously keen to hand over as little as possible to give the next doctor the best chance of keeping on top of their workload on their shift

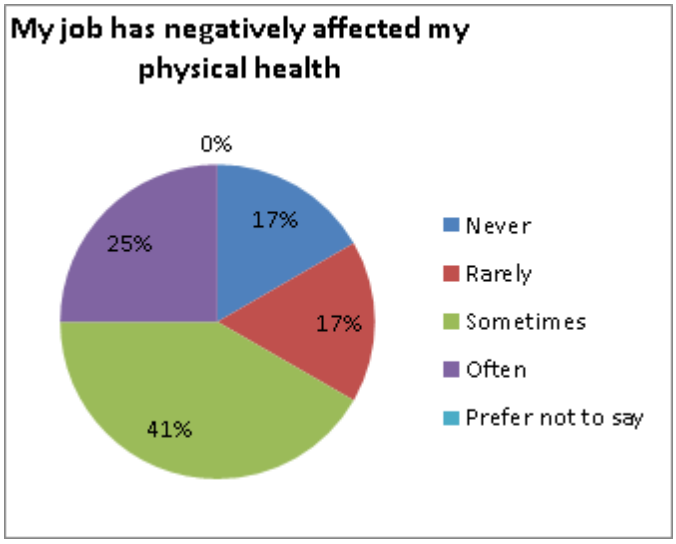
Appendix 2

Every shift- no water machine or easily accessible tap where I work. If this was changed then it would solve the issue

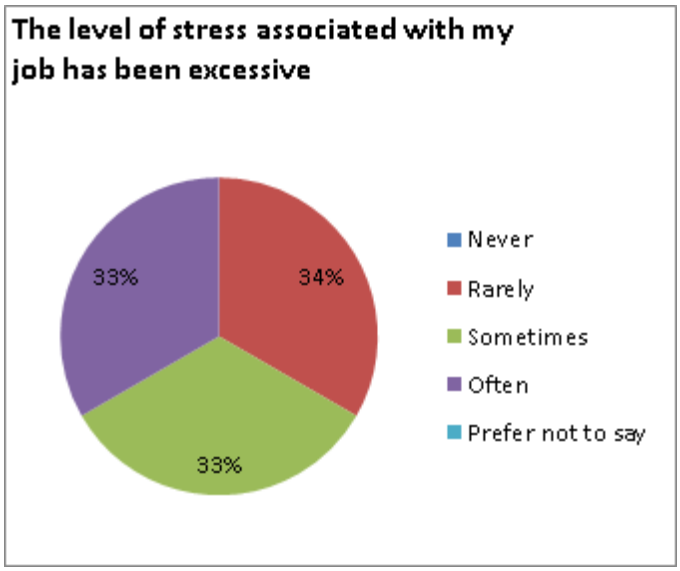


Doctors were asked to rate on a scale from 'never' to 'often', how often the following statements are true for them:

47% of responders expressed a negative impact on mental health sometimes or often in 2020.



50% of responders expressed a negative impact on physical health sometimes of often in 2020.



57% of responders reported experiencing excessive level s of work associated stress sometimes or often in 2020.

Appendix 2

Additional comments made are included below:

The change in shift times to always starting at 8am means that as I commute I am waking up very early every day. I do worry sometimes that I am not safe to drive - particularly on days after long days when I might not get home until 10pm and then still have to be up at 6 to leave the house before 7am to get to work on time. I appreciate it is my choice to live where I do, but the start time in most hospitals I have worked at is 9am, an 8am start for all medical juniors (rather than just oncall teams) is a hangover from COVID I think, that hasn't gone away. I am a first year registrar trust grade and over the last few months I have noticed increasing gaps in the registrar rota which are just not being filled pro-actively, if the rota is no longer sustainable in York due to numbers then it should be altered so that a minimum safe number is maintained rather than some shifts just having no-one and relying on the rota team to fill or others to feel pressure to fill the shifts as otherwise there would be no cover

"Irregular shift pattern and quick return to work post nights is hard. Difficult to achieve things on post nights off days like exercise and planning healthy meals due to lack of energy. Frequently stood up in a&e department for large parts of the shift resulting in back pain. Increasing a&e pressures the last few weeks impacting on job satisfaction as unable to provide the quality of care for patients that the department is capable of"

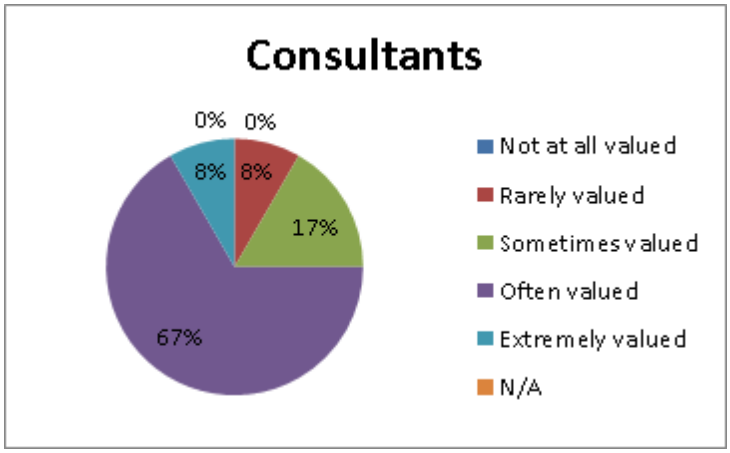
"Commuting with young children is the biggest factor"

"I think this is part of medicine and it will always be a stressful job, so I don't think it's possible to make it totally stress free. However, I would say the last 6 months have been the most stressed I have ever been at work so things are probably getting worse rather than better, it would be good if things were heading in the other direction"

Doctors were asked to rate on a scale from 'not at all valued' to 'extremely valued', how they felt from each of the following staff groups:

a) Consultants
b) Other trainees
c) Nursing staff you work with
d) Non-clinical managers.

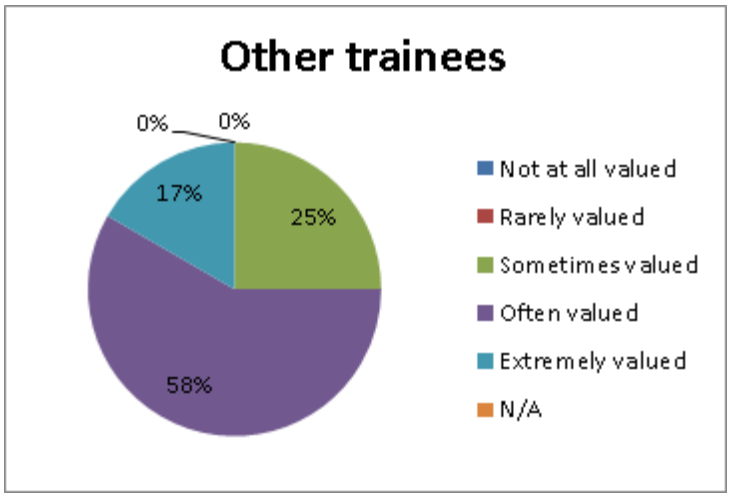
Appendix 2



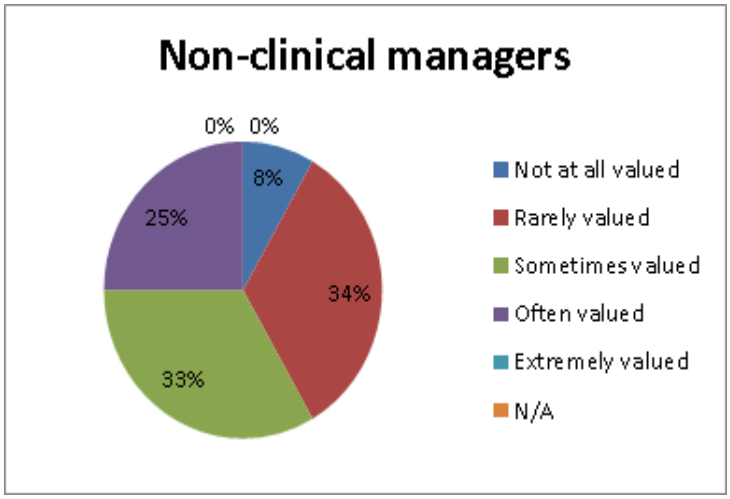
There is a clear change with Junior Doctors feeling valued more often by Consultant colleagues.

No doctors expressed feeling not valued at all which is an improvement compared to previous years.

There has also been a positive change in the proportion who express this is the case 'sometimes' versus 'often'.

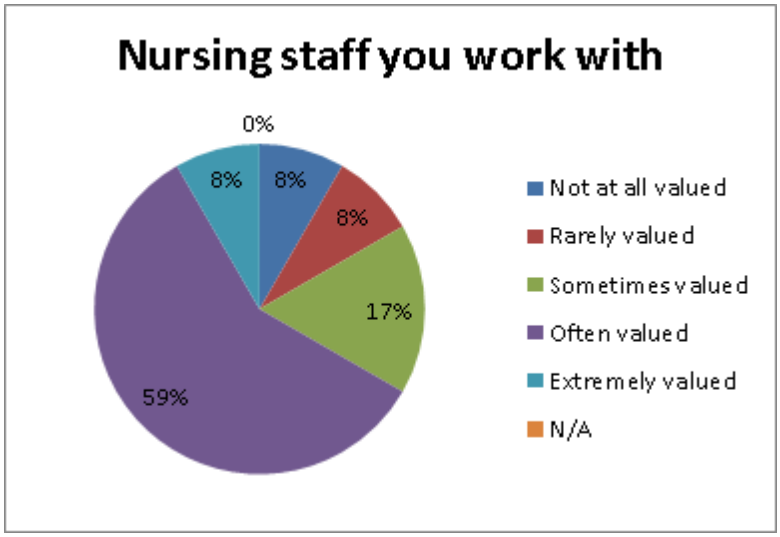


This is largely unchanged compared to previous years.



There is a lot of variation between each group each year. The proportion of Junior Doctors who express feeling 'not at all valued' or 'rarely valued' is consistently around 50%.

Appendix 2



The results vary every year with no clear trend. The largest proportion is consistently 'often valued' with a range from 41-59%.

Only one free text comment was submitted:

> ***It feels that issues are raised and then nothing happens. I feel that a lot of the issues we are having at the moment were predictable and should have been anticipated so that they could be avoided e.g. stronger leadership within the rota team re. leave for junior doctors***

Comments and suggestions:

All individuals who completed the survey (i.e. including non-Junior Doctors) were given the opportunity to comment on how they would like to see the role develop or make any other observations. Only two comments were received which reflect polar opposite views on awareness of the role.

> ***"This role is not something that I was formally aware until an issue with a junior doctor arose. Until then I had no idea about the post"***
>
> ***"Ru engages well, is valued and kind"***

Discussion and actions

Actions from last year's survey have been completed. The survey has been altered to allow more opportunity for people to leave comments and identify broadly what staff group responders fall into.

Junior Doctor Forum Twitter and Instagram accounts have been established to enhance communication with Junior Doctors as evidence exists that demonstrates poor engagement with Trust email (although this remains the primary mode of communication).

Key factors to take into account when interpreting the results from the survey are:

Appendix 2

1. The response rate.
2. COVID-19.

Minor changes in the number of responses received for any category appear more marked because of the response rate. This is also true of previous years with 2020 being an outlier. The comments left provide the richest data in these circumstances. Unfortunately, we received less free text this year compared to previous. Of the comments received many refer to issues that have been raised via other channels and are already under review or in the process of being addressed. In particular, access to annual leave, tiring ED rosters, rota gaps in medicine and access to water fountains.

COVID-19 led to a vast array of changes for Junior Doctors that likely account for the change in response rate seen in 2020. The onset of the pandemic was associated with changes in rosters, admission rates, availability of senior clinicians and greater interaction with non-clinical managers. Junior Doctors had already been in the Trust for a period of time before the pandemic began which meant relationships had already been established and individuals were relatively settled. A large proportion of Junior Doctors who form the body of this year's cohort will have joined the organisation towards the end of 2020 or early 2021. This coincides with the second wave of the pandemic and an attempt to begin recovery work. As a result resources have been spread more thinly. In addition, they haven't been afforded the same opportunity to forge networks within the organisation due to restrictions on induction, training sessions, face-to-face meetings and social activities. There have subsequently been fewer opportunities for the Guardian to interact with Junior Doctors and establish the same level of Trust and engagement.

The low response rate this year is a disappointment following the dramatic rise in 2020. The primary goal for 2021/22 is to re-establish close links with the Junior Doctor body. It is also imperative that successes are shared more widely to encourage engagement and dispel the view that the role doesn't contribute to the safe working environment for Junior Doctors.

Conclusion

The annual survey allows us to gather intelligence shortly before junior doctor changeover. Doctors will have rotated through the organisation for approximately a year giving them insight into a broad range of positives and negatives. The survey is aimed at providing the opportunity to feed this back in an anonymised manner prior to leaving the organisation. This year responses are low and the comments received have not identified new areas of concern – which one could argue demonstrates that current modes of communication are sufficient to identify problems.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
NHS England Emergency Preparedness Resilience and Response Annual Assurance

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

The Board is asked to:

- Note that following a self-assessment process against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Standards, the Trust has rated itself as "Substantially" compliant. This is the same rating reported in 2019-20.
- Note the progress with the EPRR agenda since the last update in September 2019 and the impact that COVID-19 has had on the EPRR work plan.
- Note the key priorities and updated action plan for EPRR that will be implemented over the next 12 months.

Executive Summary – Key Points

The NHS England Emergency Preparedness Resilience and Response (EPRR) Annual Assurance process was suspended for 2020-2021 as nationally, regionally and at Trust level EPRR staff were fully occupied coordinating the NHS response to COVID-19. The assurance process for 2021-2022 has been re-instated, however a number of standards have been withdrawn from this year's process acknowledging that in the last 18 months either the standards were impossible to achieve or would have been routinely achieved as part of the COVID-19 response.

The 2021-2022 EPRR Annual Assurance process consists of a self-assessment against 67 standards grouped into 10 domains. It should be noted that the "Training Domain" has been withdrawn from this year's process in its entirety acknowledging that the ability of staff to be released from duties has been difficult. The result of the self-assessment is that the Trust is declaring full compliance in 63 standards and partial compliance in 4. An action plan to remediate the partially compliant standards can be found at Appendix 2.

The Board is asked to note that following the self-assessment process against the NHS England EPRR standards, the Trust has been rated as "substantially" compliant overall. The Accountable Emergency Officer has signed the Certificate of Compliance that can be found at Appendix 1.

The pre-COVID-19 EPRR work focussed on implementing the improvements recommended as a result of LIVEX 18. The appointment of the Emergency Planning Manager has enabled the formal establishment of the EPRR portfolio. The current period has been dominated by COVID-19 and has provided the opportunity to embed command and control processes into the Trust, validate a number of plans from the lessons learnt from the COVID-19 response and to then update a number of Trust plans, including the Trust Incident Response Plan which has been refreshed and re-formatted into a single document with a number of supporting Annexes. Work conducted in this reporting period to update the Incident Response Plan and Annexes is as follows:

Document	Work Conducted Since Last Report
Trust Incident Response Plan (IRP)	Oct 20 - Refresh completed to incorporate COVID-19 lessons
Annex A – Command and Control	Oct 20 - New plan written as a result of COVID-19 experiences
Annex B – Mass Casualty Response	Oct 21 - Preparation of draft is underway
Annex C – Trust Call In Plan	Mar 21 - New plan written and implemented the CONFIRMER Mass Notification System
Annex D – Restricted Access Plan	Jun 21 - New plan in draft
Annex E – Evacuation Plan	Oct 21 – Completion of first draft is imminent
Annex F – Business Continuity Plan	Dec 20 - Re-write completed to incorporate new Trust structure and staffroom reorganised
Annex G – Adverse Weather Plan	Mar 21 - New plan written to incorporate heat, cold, flooding and air pollution
Annex H – Pandemic Flu Plan	Oct 20 - Re-write of 2015 plan to reflect lessons from COVID-19 response and include an escalation plan
Annex I – Fuel Disruption Plan	Jun 21 - New plan written
Annex J – CBRN Plan	Oct 21 - Re-write complete and awaiting dissemination

In addition to the revision of plans the EPM has completed the following major projects during this reporting period.

- The Confirmer Mass Notification System has been developed, implemented and routinely tested to provide a Trust Call In capability in the event of a major incident.
- The Trust Intranet Business Continuity page has been re-organised to reflect the Care Group structure. This required 750+ action cards to be uploaded onto the website.
- The Business Continuity working group has been re-invigorated and work continues to enhance business continuity plans.
- Contingency planning has continued throughout the period; one notable success is the preparation of a contingency plan to receive evacuees should Airedale Hospital need to be evacuated due to structural failings.

A number of strands of work in the EPRR portfolio are outstanding or require further focus as the country emerges from the COVID-19 pandemic. They are:

- **Mass Casualty Response Plan.** The majority of Trust actions required to respond to a mass casualty Major Incident are included in the Trust IRP. There are however specific actions that need to be captured into a separate plan for mass casualties and these include: the clearance of ED in 30-45 minutes, the ability to make 10% of adult general and acute beds available in 6 hours, the ability to make 20% of adult general and acute beds available in 12 hours and to double ITU Level 3 capacity for 96 hours. The EPM is currently preparing a draft of this plan for stakeholder consultation and completion of the task is envisaged in Spring 2022.
- **Evacuation Plan.** The Trust Evacuation Plan is in draft format. Stakeholder engagement is now required followed by validation of the plan through training events. This is to be completed by the Spring of 2022.
- **Training.** he availability of staff during the COVID-19 response to undertake training has been challenging which has resulted in a suspension of Emergency Planning and

Business Continuity training. The EPM is producing the 2022 Training Plan which will set out how the Care Groups will re-engage with the training of staff in emergency and business continuity plans, prioritising chemical decontamination at York Hospital. A full training programme will recommence when the COVID-19 response allows.

Recommendations

The Board is requested to:

- Approve the report and assurance rating of "substantial" compliance with the NHS England EPRR Core Standards.

Author: Richard Chadwick, Emergency Planning Manager

Director Sponsor: Wendy Scott, Chief Operating Officer and EPRR Accountable Officer

Date: 25th October 2021

1. Introduction and Background

Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can plan for and deal with a wide range of incidents and emergencies that could affect health or patient care. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

On an annual basis, The NHS England Core Standards for EPRR set out the minimum standards that NHS organisations and providers of NHS funded care must meet. The Trust is required to undertake an annual self-assessment against these standards and provide assurance to NHS England that robust and resilient EPRR arrangements are in place and maintained within the Trust. In 2016/17 and in 2017/18 the Trust reported that it was "partially" compliant with these standards – meaning it did not fully meet 10 of the core standards. In 2018/19 and 2019/20 the grading improved to "substantially" compliant – meaning that it complied with 89% to 99% of standards.

Following this year's self-assessment process the Trust is again declaring a "Substantially" Compliant rating. **The Board is requested to note this compliance rating.** The action plan in the appendix to this report sets out the key actions required to further strengthen the Trust's compliance with these standards and will be addressed over the next 12 months.

2. Significant EPRR Incidents and Events of Note in the Last 24 Months

2.1 The Impact of COVID-19 Response on Delivery of EPRR Portfolio

The initial meeting of the Pandemic Operational Group took place on 19th February 2020 and signalled the establishment of a formal command and control structure to coordinate the Trust response to the pandemic outbreak. The Emergency Planning Manager was stood down from routine duties in order to assume the SILVER Staff Officer role and coordinate the Incident Coordination Centre. Although not formally declared, the pandemic outbreak response was managed in line with Critical Incident, with levels of incident management activity fluctuating as the outbreak progressed.

The availability of staff to conduct routine training has been challenging during the response to COVID-19. This has resulted in no formal individual, team or departmental EPRR training taking place over the last 18 months. This has impacted the levels of trained staff to respond to incidents (i.e. chemical decontaminators), staff situational awareness of emergency plans and the ability for staff to respond to business continuity incidents. The requirement to operate in a command and control structure in response to the pandemic has validated Trust Emergency Plans and improved and widened the tactical level of understanding of how the Trust should operate in an incident.

The lessons identified from the 3 major waves of COVID-19 have provided objective evidence of those processes that have worked well, those that have had little impact and those that could be improved. Significant activity to re-write Trust Plans has been undertaken to exploit this learning and to incorporate lessons into existing plans. These opportunities, although welcomed, will increase the training burden in 2022 and 2023 to ensure all staff understand the amendments and adaptations.

The response to the pandemic has also resulted in scrutiny from our auditors which has been most welcome. A significant area of audit over the reporting period has been the Trust ability to recover from Business Continuity incidents. This has resulted in a total re-write of the Trust Business Continuity Plan to reflect the new and improved command and control structures and a reorganisation of the Business Continuity Working Group to reflect the new Care Group structures.

The Pandemic Outbreak resulted in the re-prioritisation of the EPM duties in order to co-ordinate the Trust response to a Critical Incident. Although this has impacted routine work it has provided an unprecedented opportunity to test, validate and adjust various plans in a practical setting.

2.2 Critical / Major Incident Command and Control

The largest EPRR benefit from the Pandemic response has been the refinement and embedding of an effective Command and Control structure that reflects the Care Group structure into the Trust. The structure is now widely understood and supported by clinical and operational managers alike.

Existing processes have been streamlined and strengthened; for example the 38 BRONZE Commands of the Directorate structure have been reduced to 10 BRONZE Commands reflecting the Care Groups and support services. There is now a single Trust SILVER Command to coordinate the Trust response across both sites. Cohorts of clinicians, nurses and operational managers have been nominated to undertake specific duties in this structure and they understand and have practiced their roles and responsibilities. The result is a structure that has pre-defined points of contact, pre-define routes for escalation of issues and an established routine of meetings that can be flexed to reflect operational pressures.

Robust governance and assurance processes are embedded into the structure that defines roles and responsibilities allowing an agile response to requests for information, the compilation of reports whilst maintaining records of information leaving and entering the Trust. The situational awareness at all levels of the structure has greatly improved as a result and the ability of the Trust to escalate and de-escalate operational outputs is now agile and timely.

2.3 Development of Trust Emergency and Business Continuity Plans

The Trust Incident Response Plan has been updated and re-formatted into a single document with a number of supporting Annexes. Work conducted in this reporting period to update the Incident Response Plan and Annexes is as follows:

Document	Work Conducted Since Last Report
Trust Incident Response Plan (IRP)	Oct 20 - Refresh completed to incorporate COVID-19 lessons
Annex A – Command and Control	Oct 20 - New plan written as a result of COVID-19 experiences
Annex B – Mass Casualty Response	Oct 21 - Preparation of draft is underway
Annex C – Trust Call In Plan	Mar 21 - New plan written and implementation of CONFIRMER Mass Notification System
Annex D – Restricted Access Plan	Jun 21 - New plan in draft
Annex E – Evacuation Plan	Oct 21 - Preparation of draft is underway
Annex F – Business Continuity Plan	Dec 20 - Re-write completed to incorporate new Trust structure
Annex G – Adverse Weather Plan	Mar 21 - New plan written to incorporate heat, cold, flooding and air pollution
Annex H – Pandemic Flu Plan	Oct 20 - Re-write of 2015 plan to reflect lessons from COVID-19 response
Annex I – Fuel Disruption Plan	Jun 21 - New plan written
Annex J – CBRN Plan	Oct 21 - Re-write complete and awaiting dissemination

2.4 Chemical, Biological, Radiological and Nuclear (CBRN)

The Pandemic outbreak has resulted in limited availability of staff to undertake routine CBRN training and the Trust capital works programme has disrupted the routine plans for a CBRN response at the YTH site.

The ED staff that provide the decontamination capability have been focussed on delivering urgent and emergency care during the pandemic outbreak. Plans are to recommence, as soon as possible, for individual training of staff in the use of the Powered Respirator Protective Suit (PRPS)

Both EDs hold appropriate numbers of trained staff however the revision of skills and the training of new starters will be a priority for both sites and this will be reflected in the Training Plan for 2022.

The ED refurbishment and extension of the ED at York has resulted in the re-positioning of the CBRN store and the location of the decontamination tent. A successful CBRN table top exercise at York has validated the interim laydown plan and all equipment has been checked on both sites for serviceability. Both EDs retain a fully functional CBRN capability.

3. Governance and Leadership Arrangements for EPRR

The refinement of the command and control arrangements for the pandemic response provided the opportunity for the SILVER Commander role to be aligned with the Deputy Chief Operating Officer responsible for EPRR. This has brought coherence to the portfolio to allow continuity between emergency planning, resilience planning for winter, responding to operational pressure and business continuity. Work is now underway to strengthen the governance and assurance of EPRR through the working groups in the governance and assurance structure.

The Emergency Planning Steering Group (EPSG) is chaired by the Deputy Chief Operating Officer who coordinates the EPRR work plan on behalf of the Accountable Emergency Officer. In order to deliver the work plan there are 4 working groups that have now been formally established to conduct work and report to the EPSG. These are:

- **Business Continuity.** Chaired by the EPM with representation from BRONZE Business Continuity Leads. This group leads on the Trust Business Continuity Plan.
- **Infectious Disease.** Chaired by the Infectious Disease Lead Consultant with clinical representation from all Care Groups and the Infection Prevention and Control Team. This group leads on the Trust Pandemic Flu Plan and the plans for responding to High Consequence Infectious Disease.
- **CBRN .** Co-chaired by the Senior Operational Managers of Care Groups 1 and 2 with clinical and nursing representation from staff with an interest in CBRN. This group leads on the Trust CBRN Plan and the training of staff.
- **Major Incident .** This group is yet to be established. There is an aspiration to appoint a senior clinician as the chair and to have representation from clinical staff who have an interest in mass casualty planning. Although not directly responsible for a Trust Plan, this group will advise the EPM on clinical input to the Trust Incident Respose Plan, the Mass Casualty Plan and the Evacuation Plan. In addition they will coordinate clinical trauma training for those injuries not normally asscocuated with routine business i.e. gun shot wounds and blast injuries. The scope of this group has been described but the group is yet to be established as a clinical chair has not been identified.

This year a formal assurance process has been introduced to verify BRONZE Command's compliance with the production of a Business Impact Analysis and associated action cards. This process will be repeated annually to coincide with the EPRR Core Standards Annual Self Assessment process.

4. Plans for EPRR 2021/22

4.1 Re-establish EPRR Training in the Trust

Opportunities to conduct individual and collective training in emergency planning and business continuity have not been available over the last 18 months due to the pandemic response. Skill fade will be present in most teams, there will be new starters within the Trust and most plans have been adapted from the COVID-19 response lessons learnt. The priority for 2022 is to re-start the cycle of progressive individual and collective training.

The response to the Pandemic has been declared as a LIVE Exercise (LIVEX) and therefore the next large scale LIVEX for the Trust is due in 2024. The Emergency Planning Manager is writing the 3 year training plan to build towards that event. The focus for 2022 will be individual training moving to departmental training in 2023 and then consolidating with BRONZE/SILVER training in early 2024 prior to the LIVEX. Subjects that will be covered include On Call Induction Training, CBRN, Command and Control desk top exercises, mass casualty Incident Response, evacuation and restricted access.

The focus of LIVEX 2024 is yet to be set by the Trust and there is a requirement to explore what the event should focus on and whether there would be benefits from conducting the exercise in an Integrated Care System construct. Discussions have begun between Regional Trust EPRR leads chaired by the Head of EPRR for the North East and Yorkshire.

4.2 Plans and Policies for Development 2022

There are 2 plans that require development, consultation, implementation, dissemination and training as a matter of priority. They are:

- **Mass Casualty Response.** The Trust is mandated to have plans, on the declaration of a Mass Casualty Major Incident, to make available 10% of the adult acute and general beds within 6 hours increasing to 20% after 12 hours and to double Level 3 ITU capacity for 96 hours. In addition a response of this nature will require the immediate creation of space in ED to receive casualties. The Trust IRP provides much of the detail as to how this will be managed, however specific details need to be worked through to produce a plan acceptable to all stakeholders and supported by action cards to ensure timely action. The Emergency Planning Manager is currently undertaking an engagement process with stakeholders to develop a first draft for consideration. It is envisaged that this work will be complete by March 2022.
- **Evacuation Plan.** The Trust currently has a draft Evacuation Plan that has been developed from the identification of best practice across the NHS. This plan now needs to be shared with stakeholders to ensure the policies and processes are applicable to this Trust. Once this is completed then collective training will need to be undertaken to validate the plan and will then need to be regularly practiced. It is envisaged that consultation on the plan will be conducted by March 2022 and then, dependant on staff availability, training can be undertaken to validate the plan.

4.3 Integrated Collaboration with ICS

The pandemic response has further improved system collaborative working and the introduction of Integrated Care Systems (ICS) have provided an opportunity for this collaborative working to be integrated into the command and control of events wider ranging than just critical and major incidents.

Winter Resilience Planning has evolved from implementing a number of “winter schemes” to a set of plans that looks holistically at the challenges to operational pressures over the winter. Other events such as EUEXIT and serious Business Continuity incidents such as the disruption of NHS supply chains have benefitted from the wider use of system command and control to coordinate responses regionally and provide mutual aid.

The Emergency Planning Manager will continue to engage with ICS and regional EPRR partners to further exploit the opportunities that integrated working will provide.

5. Conclusions

The EPRR reporting period has been dominated by the unprecedented requirement for the Trust to respond to a global pandemic. Routine EPRR work has been subjected to disruption in the same

manner to other specialities. Opportunities have been taken to explore the lessons learnt from the response delivering a much more robust and integrated command and control structure as well as improving, albeit from a conceptual perspective, many Trust emergency plans. 2022 will be key to turning those conceptual plans into activity that trains the Trust staff to implement those plans.

The Trust remains substantially compliant with the EPRR Core Standards and is well placed to resolve the minor number of issues outstanding.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.
2. EPRR Core Standards Assurance – Action Plan 2021-2022.

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2020-2021

STATEMENT OF COMPLIANCE

York and Scarborough Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, York and Scarborough Teaching Hospitals NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

20/10/2021

Date signed

04/11/2021	24/11/2021	01/09/2022
Date of Board/governing body meeting	Date presented at Public Board	Date to be published in organisations Annual Report

EPRR Core Standards Assurance – Action Plan 2021/22

Ref	Domain	Standard	Detail	Self-assessment RAG	Action to be taken	Lead	By When
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level ITU capacity for 96 hours.	Partially Compliant	Arrangements exist in multiple documents (IRP, Pandemic Escalation Plan and OPEL Full Hospital Capacity Protocol) to achieve the standards set out in the detail. EPM is to bring together arrangements into 1 overarching Mass Casualty Plan with the inclusion of Action Cards	EPM	Mar 22
20	**Duty to maintain plans**	**Shelter and Evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors to and from the organisation facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Partially Compliant	Working drafts exist for evacuation, restricting access and receiving evacuees from another site. EPM is to consult stakeholders with working draft to produce a final draft for endorsement.	EPM	Mar 22
58	**CBRN**	**HAZMAT / CBRN Risk Assessments**	HAZMAT / CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for management of hazardous waste • Impact assessment of CBRN decontamination on other key facilities	Partially Compliant	Details of arrangements are available in the Trust CBRN Plan however they do not exist in one single risk assessment document. EPM to draft and include in the CBRN Plan.	EPM	Nov 21

68	**CBRN**	**Staff Training - Decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Partially Compliant	The Trust hold mandated levels of trained staff however skill fade and the influx of new starters requires individual training to re-commence on both sites.	EPM	By Dec 21

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
Trust Operational Plan: H2 Plan Submission

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 H2 Operational Plan for the Trust, as part of the Humber Coast and Vale H2 Plan submission on the 16th of November 2021.

Executive Summary – Key Points

- The Planning Guidance for the period October 2021 to March 2022 (H2) has been published, with an expectation to eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer, hold or where possible reduce the number of patients waiting over 52 weeks and to stabilise waiting lists around the level seen at the end of September 2021.
- The Trust has worked across Care Groups to make adjustments to the Operational Plan for the remainder of the year based on capacity and workforce challenges seen across the period April to September 2021 (H1).
- The Trust Operational Plan forms part of the Humber, Coast and Vale Integrated Care System (HCV ICS) submission.

Recommendation

The Board of Directors is asked to receive and approve the Operational Plan and note the risks to delivery set out within the paper.

Author: Andrew Hurren, Operational Planning and Performance Manager

Director Sponsor: Wendy Scott, Chief Operating Officer

Date: October 2021

1. Introduction and Background

The national planning guidance for H2 was published on the 30th September 2021. The guidance sets out the activity, financial and performance expectations for the next six months. The HCV ICS is required to submit a final plan by the 16th November 2021.

In addition the Government released a short term capital scheme (Targeted Investment Fund) to support elective recovery through capital and digital programmes. The Trust has proposed a range of bids to the ICS to support local elective recovery, targeting additional surgical capacity off the acute sites to allow ongoing surgical operating during non-elective pressures.

Planning guidance activity and performance expectations:

Elective Recovery

- Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer.
- Hold or where possible reduce the number of patients waiting over 52 weeks.
- Stabilise waiting lists around the level seen at the end of September 2021.
- Ensure that patient-initiated follow-up (PIFU) is in place for at least five major outpatient specialties, moving or discharging 1.5% of all outpatient attendances to PIFU pathways by December 2021, and 2% by March 2022.
- Continue to grow remote (virtual or telephone) outpatient attendances where clinically appropriate with an overall share of at least 25%.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in the second half of 2021-22 to support activity above the level funded within system financial envelopes.

Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019/20 threshold of 89% will be able to draw down from the ERF. Part of the ERF will also be used to centrally fund systems for independent sector (IS) activity above 2019-20 levels.

System level RTT pathway activity performance against the 89% threshold will be calculated by weighting performance at specialty level, split between completed admitted and non-admitted pathways.

Where systems deliver completed RTT pathway activity above the 89% threshold, additional activity will be funded at 100% of tariff between 89% and 94%, and 120% of tariff over 94%.

Cancer

- Return the number of people waiting for longer than 62 days to the level at the end of February 2020 by March 2022
- Meet the Faster Diagnosis Standard (FDS) from Q3 2021-22, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing.

2. Planning Overview

The Trust's submission forms part of the Humber, Coast and Vale Integrated Care System H2 plan. This includes an operational activity submission and a narrative across the Integrated Care System. The narrative includes detail relating to the elective recovery 'asks' detailed above, specific actions the Trust is taking to mitigate urgent care and or COVID-19 pressures over winter to protect elective work, as well as the responses to the national 'asks' in relation to inequalities and workforce. The deadline for the Humber Coast and Vale Plan is the 16th of November 2021.

The Trust continues to operate in a 'response' state, and is required to protect surge capacity for the COVID-19 pandemic as well as agile step-up escalation.

All Care Groups have reviewed their internal annual plan at specialty and site level and made adjustments based on H1 (April to September 2021) capacity and workforce challenges. The main adjustment has been to sustain the level of ordinary elective activity seen during H1.

It is worth noting that the plan assumes 7% of the General and Acute bed base occupied by COVID-19 patients during October and 10% during November and December (circa 75 patients). Any increase on this will impact the proposed elective activity as the surge plan would require the use of surgical ward areas on the York Hospital site for COVID-19 patients.

H2 Elective Plan

The revised plan reflects the following assumptions:

- Independent Sector activity is **not** included as per the national guidance. Note that we are still continuing to use the nationally contracted Independent Sector capacity; this is in addition to any activity within the plan and is funded separately by a national/CCG contract.
- Radiological work is **excluded** from Outpatients activity.
- Other non-national contract IS sub-contracted activity is counted within the Trust plan.
- Assumes 7% of the bed base occupied by COVID-19 patients during October, 10% during November and December (circa 75 patients) returning to 7% for the period January to March 2022.
- Assumes workforce delivering job plans.
- The elective plan does not take account of Social Care delays. At the time of writing this report, there are over 100 patients who do not have a 'right to reside' in York and Scarborough Hospitals and our Community Units. The rising number of delays is an additional risk that impacts on the Trust's ability deliver elective activity.

3. Trust H2 Operating Plan - Activity Levels and Trajectories

The revised plan for October 2021 to March 2022 along with a comparison to activity delivered in 2019/20 is as follows:

POD	Year	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22*
DAY CASES	2019/20	6839	6564	5785	6760	6242	4942
	2021/22	6780	6659	5583	6515	5922	5820
	%	99%	101%	97%	96%	95%	118%
ORDINARY ELECTIVES	2019/20	773	771	536	618	592	452
	2021/22	609	637	486	435	457	445
	%	79%	83%	91%	70%	77%	98%
OUTPATIENT FIRSTS	2019/20	15975	14918	12585	15653	13982	11527
	2021/22	14204	14500	12654	13878	13125	14340
	%	89%	97%	101%	89%	94%	124%
OUTPATIENT FOLLOW UPS	2019/20	35683	33791	27842	35504	30882	27997
	2021/22	32785	32898	30244	31855	30378	33657
	%	92%	97%	109%	90%	98%	120%

*Mar-22 outturn impacted by COVID-19 Pandemic

Care Groups will continue to review and identify further activity opportunities throughout the remainder of the year.

Forecasted impact of the H2 plan on the Trust's Waiting List positon.

In fully delivering this plan, the Trust will provide:

- 82,700 cases in first Outpatients (excluding radiology).
- 191,816 cases in Follow Ups (excluding radiology).
- 37,280 day case operations.
- 3,068 ordinary elective operations.

Assuming referrals continue at current levels the forecast is that by March 2022 the Total Waiting List would reduce slightly to 34,004, with 1,497 cases waiting over 52 weeks for treatment. Clearly, if referrals increase this position will change. The Trust is reviewing all opportunities to improve the 52 week position, including additional outsourcing. In addition the Trust has committed to delivering zero 104 week waiters by the end of March 2022.

	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	1549	1697	1655	1614	1574	1535	1497
The number of incomplete RTT pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period	130	154	120	92	75	27	0
The total number of incomplete RTT pathways at the end of the reporting period (often referred to as the size of the RTT waiting list)	34261	35192	34951	34110	34651	34573	34004

Assuming that the risks do not materialise, in terms of ERF the Trust is forecasting to deliver above 89% of 2019-20 completed RTT pathways in three of the six months of H2; December, February and March.

4. Risks to Delivery

As detailed above, the plan is based upon a number of assumptions and as such carries risk in the full delivery of the plan.

Additional risks to delivery include:

- Workforce
  - Workforce availability to deliver full job plans and volunteer for extra contractual activity, in a context of potential Track and Trace, sickness and fatigue.
  - Ability to staff increased numbers of inpatient beds and clinics.
  - Workforce constraints within Independent Sector may impact their ability to deliver contracted activity levels.

- Infection Management
  - Minimising transmission risks whilst maximising on site clinical assessment and treatment.
  - National or regional changes to the Infection Prevention and Control guidance in light of national or local transmission rates.

- Urgent Care demand
  - Winter pressures on hospital capacity.
  - COVID-19 demand surge above planned levels.
  - Continued discharge delays caused by issues in Social Care.

- Theatres
  - Distancing within theatre recovery spaces and the surgical bed base to accommodate increased numbers.
  - Continued access to PPE.

- Outpatients
  - Maximising clinical space.
  - Technology to rapidly expand Attend Anywhere.

To support the Trust in the management of these risks over the coming months, the following are in place:

a) Command and Control Structure in place to support agile response during winter.

b) Winter resilience plans have been developed, including plans to manage and mitigate the risks associated with winter and COVID-19.

The risks within, and delivery of, the plan are being monitored and reviewed through the daily Command and Control ‘Silver Command’ structure.

Clinical risks in delivery of the plan and management of the waiting lists are escalated to the Quality and Patient Safety Group, chaired by the Medical Director.

Operational delivery risks are escalated to Executive Board.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
Final Group Operational Financial Plan, H2 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

To report on, and seek Board approval of, the final Group operational financial plan for H2 (October 2021 – March 2022).

Executive Summary – Key Points

Following the publication by NHSE&I in March 2021 of the 2021/22 priorities and operational planning guidance, the Board approved at its April meeting the Trust's financial plan for H1 (April 2021 – September 2021), 2021/22. At that time no guidance was available of the financial regime that would be in place for H2 (October 2021 – March 2022), 2021/22.

In late September further guidance was issued by NHSE&I on the financial regime and planning requirements for H2, 2021/22. ICSs are required to submit operational financial plans to NHSE&I by 16 November 2021, with individual provider operational financial submissions to NHSE&I by 25 November 2021.

This report will form the basis of the Group's contribution to an overall system financial submission due to NHSE&I on 16 November 2021, and an individual Group operational financial submission to NHSE&I on 25 November 2021.

Recommendation

The Board of Directors is asked to note and approve the Group's final financial plan for H2 2021/22, which will form the basis of the Group's contribution to an overall system financial submission due to NHSE&I on 16 November 2021, and an individual Group operational financial submission to NHSE&I on 25 November 2021.

Author: Graham Lamb, Deputy Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: October 2021

1. Introduction

Following the publication by NHSE&I in March 2021 of the 2021/22 priorities and operational planning guidance, the Board approved at its April meeting the Trust's financial plan for H1 (April 2021 – September 2021), 2021/22. At that time no guidance was available of the financial regime that would be in place for H2 (October 2021 – March 2022), 2021/22.

In late September further guidance was issued by NHSE&I on the financial regime and planning requirements for H2, 2021/22. ICSs are required to submit operational financial plans to NHSE&I by 16 November 2021, with individual provider operational financial submissions to NHSE&I by 25 November 2021.

The Trust has again worked with its North Yorkshire and York (NYY) system partners (as a sub-section of the Humber Coast and Vale ICS) to agree the split of the notified funding allocations for H2. The basis of the allocation primarily represents a continuation of the emergency financial framework seen during H1.

The Board of Directors is asked to consider the final version of the H2 2021/22 operational financial plan, which forms part of NYY system plan submission to NHSE&I on 16 November, and will be the basis of an individual Group operational financial submission to NHSE&I on 25 November 2021.

2. Priorities and Operational Planning Guidance 2021/22

The 2021/22 priorities and operational planning guidance was issued in late March 2021 and provided detailed policy and technical information to enable ICSs and their constituent organisations to agree and develop operational plans. Along with refinements to the guidance issued in September 2021, the guidance issued in March 2021 is still relevant to the H2 financial plan.

The key themes detailed in the original and further refined guidance are:

- The continued development of ICSs in line with the vision described in 'Integrated Care: Next Steps' published in November 2020, and in the Government's recent white paper and proposals for legislative change.

- The development of plans for elective activity, including cancer, that can be delivered through core funding, and extended funding that is available via a further £1bn (on top of the £1bn announced for H1) Elective Recovery Fund (ERF). Part of the H2 ERF will also be used to centrally fund systems for CCG-commissioned independent sector (IS) activity above 2019/20 levels. Our system plan expects to make use of this funding to support IS, and additional Trust provided, extra elective activity.

- The introduction in H2 of a Targeted Investment Fund (TIF) worth up to £700m to enable regional teams, with national support / scrutiny, to target investment at systems or individual providers in return for specific delivery commitments primarily linked to elective recovery.

- Addressing five priority areas of health inequality, through restoring NHS service inclusivity, mitigate against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes, and by strengthening leadership and accountability.

- Implementing the next steps in the transformation of maternity services in light of Donna Ockenden's initial report 'Emergency findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust'.

3. Funding Allocations and Prospective Income Plan

As was the case in H1, to simplify the planning process NHSE&I has elected to directly allocate funding envelopes to ICSs based on a rollover of the allocations used for H1 (April 2021 – September 2021); adjusted for inflation and other known factors.

In the details received by NYY (as an ICS sub-system), the majority of the allocation was directly identified to the Trust, with the distribution of some remaining growth allocations requiring agreement between the system partners. An amicable agreement and satisfactory share of these funds has been agreed for the Trust with its NYY partners for the majority of the allocation. At the time of writing this report final clarity and agreement still required around a capacity fund allocation to the system of £2.9m, and the share of a £5m residual system risk reserve. Discussions continue with the FDs/CFOs with regard to the risk reserve but responsibility for allocation of the urgent and emergency care capacity fund (winter provision) has been delegated to the A&E Delivery Boards. It is important that we secure investment from this allocation to match the Board of Directors agreed winter investment programme.

The Trust's overall share of the allocation including assumptions around the outstanding items discussed above, together with other income streams from outside the system is summarised in the table below to present the Group's prospective income plan for H2, 2021/22.

Income Plan Components	£000	Comments
Features of H2 2020/21 Rolled Forward		
Trust Income from Patient Care Activities	244,630	
Trust Other Operating Income	22,324	
System Top-Up	16,449	
Elective Recovery Fund (H1 only)	21,500	
Covid Envelope within the System	12,531	
Covid Envelope outside the System (H1 only)	3,757	
H1 2021/22 Financial Plan	**321,191**	
Remove H1 only ERF	-21,500	
Remove H1 only Covid Envelope outside the System	-3,757	
H1 2021/22 Baseline Financial Plan into H2	**295,934**	
Growth and Other Adjustments to H1 Rolled Forward Position		
Envelope growth - CCG programme allocations		
- Block growth inluding recurrent impact of 3% pay deal	2,735	Equivalent to 1.16% inflation uplift in the national guidance
- Back pay for 3% pay deal	3,158	Equivalent to 1.75% inflation uplift in the national guidance
Reduced system Covid allocation	-4,385	Equates to a 1/3 reduction agreed by the system FDs/CFOs. Used to create the system risk reserve.
Reduced support for NHS provider other income loss	-143	Equates to 25% reduction in the national guidance
Envelope growth - Capacity funding	1,500	Assumed share of £2.9m system allocation - still to be agreed
NYY system risk reserve	2,400	Assumed share of £5.0m risk reserve - still to be agreed
Adjustments with NYY System Partners	**5,265**	
Envelope growth - CCG programme allocations		
- Block growth inluding recurrent impact of 3% pay deal	316	Equivalent to 1.16% inflation uplift in the national guidance
- Back pay for 3% pay deal	476	Equivalent to 1.75% inflation uplift in the national guidance
Envelope growth - NHSE&I programme allocations		Relates to Direct and specialised commissioning
- Block growth inluding recurrent impact of 3% pay deal	360	Equivalent to 1.16% inflation uplift in the national guidance
- Back pay for 3% pay deal	542	Equivalent to 1.75% inflation uplift in the national guidance
Elective Recovery Fund	1,244	Preliminary estimate
ERYCCG Cancer allocation	399	Notified by EERY CCG
Covid Envelope outside the System	3,757	Relating to H2 only
Novated SHYPS GP direct access contracts from HUTH	3,250	Wef 1 November 2021
SHYPS unitary payment from HUTH	6,419	Wef 1 November 2021
Net increase in Trust other operating income	518	
Adjustments outside of the NYY System Allocation	**17,281**	
H2, 2021/22 Prospective Income Plan	**318,480**	

4. Income & Expenditure (I&E) Plans

The Group's final I&E plans are based on each Care Group's assessment of activity to meet both non-elective and elective threshold requirements described above; and the other requirements contained in the national priorities and planning guidance.

In summary the Group's final operational I&E plan for H2 2020/21 is presented in **Appendix A**. Also included in memo form, and for information only are the full year equivalent figures.

The income has been recast from the table in section 3 above to represent the main income sources.

In terms of expenditure, a net increase in planned operating expenditure over the general ledger baseline of £30.1m in H2, 2021/22 is planned.

The net increase in expenditure is set out in more detail in **Appendix B** (see also Section 6).

An efficiency programme of £7.507m (1.2%) has been assessed, and this is discussed in more detail in section 9.

In summary; after adjusting for the net I&E impact of donated assets, which are excluded by NHSE&I in any assessment of the Group's financial performance, an adjusted **I&E breakeven position** for H2, and 2021/22 year as a whole is planned in line with NHSE&I requirements.

5. Financial Risk

There are a number of risks and assumptions to achieving the Income and Expenditure position summarised above included in the plan and these are set out below.

- The plan assumes a significant efficiency target. Although national guidance only prescribes savings efficiencies of 0.82% for H2 (£2.5m), it has been necessary to set the cost reduction CIP target at £7.5m in H2, 2021/22. This is primarily attributable to insufficient progress being made during H1 in delivering on a recurrent basis the H1 target of £5.5m in full year terms, with the result that £5.0m of this target now falls into H2 to deliver.

  There exists a risk of non-delivery of the financial plan if the savings requirement is not met. This risk continues to be mitigated by the Corporate Efficiency Team continuing its work with the Care Groups, however in the case of efficiency associated with re-investment agreed in H1, we will specifically manage the programme so savings are released before investments are made where this is practical. The risk register will continue to recognise the delivery of the CIP target as a material risk.

- At this stage discussions with NYY system partners regarding the share of all allocations received have not concluded. There remains two outstanding allocations to be agreed:

  - Capacity allocation £2.9m. This allocation is to assist in the expected growth in activity during H2 over the whole of the Urgent and Emergency care pathway, and

is therefore open to any organisations that have a stake in this pathway. It has been agreed by the system partners that the A&E Delivery Board will determine how this is to be allocated, although for planning purposes the Group has assumed it will receive £1.5m linked to additional costs within plan of £1.78m including plans for winter.

- Residual risk allocation £5.0m. Created primarily from the reduced Covid allocations, and intended to meet other risks in the system. Currently existing risks across all system partners total approximately £7.0m, therefore it is likely that each will be required to bear a £0.5m share. The actual allocation of this reserve has yet to be agreed, although for planning purposes the Group has assumed it will receive £2.4m.

Until finally agreed there remains an element of risk around the above assumptions, but as mitigation the Group would intend to look at further slippage on planned schemes, and/or reconsider the extent to which additional winter schemes are deployed.

- The Group's activity plan and cost of delivery is based on Care Group assessments of the forecast non-elective demand; and ability to meet the elective recovery (including cancer) thresholds. The financial plan is based on the robustness of these assessments.

  There exists a risk that changes to activity outside of the Trust's control could impact the ability for the Trust to deliver its financial plan, with associated pressure being placed on operational budgets. This risk will be mitigated by close monitoring of activity levels and normal financial controls in terms of management of expenditure changes. The risk register will reflect this accordingly.

- It is also essential during H2, 2021/22, that Directorates manage non-activity related expenditure within budget, including any unforeseen pressures if the overall plan is to be achieved. In addition; the achievement of agreed cost improvements during the year are essential to delivery of the plan and will require strong leadership and commitment at all levels in the organisation.

- Delivery of the plan is also impacted by further potential surges in activity in relation to the COVID-19 pandemic. The potential for any further waves could impact on the ability to deliver elective recovery as well as impacting on operational expenditure. To mitigate this risk, although the Group's funding envelope for COVID-19 funding has been reduced from H1, it is still expected to cover the underlying run rate seen in H1, together with some further spend in H2. This position will be monitored closely and funding decisions will be taken transparently and in conjunction with the wider ICS.

- Under the current system operating rules, collective organisation responsibility exists for the overall performance of the ICS sub-system. For the Group this relates specifically to the on-going financial viability of Harrogate and District NHS Foundation Trust along with the local commissioners of Vale of York CCG and North Yorkshire CCG. System performance monitoring will continue to feature in ICS leadership discussions.

6. Planned Marginal Investments – Appendix B

Pay and Inflationary Pressures (£11.7m)

Provision has been made for new pay and non-pay inflation in H2 line with the national guidance on inflation support within allocations of 1.98%. However further provision is also made for expected increases in gas prices of £1.1m in H2, which are not considered to be covered in the allocations.

The main inflation costs covered in the H2 allocations are the impact of the 3% pay deal for NHS staff covered by the remits of the NHS pay review body, and Doctors and Dentists review body. Provision is made to cover the recurrent cost of the pay deal from October onwards, with an additional provision to cover the back pay to 1 April 2021. Junior doctors who are subject to a three year pay deal are already covered in full year terms in the base line allocation from H1.

A residual provision is made for increases in other costs, notably drugs.

Investment in Activity Related Developments (£0.6m net reduction)

In light of reduced H1 outturn spending against the H1 system Covid allocation, and as part of an agreed strategy with system partners the system allocation for Covid is being reduced in H2 by a third (£4.3m for the Group). The reduced covid allocation in H2 of £8.1m is in line with expected spending levels agreed with the Care Groups. The reduction from the allocation is being held as a risk reserve at system level.

Covid spending on out of system allocation Covid expenditure e.g. testing, vaccinations, etc., which is met by recharge to NHSE&I is expected to be £3.7m in H2. This is offset by planned equal and opposite additional income from NHSE&I.

Business Developments (£9.7m)

Provision is made for the commencement wef 1 November 2021 of the Scarborough, Hull, & York Pathology Service (SHYPS); which the Trust will host. The additional cost includes former Hull University Teaching Hospital NHS Trust (HUTH) pathology staff that will have TUPE'd to the Trust by the commencement date, as well as increased consumable and other costs. The additional cost is met be increased income resulting from GP Direct Access contracts novated from HUTH to the Trust, and unitary payment income from HUTH for services provided by the hosted service.

Other Costs (£8.7m)

Provision is also made for essential new investments and cost pressures (£7.3m), which are presented in more detail in Appendix B(i). This figure includes £1.244m of costs linked to elective recovery for which equivalent income through the Elective Recovery Fund is assumed. These are partially netted off by an increase in planned slippage on new investments, and H1 provisions and contingencies.

An expected reduction in leasing costs of £2.1m in built into the plan.

Prior period (H1) unachieved CIP (efficiency) targets of £5.0m are identified, and add to the H2 new CIP target.

Additional cost provisions to reflect planned increases in other income sources, representing a net neutral impact on overall I&E are included (£2.5m)

Adjustments below EBITDA (£0.5m)

An expected marginal increase in PDC (£0.6m) and a net reduction in interest payable on loans and leases are expected, and have been included in the plan.

7. York Teaching Hospitals Facilities Management LLP (LLP)

The plan presented here is for the overall Group. As an independent company incorporated at Companies House, but a wholly owned subsidiary of the Trust, the LLP develops and has approved a financial plan in its own right. This plan is ultimately approved by the Board, and is contained within this overall Group plan presented to the Board for approval at this meeting.

8. Operational Budget Setting

Operational budget-setting discussions with Care Groups, Directorates and the LLP have focussed on an analysis of the service pressures incurred during H1 and those that are anticipated during H2, 2021/22; together with assessments of the means and cost of delivering planned activity in 2021/22 in line with the notified national priorities. Overall net additional provisions of £7.3m in H2, 2021/22 have been assessed in the overall strategy to supplement qualitative, risk, and general service pressures.

9. Efficiency Target

For H1, the Group was required to deliver a cost improvement target of £2.774m, equating to a full year target of £5.547m in order to deliver a balanced financial plan. This comprised a national efficiency requirement of 0.28%; an equal share of a further £1.7m (£0.424m for the Group) efficiency target allocated by NHSE&I; and to meet new essential investments made by the Executive Committee, and the requirement for the Group to participate in the national N365 Microsoft rollout during 2021/22 (£1.582m in H1 rising to £3.164m in full year terms). Of this target only £0.568m was delivered in full year terms, leaving the full year balance of £4.979m to be delivered in H2.

For H2, there is a further new national efficiency improvement requirement implicit in the announced allocations of 0.82%, which equates to a further target for the Group of £2.528m. The full target for H2 is therefore £7.507m.

Work to develop and implement initiatives to deliver the efficiency target is continuing. Care Groups, Directorates and the LLP have been set local efficiency targets and numerous meetings have been held with each to develop their local programmes.

Appendix C illustrates that schemes identified to date amount to £4.961m full year in H2 2021/22 thereby giving a current planning shortfall of £2.546m full year.

As always, delivery of the plans is paramount and these will be monitored closely as the year progresses. If required, to mitigate against non-delivery, the Board may need to exercise delay and deferral of any and all new investment programmes.

The table below summarises the allocation of the efficiency target across the Group for H2, 2021/22.

2021/22 CIP Target Allocations		
Care Group	**H2 Target CIP**	**Full Year CIP Target**
	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£1,373	£1,510
2. Acute, Emergency and Elderly Medicine (Scarborough)	£643	£704
3. Surgery	£1,450	£1,580
4. Cancer and Support Services	£1,062	£1,153
5. Family Health	£765	£775
6. Specialised Medicine	£932	£1,025
7. Corporate Functions	£548	£584
Sub-Total	**£6,773**	**£7,330**
YTHFM LLP	£734	£745
Group Total	**£7,507**	**£8,076**

10. Non Recurrent Expenditure Programme

The non-recurrent expenditure and leasing programme of £6.5m in H2 21/22 is held centrally to support equipment leasing programmes, equipment purchases, non-recurrent revenue costs associated with capital schemes, minor works schemes and other significant non-recurrent costs including expensive equipment repairs. Centralising these budgets provides flexibility to cover expenditure that can vary significantly from year to year. The Programme mainly covers existing commitments, but also allows for the lease cost of additional equipment to support the capital equipment replacement programme, and the planned replacement of ward based medical equipment, and surgical instruments.

11. Capital Programme Expenditure

The total resource available for capital investment in 2021/22 is has been revised to £25.2m. This is derived from depreciation, loan, and PDC funding including an amount of £1.0m funded from the Trust and external charities.

The main schemes planned during the year are:

- York Emergency department extension £13m PDC funded scheme, which is due to complete in March 2022, together with the ICU 6 bedded bay extension due to complete in Q3 of this year.

- Spend on the VIU development has currently being suspended whilst the capital team evaluate all available options to the Trust on how the scheme should proceed, therefore expected expenditure has reduced to £2m.

- The full business case for the Scarborough Emergency department and critical infrastructure project is to be developed costing £1.4m in fees. Once approval to the full business case is granted by the Department of Health, this will release funding for the build stage to commence.

- A scheme to extend the Trust's footprint at the community stadium to relocate Rheumatology, MSK and Tier 2 weight management has been approved at a cost of £0.9m, this will commence in H2 and complete in 2022/23.

- £0.5m has been set aside to invest in critical minor schemes across the Trust. This will be managed by a sub group of the capital programme executive group (CPEG) and will oversee critical schemes that are individually less than £50k.

- For ward refurbishments £0.4m has been allocated to the Chief Nursing team to prioritise areas across the Trust that requires investment, as part of an ongoing refurbishment plan.

- Due slippage on the H1 plan the now available funding of £1.2m has been allocated across all Care Groups including the LLP to be spent on urgent and critical schemes including replacement equipment. A further £1.0m has been allocated to concentrate on backlog maintenance meaning plans for 2022/23 have been brought forward.

- The balance of the available funding will be allocated to the Digital Information Service in order to maintain and develop the Trust's IT capability; to the LLP to assist reduce the Trust's critical backlog maintenance and improve statutory compliance, and an amount set aside to invest in the replacement of the failure of the Telemetry system.

The DoH has further deferred the introduction of the accounting standard IFRS16 on Trust's, which moves all lease contracts onto the balance sheet, and therefore removes the requirement for leases to be funded through the capital programme until April 2022. This will enable the replacement of equipment to continue to be mainly funded through a revenue lease budget where appropriate.

The Butterfly scheme funded from the Trust charity will complete this financial year and charitable funding will continue to be used where appropriate.

12. Balance Sheet

Fixed assets have increased due to central PDC funding during 2020/21, which will continue during 2021/22. Long term liabilities have reduced by £31m due to DoH having issued funding to clear all Trusts' revenue (working capital) loans.

The last loan to drawdown for capital expenditure is for the funding of the VIU project, this has reduced to £2.0m in H2 leaving a balance of £9.7m to draw in future years.

The forecast balance sheet as at the end of March 2022 is attached at **Appendix D.**

13. Cash Flow Forecast

Cash levels are expected to reduce through 2021/22 due to the return of commissioners making payments in month; compared to having paid one month in advance during 2020/21 to support provider organisations during early stages of the Covid pandemic.

The forecast cash flow is attached at **Appendix E.**

14. Use of Resources Rating

The ‘Use of Resources’ rating is an aggregate score over five individual measures: Capital Service Cover, Liquidity, I&E Margin, I&E Margin Variance from Plan, and performance against the Trust’s allocated agency cap.

Each measure has an equal weighting, with a score of 4 (low) to 1 (high) in each case, with the overall rating being an average of these.

As was the case during 2020/21, the Use of Resources’ rating has been suspended for H2 2021/22 as the measures are not compatible with the emergency financial framework.

15. Recommendation

The Board of Directors is asked to:

- Note and approve the Trust’s final financial plan for H2 2021/22, which will form the basis of the Group’s contribution to an overall system financial submission due to NHSE&I on 16 November 2021, and an individual Group operational financial submission to NHSE&I on 25 November.

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
SUMMARY INCOME & EXPENDITURE POSITION H2 2021/22

	H2 (Oct-Mar)	Memo: Full Year
	£000	£000
INCOME		
Operating Income from Patient Care Activities		
NHS England	33,817	66,732
Clinical Commissioning Groups	242,008	494,707
Local Authorities	2,390	4,718
Private Patient Income	133	263
Other Non-protected Clinical Income	902	1,780
	279,250	**568,200**
Other Operating Income		
Research & Development	1,262	2,484
Education & Training	10,495	19,867
Donations & Grants received of cash to buy PPE & Intangible Assets	240	480
Other Income	27,233	48,640
	39,230	**71,471**
Total Income	**318,480**	**639,671**
EXPENDITURE		
Baseline Expenditure	-286,026	-597,308
Pay and Inflationary Pressures	-11,740	-11,740
Investment in Activity Related Developments	563	563
Business Developments	-9,669	-9,669
Other Costs	-8,701	-8,701
Less: CIP	7,507	7,507
Total Expenditure	**-308,066**	**-619,348**
EBITDA	**10,414**	**20,323**
Profit/ Loss on Asset Disposals	0	0
Fixed Asset Impairments	0	0
Depreciation on purchased and constructed assets	-5,945	-11,890
Depreciation on donated assets	-240	-480
Interest Receivable	20	25
Interest Expense on Loans and Leases	-206	-464
PDC Dividend	-4,058	-7,542
NET SURPLUS/ DEFICIT	**-14**	**-28**
ADJUSTED FINANCIAL PERFORMANCE		
Net Surplus/ (Defciit)	-14	-28
Add Back		
Remove capital donations/grants I&E impact - Income	-226	-452
Remove capital donations/grants I&E impact - Depreciation	240	480
ADJUSTED FINANCIAL SURPLUS/(DEFICIT)	**0**	**0**

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
FINANCIAL PLANNING H2, 2021/22
MARGINAL EXPENDITURE PLANS

MARGINAL EXPENDITURE CHANGES	H2, 2021/22 £000	Memo: Full Year £000
1. INFLATIONARY ISSUES		
Other inflation issues not covered below	-629	-629
3% pay deal	-5,285	-5,285
3% pay deal - back pay (April to September)	-4,695	-4,695
Increased gas prices	-1,132	-1,132
	-11,740	-11,740
2. ACTIVITY RELATED DEVELOPMENTS		
Continuation of Covid schemes within the system allocation envelope established during H1, but with reduced spend in H2.	4,320	4,320
Covid spend outside of the system envelope in H2	-3,757	-3,757
	563	563
3. BUSINESS DEVELOPMENTS		
Commencement of York hosting the SHYPS wef 1 November 2021	-9,669	-9,669
4. OTHER ISSUES		
Reduced leasing spend	2,109	2,109
Additional costs associated with increases in Direct Credit income (contra income)	-2,539	-2,539
Pressure from prior period (H1) unachieved CIP	-4,979	-4,979
Care Group, Directorate and LLP underlying cost pressures (see Appendix B(i))	-7,322	-7,322
Increase planned slippage, H1 contingencies and provisions, etc	4,031	4,031
	-8,701	-8,701
SUB-TOTAL (To EBITDA)	**-29,547**	**-29,547**
Reduced interest payable on loans and leases	52	52
Increased PDC	-573	-573
TOTAL	**-30,068**	**-30,068**

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
FINANCIAL PLANNING H2, 2021/22
COST PRESSURES

Cost Pressure Increases	Cost H2 2021/22	FYE Impact 2022/23	Comments
	£000	£000	
Cauda Equina Case	188	565	Transfer of out of hours scanning for CE patients from Hull to York.
DIS Investment Case	492	275	Business Case restructure of DIS. Staff in process of being appointed.
MS Licenses	62	30	Unavoidable cost of MS licenses - renewal of aspiring software licenses - previosuly paid upfront for 3 years (due to expire soon).
Business case 2021/22-19 Nutritional Support	41	99	Appointment of additional Nutritional Specialist Nurses - approved BC
Building Better Care Programme	271	tbc	The Executive Committee and Trust Board have agreed to establish a time limited (2021-2023) Building Better Care Transformation Programme to support the delivery of the draft Clinical Strategy and support post-pandemic recovery. Recruitment underway.
Temp Supply of portering/domestics to ED	79	56	Non Rec 1st Sep 2021 to 31st Aug 2022 - excludes additional security at the
Winter Plan (approved schemes)	1,094	1,094	Board approved plan
Digital Fellow	20	14	2 days per week for 1 year wef Sep 2021(cost approx £7k per month for FT).
Civica contract	9	6	
2021/22 21 Cross site ED Consultant Investment	3	6	Additional PAs approved at Scarborough ED.
Endoscopy Outsourcing/Insourcing	500	0	Restoration of activity due to backlog.
Endoscopy WLI	187	0	Restoration of activity due to backlog.
Obs & Gynae Consultant expansion	100	200	Job offers have been made.
DIS - Service Contracts previously funded by Capital	175	320	Previously coded to capital. Should be Revenue.
Histology Outsourcing	225	300	Linked to restoration of activity, paused due to covid period due to reduction in workload.
Winter Flu Testing Kits	300	300	Only needed in winter.
SHYPS Running costs	110	220	York share of increased running costs.
Cardiac CT	246	717	Approved BC - change in patient pathway.
1 WTE Consultant Urologist (approved as a 12 Month Fixed Post)	51	153	Additional post approved as a 12 months fixed post. Linked to elective recovery.
Admin Support for Cons Urologist (1.5 wte B2/3)	8	34	Linked to elective recovery.
3 WTE Jun Doctor posts - TACC (approved until end of Jan 22)	124	248	Additional posts - Andy approved on 17.06.21 only until end of Jan 22 - planning assumes recurrent costs wef. Oct 21
Various Recovery posts	251	722	Additional posts - linked to elective activity recovery.
AHP 1 WTE B6 post	21	41	Additional post linked to elective recovery.
ICU POD	218	658	Linked to new build (modular ICU building)
East Coast Managed Service for Heart monitoring analysis backlog	46	0	4 month trial starting 4th October.
East Coast Managed Service for Heart monitoring analysis on going	24	141	3 months of 12 month contract for ongoing service.
ED See & Treat – approved at Exec Comm	162	304	Temporary arrangement re: streaming during works, relocation of entrance and net 6 bay loss.
2020/21-61 - Renal Consultant workforce	125	250	2 consultants approved.
Nurse Documentation project	77	230	BC Exec committee approved.
Resusitation officers	39	77	Exec committee approved.
Facefit testing	21	43	1.4wte B4 approved by Exec Committee.
Ophthalmlogy EPR charge	8	30	BC Exec committee approved.
Security Contract	53	107	Needed for recruitment/retention.
CG3 Anaesthetist resident on call cover SGH (accommodation)	20	43	York Consultants covering on call at SGH.
2018/19 07 Recruiting ACPs to cover ENT first line on call	53	158	BC approved for 3 wte B7s. 2wte B7s appointed in H2. Full year costs for 3 WTEs 22/23 (3 WTE).
IPT Support roles	36	123	
Additional Staff York, Scarb & Bridlington to reduce patient movements by nursing staff	130	0	Suggested trial of additional staff over winter period following concerns raised by Chief Nurse regarding Porter availability.
Breast Screening SECTRA contract for PACS system.	4	7	
N365 Licences - Increase in requirment from approved Case -	250	250	BC awaited.
Scarborough CT - Acute Work Pressures -	55	111	Unsafe sole working BC awaited.
Resident On-call at SGH- Anaesthetist Rota (wef. Mid Oct 21)	128	279	BC awaited.
Resident On-call at SGH- ICU Rota (wef. Jan 22)	45	178	BC awaited.
Appointment of 1 Specialty Doctor - TACC	25	101	Linked to lost activity re: resident on call or elective.
Decon staff - SGH (6 B3s & 1 B2 wef Jan 22 + £18k upgrades)	61	172	Decon Team structure changes to support improved working (£18k definitely required in 22-23 due to agenda for change upgrades 10WTEs @ £1k p/wte * 18 months)
Capital funded through revenue	1,137	0	
Clinical Coding Team Restructure	50	100	Linked DIS restructure.
	7,322	**8,762**	

APPENDIX C

York Hospitals NHS Foundation Trust
Cost Improvement Programme 2021/22
@ Nominal Pay & Price Levels

Themes	2021/22 H2	2021/22 Full Year	Notes
	£'000	**£'000**	
H1 Target	5,547	5,547	
Less: H1 Delivered CIP	-568	-568	
	4,979	4,979	
H2 Additional Target	2,528	2,528	
Total target	**7,507**	**7,507**	
	£'000	**£'000**	
1 Identified with high achievability			
Low risk			
1 Carter Workforce	1,234	1,234	Workforce schemes - pension, retire and return savings; Medical Bank software solution, International Nurse Recruitment and skill mix across Care Groups in line with Carter themes.
2 Carter Procurement	1,229	1,229	Procurement savings - stock rationalisation and standardisation; improved procurement for clinical supplies and services in line with Carter themes
3 Carter Hospital Pharmacy and Medicine	413	413	Procurement savings; generic drugs and Biosimilar in line with Carter themes.
4 Carter Estates and Facilities	298	298	Estates optimisation; review of maintenance and services contracts in line with Carter themes
5 Other Plans	774	774	Service development - improved productivity and performance
Low risk	**3,948**	**3,948**	
2 Identified with medium achievability			
Medium risk			
1 Carter Workforce	194	194	Workforce schemes - incl reduced posts, in line with Carter themes.
2 Carter Procurement	62	62	stock rationalisation and management improvements; improved procurement for clinical supplies and services in line with Carter themes
3 Carter Hospital Pharmacy and Medicine	49	49	Procurement savings; Drugs at home scheme, in line with Carter themes.
4 Carter Estates and Facilities	346	346	Estates optimisation; standardisation of parts in line with Carter themes
5 Other Plans	291	291	Service development - improved productivity and performance
Medium risk	**943**	**943**	
3 Identified with Low achievability			
High risk			
1 Carter Workforce	0	0	
2 Carter Procurement	0	0	
3 Carter Hospital Pharmacy and Medicine	0	0	
4 Carter Estates and Facilities	60	60	Estates optimisation - development of services linked to travel and car parking
5 Other Plans	11	11	
High risk	**70**	**70**	
Grand Total	**4,961**	**4,961**	
Shortfall against Target	**-2,546**	**-2,546**	

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
BALANCE SHEET
FOR THE PERIOD ENDING

	Full Year 2021/22 £000
ASSETS, NON CURRENT	
Intangible Assets	10,455
Other Property, Plant and Equipment	258,553
Other Financial Assets	4,221
Total Fixed Assets	273,229
ASSETS, CURRENT	
Inventories	9,456
Receivables due from NHS and DHSC group bodies	3,172
Receivables due from non-NHS/DHSC group bodies	6,035
Accrued Income	5,000
Prepayments	4,043
Cash and Cash Equivalents: GBS/NLF	31,769
Cash and Cash Equivalents: Commercial/ In Hand/ Other	25
Total Current Assets	59,500
CURRENT LIABILITIES	
Trade and Other Payables: Capital	-3,000
Trade and Other Payables: Non-Capital	-24,339
Accruals	-15,300
Payments on Account	-74
Borrowings	-3,458
Provisions	-411
Other liabilities - Deferred Income including Contract Liabilities	-1,107
Total Current Liabilities	-47,689
TOTAL ASSETS LESS CURRENT LIABILITIES	**285,040**
NON CURRENT LIABILITIES	
Borrowings	-23,124
Trade and Other Payables	-66
Provisions	-2,193
NON CURRENT LIABILITIES	**-25,383**
TOTAL ASSETS EMPLOYED	**259,657**
TAXPAYERS' EQUITY	
Public Dividend Capital	155,837
Revaluation Reserve	67,169
Income and Expenditure Reserve	36,651
TOTAL TAXPAYERS' AND OTHERS' EQUITY	**259,657**

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
CASH FLOW
FOR THE PERIOD ENDING

	Full Year 2021/22 £000
CASH FLOW FROM OPERATING ACTIVITIES	
Surplus/(deficit) after tax	20,313
Non Cash Income and expense	
Non-cash flows in operating surplus/(deficit)	
Income recognised in respect of capital donations (cash and non-cash)	0
(Increase)/decrease in receivables	4,196
Increase/(decrease) in trade and other payables	-12,727
Increase/(decrease) in other liabilities	17
Net cash generated from / (used in) operations	**11,799**
CASH FLOW FROM INVESTING ACTIVITIES	
Interest received	25
Purchase of intangible assets	0
Purchase of property, plant and equipment and investment property	-31,034
Receipt of cash donations to purchase capital assets	38
Net cash generated from/(used in) investing activities	**-30,971**
CASH FLOW FROM FINANCING ACTIVITIES	
Public Dividend Capital Received	13,000
Loans from Department of Health and Social Care - Received	2,000
Loans from Department of Health and Social Care - Repaid	-3,150
Capital element of lease rental payments	-70
Interest paid	-454
Interest element on leases	-9
PDC dividend (paid)/refunded	-7,647
Net cash generated from/(used in) financing activities	**3,670**
Increase/(decrease) in cash and cash equivalents	**-15,502**
Cash and cash equivalents at start of period	47,296
Net increase/(decrease) in cash	-15,502
Cash and cash equivalents at end of period	**31,794**

J3

NHS
York Teaching Hospital
Facilities Management

Board of Directors – 24 November 2021
Operational Financial Plan H2, 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

To report on, and seek the Management Group's approval on YTHFM LLPs final Operational Financial Plan for H2 (October 2021 – March 2022).

Executive Summary – Key Points

Following the publication by NHSE&I in March 2021 of the 2021/22 priorities and operational planning guidance, the Management Group approved at its April meeting the LLPs financial plan for H1 (April 2021 – September 2021), 2021/22. At that time no guidance was available of the financial regime that would be in place for H2 (October 2021 – March 2022), 2021/22.

In late September 2021, further guidance was issued by NHSE&I on the financial regime and planning requirements for H2, 2021/22. ICSs are required to submit operational financial plans to NHSE&I by 16 November 2021, with individual provider operational financial submissions to NHSE&I by 25 November 2021.

As part of the Group, this report will form part of the Group's contribution to both the ICS and individual Group submissions to NHSE&I.

Recommendation

The Management Group is asked to:

- Note and approve YTHFM LLPs final Operational Financial Plan for H2 2021/22.

- Note the final Operational Financial Plan will also require approval from the Trust Board of Directors and NHFML.

Authors: Penny Gilyard, Director of Resources, YTHFM LLP
Graham Lamb, Deputy Finance Director, YSTHFT

Director Sponsor: Delroy Beverley, Managing Director

1. Introduction

Following the publication by NHSE&I in March 2021 of the 2021/22 priorities and operational planning guidance, the Management Group approved at its April meeting the YTHFM LLPs (LLP) financial plan for H1 (April 2021 – September 2021), 2021/22. At that time no guidance was available of the financial regime that would be in place for H2 (October 2021 – March 2022), 2021/22.

In late September further guidance was issued by NHSE&I on the financial regime and planning requirements for H2, 2021/22. ICSs are required to submit operational financial plans to NHSE&I by 16 November 2021, with individual provider operational financial submissions to NHSE&I by 25 November 2021.

The Trust has again worked with its North Yorkshire and York (NYY) system partners (as a sub-section of the Humber Coast and Vale ICS) to agree the split of the notified funding allocations for H2. The basis of the allocation primarily represents a continuation of the emergency financial framework seen during H1.

The Management Group is asked to consider the final version of the H2 2021/22 operational financial plan, which forms part of the Group's NYY system plan submission to NHSE&I on 16 November, and will form part of the basis of an individual Group operational financial submission by the Trust to NHSE&I on 25 November 2021.

2. Priorities and Operational Planning Guidance 2021/22

The 2021/22 priorities and operational planning guidance was issued in late March 2021 and provided detailed policy and technical information to enable ICSs and their constituent organisations to agree and develop operational plans. Along with refinements to the guidance issued in September 2021, the guidance issued in March 2021 is still relevant to the H2 financial plan.

The key themes detailed in the original and further refined guidance are:

- The continued development of ICSs in line with the vision described in 'Integrated Care: Next Steps' published in November 2020, and in the Government's recent white paper and proposals for legislative change.

- The development of plans for elective activity, including cancer, that can be delivered through core funding, and extended funding that is available via a further £1bn (on top of the £1bn announced for H1) Elective Recovery Fund (ERF). Part of the H2 ERF will also be used to centrally fund systems for CCG-commissioned independent sector (IS) activity above 2019/20 levels

- The introduction in H2 of a part of a Targeted Investment Fund (TIF) worth up to £700m to enable regional teams, with national support / scrutiny, to target investment at systems or individual providers in return for specific delivery commitments primarily linked to elective recovery.

- Addressing five priority areas of health inequality, through restoring NHS service inclusivity, mitigate against digital exclusion, ensuring datasets are complete and timely, accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes, and by strengthening leadership and accountability.

- Implementing the next steps in the transformation of maternity services in light of Donna Ockenden's initial report 'Emergency findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust'.

3. Group's Income Plan H2, 2021/22

As was the case in H1, to simplify the planning process NHSE&I has elected to directly allocate funding envelopes to ICSs based on a rollover of the allocations used for H1 (April 2021 – September 2021); adjusted for inflation and other known factors.

In the details received by the NYY (as an ICS sub-system), the majority of the allocation was directly identified to the Trust, with the distribution of some remaining growth allocation requiring agreement between the system partners. An amicable agreement and satisfactory share of these funds has been agreed for the Trust with its NYY partners for the majority of the allocation, although as this report is being written some final clarity and agreement still required around a capacity fund allocation to the system of £2.9m, and the share of a £5m residual system risk reserve.

4. YTHFM Income & Expenditure (I&E) Plans H2, 2021/22

YTHFMs I&E plans are based on expected demands from the Trust during H2; and the other requirements contained in the national priorities and planning guidance.

In summary YTHFMs, operational I&E plan for H2 2020/21 is presented in **Appendix A,** and presents a net I&E surplus of £1.179m (full year £2.393m) before the distribution of profits in accordance with the Members Agreement. Also included in memo form, and for information only are the full year equivalent figures.

The marginal revenue operational expenditure changes over the baseline plan represent an increased spend of £3.2m and are presented in **Appendix B.**

An efficiency programme of £734k for H2 has been assessed, and this is discussed in more detail in section 5 below.

5. Cost Improvement Programme

For H1, the Group was required to deliver a waste reduction target of £2.774m, equating to a full year target of £5.547m in order to deliver a balanced financial plan. This comprised a national efficiency requirement of 0.28%; an equal share of a further £1.7m (£0.424m for the Group) efficiency target allocated by NHSE&I; and to meet new essential investments made by the Executive Committee, and the requirement for the Group to participate in the national N365 Microsoft rollout during 2021/22 (£1.582m in H1 rising to £3.164m in full year terms). Of this target only £0.568m was delivered in full year terms, leaving the full year balance of £4.979m to be delivered in H2.

For H2, there is a further new national efficiency improvement requirement implicit in the announced allocations of 0.82%, which equates to a further target for the Group of £2.528m. The full target for H2 is therefore £7.507m.

The required CIP for YTHFM was £256k in H1 (full year £512k). Of this target only £11k has been recorded as achieved on a recurrent basis, meaning that the full year balance of

£501k now falls for delivery in H2. In addition, YTHFMs share of the new and additional H2 target is £233k, thereby giving an overall target for delivery in H2 of £734k.

The cost improvement plan for YTHFM is presented at Appendix C. As always the delivery of the plans is paramount and these will be monitored closely as the year progresses. If required, to mitigate against non-delivery, the Management Group may need to exercise delay and deferral of any and all new investment.

6. Balance Sheet

Due to revised project schedules the financial debtor outturn forecast has reduced in H2 by approximately £13m and will not be recognised until 2022/23, and therefore work in progress will increase has a result. This will impact the capital loan requirement of YTHFM reducing it by approximately £5m which will reduce the interest charges for 2022/23. Work has suspended on the VIU project until a viable solution has been approved this has also contributed to the reduced capital expenditure in 2021/22.

The forecast balance sheet as at the end of March 2022 is attached at **Appendix D.**

7. Cash Flow Forecast

Cash balances at month 12 (March 2022) are expected to be at a level of £2.563m.

The forecast cash flow is attached at **Appendix E.**

8. Capital Expenditure

The total resource available for capital investment in 2021/22 has reduced from H1 projection of £30.9m to £23.2m. These resources are derived from depreciation, loan, and PDC funding with an amount of £1.0m funded from the Trust's charity.

The main schemes planned during the year are:

- York Emergency department extension £13m PDC funded scheme, which is due to complete in October 2023, together with the ICU 6 bedded bay extension due to complete in Q3 of this year.

- Spend on the VIU development has currently being suspended whilst the capital team evaluate all available options to the Trust on how the scheme should proceed, therefore expected expenditure has reduced to £2m.

- The full business case for the Scarborough Emergency department and critical infrastructure project is to be developed costing £1.4m in fees. Once approval to the full business case is granted by the Department of Health, this will release funding for the build stage to commence.

- A scheme to extend the Trust's footprint at the community stadium to relocate Rheumatology, MSK and Tier 2 weight management has been approved at a cost of £0.9m, and will commence in H2 and complete in 2022/23.

- £0.5m has been set aside to invest in critical minor schemes across the Trust. This will be managed by a sub group of the capital programme executive group (CPEG) and will oversee critical schemes that are individually less than £50k.

- For ward refurbishments £0.4m has been allocated to the Chief Nursing team to prioritise areas across the Trust that requires investment, as part of an ongoing refurbishment plan.

- Due slippage on the H1 plan, released funding of £1.2m has been allocated across all Care Groups including YTHFM to be spent on urgent and critical schemes including replacement equipment. A further £1.0m has been allocated to concentrate on backlog maintenance meaning plans for 2022/23 have been brought forward.

- The balance of the available funding will be allocated to the Digital Information Service in order to maintain and develop the Trust's IT capability; to YTHFM to assist reduce the Trust's critical backlog maintenance and improve statutory compliance, and an amount set aside to invest in the replacement of the failure of the Telemetry system.

9. Projected Profit

A projected profit in H2 of £1.175m (full year £2.389m) is available for distribution to LLP partners. In accordance with clause 9 of the Members Agreement between the Trust and NHFML regarding profit share and distribution; the lower of £25k or 20% of the LLP's profit for 2021/22 will be distributed to NHFML, with the balance being distributed to the Trust.

10. Financial Risk

There are a number of risks and assumptions to achieving the Income and Expenditure position summarised above included in the plan and these are set out below.

- The plan assumes a significant efficiency target. Although national guidance only prescribes savings efficiencies of 0.82% for H2 (£233k), it has been necessary to set the cost reduction CIP target at £734k in H2, 2021/22. This is primarily attributable to insufficient progress being made during H1 in delivering on a recurrent basis the H1 target of £512k in full year terms, with the result that £501k of this target now falls all into H2 to deliver.

  There exists a risk of non-delivery of the financial plan if the savings requirement is not met. The risk register will continue to recognise the delivery of the CIP target as a material risk.

- At this stage discussions between the Trust and its NYY system partners regarding the share of all allocations received have not concluded. There remains two outstanding allocations to be agreed:

  - Capacity allocation £2.9m. This allocation is to assist in the expected growth in activity during H2 over the whole of the Urgent and Emergency care pathway, and is therefore open to any organisations that have a stake in this pathway. It has been agreed by the system partners that the A&E Delivery Board will determine how this is to be allocated, although for planning purposes the Group has been assumed it will receive £1.5m linked to additional costs within plan of £1.78m including plans for winter.

- Residual risk allocation £5.0m. Created primarily from the reduced Covid allocations, and intended to meet other risks in the system. Currently existing risks across all system partners total approximately £7.0m, therefore it is likely that each will be required to bear £0.5m share each. The actual allocation of this reserve has yet to be agreed, although for planning purposes the Group has been assumed it will receive £2.4m.

Until finally agreed there remains an element of risk around the above assumptions, but as mitigation the Group would intend to look at further slippage on planned schemes, and/or the deployment of possible further balance sheet flexibilities to offset any shortfall.

- It is also essential during H2, 2021/22, that YTHFM manages non-activity related expenditure within budget, including any unforeseen pressures if the overall plan is to be achieved. In addition; the achievement of agreed cost improvements during the year are essential to delivery of the plan and will require strong leadership and commitment at all levels in the organisation.

- Delivery of the plan is also impacted by further potential surges in activity in relation to the COVID-19 pandemic. The potential for any further waves could impact on the ability to deliver elective recovery as well as impacting on operational expenditure. To mitigate this risk, although the Group's funding envelope for COVID-19 funding has been reduced from H1, it is still expected to cover the underlying run rate seen in H1, together with some further spend in H2. This position will be monitored closely and funding decisions will be taken transparently and in conjunction with the wider ICS.

- Under the current system operating rules, collective organisation responsibility exists for the overall performance of the ICS sub-system. For the Group this relates specifically to the on-going financial viability of Harrogate and District NHS Foundation Trust along with the local commissioners of Vale of York CCG and North Yorkshire CCG. System performance monitoring will continue to feature in ICS leadership discussions.

11. Recommendation

The Management Group is asked to:

- Note and approve YTHFMs operational financial plan for H2 2021/22

- Note the operational financial plan will also require approval from the Trust Board of Directors and NHFML.

York Teaching Hospital Facilities Management LLP
Summary Income & Expenditure H2, 2021/22

	2021/22	
	H2	Memo: Full Year
	£000	£000
Income		
York Teaching Hospital NHS Foundation Trust		
Unitary Payment		
Other income	-1,952	-3,904
Other income: Covid lost car parking income	392	927
Payroll expenditure	13,963	27,238
Non-pay direct expenditure	8,032	14,940
Non-pay indirect expenditure - pass through	4,527	7,922
Property rental charge	9,362	18,723
Lifecycle - backlog maintenance	3,156	3,350
Profit - lifecycle (3.5% on Direct pay and non-pay)	51	117
Profit - operations (3.5% on Direct pay and non-pay)	770	1,476
	38,301	**70,791**
Capital Revenue		
Capital Revenue	7,156	7,156
New Leases 2021/22	4,635	5,025
	11,791	**12,181**
	50,091	**82,971**
Other Income		
Accommodation	57	113
Car Parking Services & Security	294	588
Catering - Scarborough	144	288
Catering - York	295	591
EBME	19	37
Energy & Sustainability	97	194
Estate Services - Scarborough	48	96
Estate Services - York	23	46
Estates & Facilities Management	6	11
Finance	5	9
Operational Facilities - Scarborough	28	56
Operational Facilities - York	43	87
Postage	39	77
Property Management	836	1,673
Trust Transport Department	19	37
	1,952	**3,904**
	52,043	**86,875**
Operating Expenditure		
Capital Expenditure		
Capital Expenditure	-7,120	-7,120
New Leases 2021/22	-4,612	-5,000
	-11,732	**-12,120**
Revenue Expenditure		
Payroll expenditure	-13,963	-27,238
Non-pay direct expenditure	-8,766	-15,674
Non-pay indirect expenditure - Utilities and Rates pass throug	-4,527	-7,922
Annual lease rental	-9,362	-18,723
Lifecycle - backlog maintenance	-3,156	-3,350
Less: CIP	734	734
	-39,040	**-72,174**
	-50,772	**-84,294**
Operating Profit	**1,271**	**2,582**
Interest Receivable - Financial Debtor	606	1,211
Interest Receivable - Leases	231	461
Interest Payable - Loans	-703	-1,406
Interest Payable - leases	-230	-459
	-96	**-192**
Profit Before Tax	**1,175**	**2,389**
LLP Share of profit: allocated to YTHFT	-1,163	-2,364
LLP Share of profit: allocated to NHFML	-13	-25
Profit for the Year	**0**	**0**
Retained Profit	**0**	**0**

Appendix B

York Teaching Hospital Facilities Management LLP
Financial Plan H2, 2021/22
Marginal Expenditure Plans

MARGINAL EXPENDITURE CHANGES	2021/22	
	H2	Memo: Full Year
	£000	£000
1. Inflationary Issues		
3% Pay award October 2021 to March 2022	411	411
Pay arrears for April to September 2021	349	349
Gas price increases October 2021 to March 2022	1,132	1,132
Pay & non pay inflation on issues not covered elsewhere	279	279
	2,171	**2,171**
2. Cost Pressures		
Additional Porters and Domestics for York ED build	79	79
Security contract increase for recruitment and retention	53	53
Additional Porters to reduce patient movements by nursing staff	130	130
	262	**262**
3. Other Costs		
Capital items to be funded through revenue	1,137	1,137
Assessment of H2 expenditure on Covid initiatives	-281	-281
Lifecycle backlog maintenance	-450	-450
	406	**406**
TOTAL	**2,839**	**2,839**

York Teaching Hospital Facilities Management LLP
Efficiency Programme H2, 2021/22

Themes		2021/22	
	Recurrent/Non-recurrent (R/NR)	H2	Full Year
		£000	£000
H1 efficiency target		512	512
Less: H1 Recurrent Delivered CIP		-11	-11
		501	501
H2 Additional Target		233	233
Total Target		**734**	**734**
		£000	£000
1 Identified with high achievability			
Low risk			
1 Novation of Vital Energi contract to LLP	R	120	120
2 AE Provision cross-site for decontamination	R	1	1
3 Cancellation of PoF Maintenance & Servicing Contracts	R	10	10
4 New Mitie Waste Contract	R	60	60
5 Review of car parking subscriptions	R	1	1
6 Retender of hoist contract		2	2
7 Remove contract for coin counting machines	R	0	0
Low risk		**206**	**206**
2 Identified with medium achievability			
Medium risk			
1 Waste segregation project	R	8	8
2 Savings on Schneider maintenance contract	R	6	6
3 Review of York site rateable value	R	323	323
4 York rates review savings backdated to October	NR	436	436
Medium risk		**772**	**772**
3 Identified with Low achievability			
High risk			
1 In-house Bloodfast service	NR	5	5
2 Profit from non MSA work	NR	13	13
3 Travel and subsistence savings	NR	6	6
High risk		**24**	**24**
Grand Total		**1,002**	**1,002**
Surplus/ (Deficit) against Target		**268**	**268**

York Teaching Hospital Facilities Management LLP
Balace Sheet
For the Period Ending

	2021/22
	Full Year
	£000
ASSETS, NON CURRENT	
Finance Debtor - Built Assets	21,475
Finance Debtor - Leases	15,226
Other Debtors	0
Total Fixed Assets	36,701
ASSETS, CURRENT	
Inventories - Stock	598
Inventories - Work in Progress	23,184
Interest Receivable	0
Trade Receivables	15,342
Other receivables	2,216
Cash in Commercial Accounts/in Hand/Other	2,563
Total Current Assets	43,903
CURRENT LIABILITIES	
Trade and Other Payables: Capital	-1,461
Trade and Other Payables: Non-Capital	-6,083
Current Tax Payables	-1,262
Borrowings	-1,618
Leases	-2,877
Provisions	0
Total Current Liabilities	-13,301
TOTAL ASSETS LESS CURRENT LIABILITIES	**67,303**
NON CURRENT LIABILITIES	
Trade and Other Payables: Non-Capital	0
Borrowings	-54,685
Non current lease	-7,046
NON CURRENT LIABILITIES	**-61,731**
TOTAL ASSETS EMPLOYED	**5,572**
PARTNERSHIP FUNDS	
Partners Debt	25
Retained Profit	5,547
TOTAL TAXPAYERS' AND OTHERS' EQUITY	**5,572**

York Teaching Hospital Facilities Management LLP
Cash Flow
For the Period Ending

	2021/22 Full Year £000
CASH FLOW FROM OPERATING ACTIVITIES	
Surplus/(deficit) after tax	2,581
Non Cash Income and expense	
Movement in Inventories	-16,078
Movement in Financial Debtor	-4,741
(Increase)/decrease in Trade receivables	0
(Increase)/decrease in Other receivables	319
Increase/(decrease) in trade payables	0
Increase/(decrease) in other Capital Trade payables	0
Increase/(decrease) in other liabilities	0
Net cash generated from / (used in) operations	**-17,920**
CASH FLOW FROM FINANCING ACTIVITIES	
Loans from York Teaching -Capital funding received	23,234
Loans repaid	-1,042
Lease payments	-2,877
Interest received	1,673
Interest loans	-1,406
Interest leases	-459
Partners Equity	-25
Net cash generated from/(used in) financing activities	**19,098**
Increase/(decrease) in cash and cash equivalents	**1,178**
Cash and cash equivalents at start of period	1,380
Net increase/(decrease) in cash	1,178
Cash and cash equivalents at end of period	**2,558**

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021
Pre-commitment of Capital Expenditure against the Scarborough Urgent and Emergency Care Build

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 request that the Board of Directors approves preliminary capital expenditure associated with the Scarborough Urgent and Emergency Care build, in advance of the Full Business Case approval.

Executive Summary – Key Points

This paper describes a case of need, as well as a series of benefits, from investing early in the Scarborough UEC build project. Support has been secured from the ICS, NHSE/I and from local commissioners.

Recommendation

The Board of Directors are asked to approve preliminary capital expenditure, at risk, ahead of the Full Business Case approval.

Author: Andrew Bertram, Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: November 2021

1. Introduction and Background

The Board of Directors have approved both the Strategic Outline Business Case (SOC) and the Outline Business Case (OBC) for the £47m investment in the Scarborough Urgent and Emergency Care build (UEC).

The Board of Directors are due to receive the Full Business Case (FBC) at the December 2021 meeting. The case will be released to NHSE/I at that point for full and final approval. Confirmation of approval of the FBC by the DHSC is not expected until the new calendar year (March in all likelihood).

2. Requirements, Benefits and Risks for Early Capital Expenditure Ahead of FBC approval

There does in fact exist a requirement for the Trust to proceed at risk with additional early in year capital spend of £4.8m on this project. £1.4m has already been approved through the annual capital plan for fees, therefore the in-year spend being targeted totals £6.2m. The expected split of spend would be a further £0.8m on fees, taking the total fees spend to £2.2m, and £4m spent on work and materials.

The main requirement to proceed with this spend is because of further delays to the York ED scheme and the need to broker CDEL cover. In addition, further delays to the York VIU scheme have emerged and also require brokerage of CDEL cover. The ICS is not in a position to help broker CDEL cover and neither are the national team. The Trust requires its own solution to this issue. Essentially, the proposal here is to use York ED CDEL alongside VIU CDEL to temporarily support the early spend on the Scarborough UEC build. In the 2022/23 financial year we would then reverse this arrangement. There are no long term consequences on any scheme.

The national and regional NHSE/I ask of the Trust to manage this issue internally assumes an approach such as described in this paper.

In addition to the clear requirement to proceed on this basis, there are three key benefits from progressing with preliminary expenditure against this scheme:

a. The construction industry is currently experiencing significant volatility with regard to raw material costs. Commencing this scheme with early orders for raw materials and equipment will help mitigate this risk.

b. The Board of Directors are aware of the incredibly long and protracted national approval process for this scheme. Construction is not likely to start in earnest until April 2022 (with FBC approval anticipated in March 2022). The scheme is a 104 week construction project. Placing orders for early work will help ensure the scheme is completed by March 2024, the point at which full draw down of central funding is required to be complete. Clearly, the Trust has a very strong desire to bring this new facility into operation at the earliest possible opportunity.

c. Placing orders, and undertaking visible activity on site, will be of huge significance to the local population and to our staff working in the currently extremely pressured urgent and critical care environments on the Scarborough Hospital site.

There is a small risk to progressing with this expenditure that links to potential delay or non-approval of the FBC. Having completed and gained SOC and OBC approval, this risk is considered to be low.

In addition, the Scarborough UEC Project Board has secured full support for taking this risk from the ICS, NHSE/I and from local Commissioners. All parties recognise the pressure on the Trust and agree to this action.

Ultimately, the risk is the Trust's; but with practical capital support from the ICS. In the case of failure to secure FBC approval any expenditure would have to be a first call on the Trust's own capital programme. We would also seek to negotiate a contribution from the ICS agreed share of scheme costs. At the advanced level of spend proposed, the Trust with the ICS could support this position. There would be consequences on the Trust's capital programme in terms of reduced availability of funds but the position could be managed.

It should be noted that having secured SOC and OBC approval, and having responded to all outstanding questions and queries, it is believed to be unlikely that the FBC will not be supported. That is the view of the Project Board, NHSE/I and the ICS.

3. NHSE/I and ICS Context

The Scarborough UEC Project Board met on Tuesday 16 November 2021 and discussed this issue. Attendees included Chris O'Neil, representing the ICS, Donna Cassidy, representing NHSE/I, and Simon Cox, representing local Commissioners.

The project Board openly and fully discussed the need for the Trust to proceed at risk with some preliminary capital expenditure. Indeed Chris O'Neil commented that in managing the multitude of capital scheme slippage that there are no other options available to the Trust or the ICS.

Chris O'Neil supported the recommendation to proceed at risk.

Donna Cassidy supported the recommendation to proceed at risk, recognising that the Trust and ICS were in fact committing the expenditure that they have agreed to commit as part of the scheme anyway (i.e. the balancing £7m).

Simon Cox supported the recommendation to proceed at risk.

4. Recommendation

The Board of Directors are asked to approve preliminary capital expenditure, at risk, ahead of the Full Business Case approval.

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York Teaching Hospital
Facilities Management

Board of Directors – 24 November 2021
Annual Report of Sustainable Development Group including Green Plan for Trust approval

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 annual report and an update on key sustainability successes, advise on new NHS carbon reduction targets, and seek to reaffirm and extend the YTHFM and Trust Board commitments in line with the current requirements of the NHS Standard Contract Service Condition 18, and other guidance published in 2020/21. The report also seeks approval for the appended Green Plan to replace the previously Board-approved Sustainable Development Management Plan 2017-2020.

Executive Summary – Key Points

The key points for discussion, assurance are as follows.

- There has been an overall reduction in carbon emissions for the fourth consecutive year in the Trust. However, in 2019/20, an annual reduction of only 0.8% was achieved, largely due to an increase in procurement emissions that resulted in a falling behind against the carbon reduction targets. Section 2.2 of this report outlines a number of achievements that have contributed to the overall reduction in carbon emissions in the Trust. Carbon reduction progress has, however, been decreasing and is now at risk of going in the wrong direction due to increasing spend without making sufficient investment in lower carbon choices.
- Much of the focus in the eighteen months has consequently been on work to secure external funding to achieve additional carbon reduction, so far with limited success due to the highly competitive demand for funding with first come first served allocation and ever changing strict criteria. A recent review of York Hospital, for

example, provided high-level basic cost indications of a need to invest £14.4million to achieve a 72% reduction by 2032 from current levels.

- The Climate Change Act sets a target for all of net zero by 2050, although the International Panel on Climate Change (IPCC) scientific assessment has suggested that the deadline for net zero should be much earlier than 2050 (e.g. 2030). In October 2020, the publication of 'Delivering a Net Zero National Health Service' set out the NHS aspiration for the UK to have the world's first net zero health service. The document set new targets for all NHS organisations a) to achieve net zero carbon from emissions that we directly control by 2040 (with an 80% target by 2032) and, b) net zero target for emissions that we can influence by 2045 (with 80% by 2039). Emissions that we can influence include those emissions embedded within the goods and services we procure and the carbon emissions from the travel of patients and visitors and staff commute.
- During the last 18 months, 32 new NHS sustainability and carbon reduction targets have been introduced broadening out the portfolio of the sustainability team and also providing new requirements to accelerate the development of carbon reduction and climate change adaptation work plans (see **Appendix 1** for the list of targets categorised according to progress made). Work is continuing both within the LLP and the Trust through the Sustainable Development Group to deliver against the targets set out in **Appendix 1**. A further report will be brought back with a revised Green Plan for approval before the end of this financial year and will give a further update on progress.
- One of the new requirements of the NHS Standard Contract 2021/22 is the production of a Green Plan to replace the Sustainable Development Management Plan and a draft document is attached for approval.
- Another requirement of the newly introduced targets is to ensure that all trusts have a Board-level lead with net zero in their portfolio by April 2022. This report seeks clarity about which Board-level colleague will have the net zero lead role as part of their portfolio.
- The LLP Management Group, Executive Committee and Resource Committees are asked to consider the existing commitments in the context of the changing climate, the net zero and other targets (as set out in **Appendix 1**) noting that the 2017 mission statement says "*The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does*". It is proposed that the 2017 mission should be updated with "***The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services and its premises in line with NHS targets***"

Recommendations

It is recommended that the LLP Management Group, Executive Committee, Resources Committee and Board of Directors:

i. Note the work of the Sustainable Development Group and the recent successes as set out in section 2.2.

ii. Note the Trust-wide carbon reduction trends, which are slowing due to lack of investment in carbon reduction projects and also note the anticipated negative impact of Covid against the current carbon emissions reporting.

iii. Ask the Board to approve the summary and full versions of the Trust Green Plan for 2021 onwards incorporating the new Net Zero carbon targets and other new

requirements (a summary version of the Green Plan is included at **Appendix 2** and full version at **Appendix 3**).

iv. Approve that the Net Zero lead role is explicitly designated and stated within the Portfolio of a Trust Board level executive member to facilitate and champion Board support for activities to achieve Net Zero.

v. Seek the Trust Board commitment to achieving net zero in line with NHS targets and amend its sustainability Mission to say "*The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services and its premises in line with NHS targets."*.

Author: Jane Money, Head of Sustainability, YTHFM

Director Sponsor: Mark Steed, Director of Property and Asset Management, YTHFM

1. Introduction

1.1 This report has been written with the aim of updating the Management Group, Executive Committee, Resources Committee and Board of Directors of York and Scarborough Teaching Hospitals NHS FT ('the Trust') and the YTHFM LLP ('the LLP') of the progress made and changes introduced over the last 18 months, following the last report to the Trust Resources Committee in March 2020, when sustainability quarterly reporting was halted due to Covid.

1.2 Annual progress has continued through the Trust Annual Report and Accounts sustainability section and the Board Assurance Framework includes reporting against the risk of failure to deliver trust wide environmental sustainability agenda

1.3 The Trust's Sustainable Development Group has met four times since March 2020 and these meetings bring together the leads with responsibility for the various strands of Sustainable Development as defined by the NHS Sustainable Development Unit. In the last year, the NHS Sustainable Development Unit has been reformed and rebranded as the "Greener NHS" team within NHS England and Improvement (NHSE/I). During the last eighteen months new guidance and requirements have been introduced with further guidance planned.

1.4 The Trust's Sustainable Development (SD) Group exists to ensure integration of sustainability into all areas of Trust business and to provide assurance to the Trust. The work plan was established through the Board-approved Sustainable Development Management Plan (SDMP) in 2015 and subsequently refreshed in 2017 (as a three year plan) in line with national NHS guidance. All of the actions in the original plan have been reviewed with the vast majority delivered. In subsequent years from 2017, progress has been reviewed annually against the Good Corporate Citizen Assessment Tool which was refreshed and relaunched as the Sustainable Development Assessment Tool (SDAT) in 2018. The outputs from each of these assessments resulted in the development of an action plan for the coming year and these were reported through to the Resources Committee. From an overall score at the start of 2017 of 44%, progress was made in all areas to achieve the overall score in 2021 of 65% with scores ranging from 46% to 75% with half of the assessment theme modules being 70% and above (more information is available in the **attached** Green Plan).

1.5 The Trust's SD Group receives regular highlight reports at its quarterly meetings from all of its members on their progress in delivering the Trust's Sustainable Development Action Plan and the targets which have been introduced within the last year. Some meetings were cancelled in the peak of the pandemic, but the group has continued to monitor progress and begun tackling the new work areas and targets that have been introduced. Thirty two new targets have been established nationally through the

- NHS Long term Plan,
- NHS Standard Contract Service Conditions 2021/22,
- Delivering a Net Zero National Health Service,
- Delivering a Net Zero NHS: Memorandum of Understanding for regional leadership and delivery 2021/22,
- Various additional guidance and briefings from the Greener NHS.

2. Review of Progress

2.1 Whilst, the work of the Sustainable Development Group, facilitated by YTHFM LLP's Head of Sustainability, has made good progress in a number of existing and new work areas, 2020/21/22 has been a time of significant change. These changes were as a result of the impact of Covid; the movement of the Sustainability Team from the Directorate of Estates and Facilities to the Chief Nurse Directorate within the Trust and then fifteen months later into YTHFM LLP into the Property and Asset Management Division and also due to the introduction of a multitude of new guidance documents, contractual requirements and new targets (see **Appendix 1**).

2.2 Successes in the last eighteen months include

- Significant reduction in use of desflurane anaesthetic gas (18 times greater global warming potential than sevoflurane) in favour of more environmentally friendly gases. The work undertaken resulted in the Trust over achieving against the new 10% target (as a proportion of sevoflurane).
- 25% of out-patient appointments were non-face to face between March 2020 and February 2021 as compared to less than 2% in the February 2020.
- Introduction of a walking aids and equipment procedure that has reduced equipment losses and encouraged recycling.
- Significant changes in working practices to allow staff to work from home and to reduce travel at work and staff commute.
- Movement to a green electricity tariff from April 2020.
- Development of a new Adverse Weather Plan to improve data collation to inform future capital estate programmes on longer term adaptation needs.
- Supporting a new 80 strong Green Champions network to help develop new ideas and champion the sustainability message.
- Implementation of the Sustainable Design Guide during the development of the new Scarborough Emergency Department.
- Over £200,000 charitable funding secured for staff well-being gardens.
- Introduction of the material and furniture re-use portal "Warp- It" saving £6600, 3800kg of CO2e emissions and 1100kg of waste saved from disposal by March 2021.
- Introduction of a journey travel planning tool and 25 free uses of the York Hospital bus Park and Ride for staff to encourage the use active travel and public transport.
- Introduction of electric scooters and bicycles in and around York Hospital as a low carbon alternative to the car for shorter journeys.
- The installation of additional heat and power meters and monitoring software to support better management and control of heat and power use (fully funded by BEIS. the government department of Business, Energy and Industrial Strategy).
- New Standard Operating Procedures introduced in relation to the Building Management System method of operation and how this integrates with energy related repairs, capital works and routine maintenance.
- Significant gas and carbon savings at Malton and St Monica's Hospitals as a result of replacing obsolete boilers with much more energy efficiency boilers.

2.3 In early 2020, the Trust in conjunction with the LLP, began an energy engineering review of the York hospital estate, having been chosen (following an application) to take part in a national project commissioned by BEIS (the government department of Business, Energy and Industrial Strategy). York hospital was only one of 12 hospitals in the UK to receive a free engineering review of opportunities for carbon reduction and the development concept design of the next steps carbon reduction measures. The aim was to identify measures to achieve a 50% reduction in carbon emissions by 2032 at this Trust's main hospital in line with the BEIS policy/ government commitment in 2017 of a "Clean Growth Strategy". The findings proposed an approach over the next ten years and gave high level basic cost indications of a need to invest £14.4million to achieve a 72% reduction by 2032 from current levels. Further surveying and energy modelling work is needed to confirm/update these estimates and this work is being developed through the Energy Reduction Project Board facilitated by the LLP Energy Manager as a sub-group of the Trust Sustainable Development Group. This work follows on from a successful behaviour change project with consultants WRM who recommended and supported the establishing of the group and provided training for key staff on a range of energy related projects.

2.4 In terms of overall carbon emissions the most recent annual sustainability section of the Trust's Annual Report and Accounts, concluded that for the year 2019/20, this is the fourth consecutive year that the Trust has been able to report a reduction in carbon emissions. In 2019/20 total CO2e emissions reduced by 760 tonnes (0.8%) from 2018/19 which continues a trend of reductions that have resulted in a decrease in emissions of more than 20% since 2015/16 with per patient emissions falling by 49% between 2007/8 and 2019/20.

2.5 Whilst all of the published annual reports have shown a reduction year on year since 2014/15, it is anticipated that the emissions for the current year are likely to have increased (from the figures reviewed to date). There have been significant carbon savings from staff, travel and patient and visitor travel due to the increased use of WebEx, home working and non-face to face appointments, but the likelihood is that there will still be an overall increase in carbon emissions due to the amount of procurement activity, the amount of gas consumed to heat well-ventilated areas and, the amount of waste produced to tackle the Covid pandemic.

2.6 Much of the focus in the eighteen months has been working on securing external funding to achieve additional carbon reduction, so far with limited success due to the highly competitive demand for funding with first come first served allocation and ever changing strict criteria.

2.7 Reports requesting funding allocation support from the Trust Executive Committee, within the last eighteen months, for energy survey work and electric vehicle installations, were unsuccessful due to the prioritisation of IT infrastructure and other clinical needs. However, in June 2021, it was agreed to allocate £18k to support the development of shovel ready energy projects for use in future funding bids. Work is on-going to develop new shovel ready projects.

3. Introduction of New NHS Net Zero and other targets

3.1 Major publication relating to specific net zero NHS targets, "Delivering a Net Zero National Health Service" (NHSE &I publication, October 2020), set out the NHS vision to become the world's first net zero carbon health service and respond to climate change, improving health now and for future generations. The document set new targets for all NHS organisations, a) to achieve net zero carbon from emissions that we directly control by 2040 (with an 80% target by 2032) and, b) net zero target for emissions that we can influence by 2045 (with 80% by 2039). Emissions that we can influence include those emissions embedded within the goods and services we procure and the carbon emissions from the travel of patients and visitors and staff commute**.**

3.2 Nationally, the collective target is net zero by 2050 and 78% by 2035 as prescribed under the Climate Change Act 2008 (as amended). The International Panel on Climate Change (IPCC) scientific assessment has suggested that the deadline for net zero should be much earlier than 2050 (e.g. 2030). The IPCC said that the next decade is crucial in order to restrict global warming to a $1.5^{O}C$ temperature rise to avoid dangerous or 'runaway' climate change.

During the last 18 months, 32 new NHS sustainability and carbon reduction targets have been introduced broadening out the portfolio of the sustainability team and also providing new requirements to accelerate the development of carbon reduction and climate change adaptation work plans (see **Appendix 1** for the list of targets categorised according to progress made).

3.3 One of the new requirements of the NHS Standard Contract 2021/22 is the production of a Green Plan to replace the Sustainable Development Management Plan and a draft document is attached for approval (see **Appendix 2** for the summary version and **Appendix 3** for the full version). Unfortunately the latest guidance on how to produce a Green Plan was not made available until July this year, when the work had already been completed to draft this document (which is based on the 2020 guidance). It is proposed therefore, to issue the attached versions of the plan and to review this later this year when the 2020/21 data has been fully analysed and more work has been undertaken in relation to the new categories of work areas detailed in the 2021 guidance.

3.4 The Humber Coast and Vale (HCV) Sustainability Network is also in the process of developing its Green Plan through the setting up sub groups to agree work plans and priorities as an Integrated Care System (ICS).

3.5 The 2021 Green Plan guidance introduced new categories of work required to contribute to achieving Net Zero and therefore the next iteration of the Green Plan will focus on plans to achieve net zero using the following categorisation of work areas in line with the new guidance

- Workforce and leadership – through governance arrangements and engagement with the workforce and training (measurement through workforce/ green champions pledges to action),
- Sustainable Models of Care – embedding net zero principles across all clinical services, default to lower carbon options where clinically equivalent (measurement through corporate efficiency team on Corporate Improvement Programme work),

- Digital Transformation - to assist with service streamlining, improving use of resources and reducing carbon emissions e.g. expand telemedicine to deliver remote care, use digital system to reduce paper records, printing and postage (measurement through increase in non- face to face meetings as compared to Face to face and patient and visitor transport, paper use reduction (or avoided growth in use of paper),
- Travel and Transport - carbon reduction through modal shift and use of active travel and public transport, investment in EVs, maximising efficiency in transport of good and services (measured through travel surveys & possibly through use of secure cycle storage and mileage claims and fuel usage and type of vehicles),
- Estates and Facilities – carbon reduction from utilities usage (achieved from energy efficiency measures, better control, behaviour change and decarbonising heating systems (switching to heat pumps), building design and refurbishment standards, waste reduction and circular economy, (measured through utility carbon emissions, waste carbon emission and proportions/ quantities of each type of waste and projected changes in energy use carbon emissions from new buildings and refurbishments),
- Medicines - carbon reduction through medicines optimisation, reducing waste and lower carbon alternatives with anaesthetic gases and inhalers targeted for early action (measured through carbon emission from medical gases use and inhalers use and disposal methods),
- Supply chain and Procurement – carbon emissions reduction from reduction in single use plastics, reuse and reprocessing (measurement through Greener NHS SRP model – new guidance to follow - expected within next 6 months),
- Food and Nutrition – Reduce carbon emissions from food waste, food processing, food transport, local supply, seasonal menus, high in fruit and veg (measured through reduction in food waste, reduction in food orders and reduction in transport miles),
- Adaptation – reducing risk through mitigating actions (measured through activities and actions to mitigate effects of flooding or heatwaves on organisation's infrastructure, patients and staff, plus number of adverse weather events).

3.6 Another of the other requirements of the newly introduced targets is to ensure that all trusts have a Board-level lead with net zero in their portfolio by April 2022. Currently the Chief Nurse is identified as the Board level sustainability lead and it is suggested that this role could be explicitly restated as the net zero lead.

4. Current and Proposed Board Commitments to Sustainability and Carbon Reduction

4.1 The 2017- 2020 Sustainable Development Management Plan set out the current Trust Board commitments encompassing.

(i) commitment to sustainable development principles
(ii) commitment to carbon reduction
(iii) commitment to the Good Corporate Citizenship Assessment Model (which became the Sustainable Development Assessment Tool in 2018)
(iv) commitment to delivering a plan for adapting to Climate Change

(v) a Mission statement

Whilst all except (iii) above are still as relevant today as they were in 2017, the commitment to delivering Net Zero NHS needs to be considered and added in to the previously agreed Mission statement. Item (iii) refers to an assessment tool which has now been withdrawn but the author understands that there is a plan to reintroduce this in a new format to take account of the alignment with the net zero targets.

4.2 The LLP Management Group, Executive Committee, Resource Committees and Board of Directors are asked to consider the existing commitments in the context of the changing climate, the net zero and other targets (as set out in **Appendix 1**) noting that the 2017 mission statement says "The York Teaching Hospital Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does". It is proposed that the 2017 mission should be updated with "The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services and its premises in line with NHS targets".

5. Recommendations

5.1 It is recommended that the LLP Management Group, Executive Committee, Resources Committee and Board of Directors:

i. Note the work of the Sustainable Development Group and the recent successes as set out in section 2.2.
ii. Note the Trust-wide carbon reduction trends, which are slowing due to lack of investment in carbon reduction projects and also note the anticipated negative impact of Covid against the current carbon emissions reporting.
iii. Ask the Board to approve the summary and full versions of the Trust Green Plan for 2021 onwards incorporating the new Net Zero carbon targets and other new requirements (a summary version of the Green Plan is included at **Appendix 2** and full version at **Appendix 3**).
iv. Approve that the Net Zero lead role is explicitly designated and stated within the Portfolio of a Trust Board level executive member to facilitate and champion Board support for activities to achieve Net Zero.
v. Seek the Trust Board commitment to achieving net zero in line with NHS targets and amend its sustainability Mission to say "The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services and its premises in line with NHS targets.".

Appendix 1

Targets introduced since March 2020

Completed but regular monitoring/ input needed from Sustainability Team

1. **All trusts have a Board-level lead with net zero in their portfolio by April 2022** – *Chief Nurse is Board level Sustainability lead*
2. **Reduce the proportion of desflurane used in surgery to less than 10% of overall volatile anaesthetic gases by volume in all trusts –** *achieved in 2019/20*
3. **Business mileage reduced by 20% by 2023/24** *teleconferencing and Covid achieved reductions in 2020/21*
4. **Provide a salary sacrifice cycle-to-work scheme in place for staff –** *Completed*
5. **Ensure trust has a cycle-to-work lead –** *Dan Braidley, Environment & Sustainability Manager*
6. **Purchase 100% of its electricity from renewable sources-** *purchased since April 2020*

Work started but much more to do

7. **All trusts have a Green Plan that aligns to ambitions in Delivering a Net Zero National Health Service by January 2022 (Net Zero by 2040 for emissions we control and 2045 for emissions that we can influence) –** *completed first draft Green Plan, but to be reviewed late 2021 to update with latest guidance and Net Zero Action Plan needed*
8. **Undertake a review of the existing fleet –** *In progress – first draft report due from Energy Saving Trust in October 2021*
9. **Provide facilities to encourage active travel for staff and visitors (e.g. cycle storage, showers, lockers) by 31st March 2022-***work started in July 2021 on reviewing facilities and providing showers and other opportunities to reduce staff car travel to site such as better integration with Park and Ride and hospital site*
10. **Support patient choice of less carbon intensive inhalers, for example dry powder inhalers, where clinically appropriate, resulting in a 2% reduction of emissions by March 2022** – *Clinical prescription of Green Inhalers in local care pathway in conjunction with CCGs -work just starting through Humber Coast and Vale Integrated Care System (HCV) at regional level*
11. **Work with national team to ensure schemes for green disposal of inhalers are rolled out across the region –** *work just starting through HCV*
12. **Implement approaches to optimise use of medical gases, including reducing waste and preventing the atmospheric release of medical gases-** *work started in July 2021on auditing medical gases storage and use*
13. **Make provision with a view to maximising the rate of return of equipment such as walking aids for re-use or recycling**- *in progress, system now in place to prevent losses from receipt by Trust to provision to patients*
14. **Outpatient appointments reduced by 1/3 by 2023/24 –** *non–face to face appointments increased to 25% during Covid pandemic, needs further monitoring and development support*
15. **Independent Review of NHS Hospital Food 2020, recommends a digital meal ordering system the use of seasonal menus with seasonal and local**

ingredients? and states "In a number of hospitals, digital solutions are helping healthcare teams to collate food choices, manage allergies and diets, and minimize waste. Every hospital to implement a digital meal ordering system by 2022"- *comments made recently to Catering Manager on draft Food and Drink Strategy, follow-up needed on delivery timeframe*

Work not started but action required by 31st March 2022 and/or 2023/24

16. **Solely purchase and lease cars that are ULEV or ZEV by 31st March 2022**
17. **Purchasing vans under 3.5 tonnes that are ULEVs or ZEVs 31st March 2022**
18. **Ensure that only ULEVs or ZEVs are available to staff through car salary sacrifice schemes by 31st March 2022**
19. **Fleet air pollution emissions to be reduced by 20% by 2023/24** (through change to EV)
20. **Develop and operate expenses policies for Staff which promote sustainable travel choices –***includes flow chart to encourage sustainable choices but needs changing to include other targets and regular promotion*
21. **Take action to phase out oil and coal for primary heating and replace them with less polluting alternatives by 31st March 2022***- one site left where property has 7 year lease*
22. **Put in place plans by 31st March 2022 to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service (i.e.net zero by 2040 and 80% reduction by 2032)-** *activities currently limited to new procurement, behaviour change and adjusting controls. Work started on Net Zero Estate Plan in June 2021.*
23. **Put plans in place by 31st March 2022 on how the Trust will to take action to adapt the Provider's Premises and the manner in which Services are delivered to mitigate risks associated with climate change and severe weather** - *In 2021 Trust Adverse Weather Plan replaced cold weather and heatwave plans (by Emergency Planning Manager) and agreed to annual review of impacts of adverse weather*
24. **Give due regard to the potential to secure wider social, economic and environmental benefits for the local community and population in its purchase and specification of products and services, and review on an annual basis, which impacts it will prioritise for action-** *included in some Procurement specifications. Prioritisation limited to energy question on Medical Equipment and Resources Group (MERG) and mandatory consultation on sustainability on business case forms*

Work not started but longer term targets.

25. **At least 90% of Trust fleet to use low emissions engines by 2028 and all by 2032**
26. **Net zero to be achieved for fleet and business travel by 2040** *plan needed post fleet review – see above*
27. **Net zero to be achieved for patient and visitor travel and staff commute by 2045**
28. **Achieve Net zero on all procurement by 2045-** *national guidance to follow later this year*
29. **Put in place plans to reduce waste and water usage through best practice efficiency standards and adoption of new innovations/ achieve Net Zero by 2040***- water and waste currently each circa Trust1% of Trust NHS Carbon*

Footprint so treated as lower priority -waste strategy group being established September 2021

30. **Reduce avoidable use of single use plastic products including by signing up to and observing the Plastics Pledge** – *Plastic Pledge signed*
31. **So far as clinically appropriate, to cease use of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics** - *new waste contract to be established that will include waste stream for compostables*
32. **Reduce the use of single-use plastic food and beverage containers, cups, covers and lids**- *new waste contract to be established that will include waste stream for compostables.*

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust Green Plan 2021-2026 (Summary Version)

Summary

Scope and Overview

This 2021-2026 Green Plan has been developed to replace the 2017-2020 Sustainable Development Management Plan, taking account of the guidance released in 2020 on Delivering a Net Zero National Health Service (published by NHS England/Improvement in October 2020).

Achieving the net zero carbon target which relates to the emissions that we directly control (referred to as our NHS Carbon Footprint) through reducing our energy use, our fleet and business travel, our use of anaesthetic gases and with changes to prescribing inhalers, is to be achieved by 2040 with 80% of this delivered by 2032. For emissions that we can influence but can't directly control, the net zero target is 2045 for our NHS Carbon footprint Plus. The NHS Carbon Footprint Plus includes the embodied carbon emissions from the things we buy such as medicines and medical devices and also the carbon footprint of patient and visitor travel together with the staff commute.

Carbon Footprint Analysis

Analysis of our NHS Carbon Footprint shows that 75% of the footprint is due to our energy use with 57% of the footprint coming from our gas consumption. Fleet and business travel contributes 7% of our carbon emissions but patients and visitor travel accounts for the largest portion (26%) of the Carbon Footprint Plus. In summarising the actions required to achieve carbon and greenhouse gas reduction, there is a strong focus on energy, through better control, improvements to building fabric, installation of renewables and building to net zero standards, and also travel, through improvements of facilities for active travel and electric vehicle charging, but also noting that this is about total reduction to net zero through emerging technology, the way that we deliver services to minimise waste and procurement decisions that capture requirements to reduce the carbon impact and lead to net zero.

Contents

This summary version of the Green Plan highlights key targets and work areas as well as providing an overview of historical and projected future emissions.

The full version which contains significantly more detailed information can be accessed here:

Carbon reduction progress

CO_2e emissions 2007/8 – 2019/20

Scopes of emissions

Scope 1: Emissions that come directly from our estate - examples include gas used for heating and power generation, anaesthetic gases used in surgery and the fuel used by our vehicle fleet

Scope 2: Our only emissions in this area are from the electricity we import from the grid

Scope 3: Downstream emissions such as the carbon embedded in what we buy, our grey fleet business travel and the travel of our patients and visitors

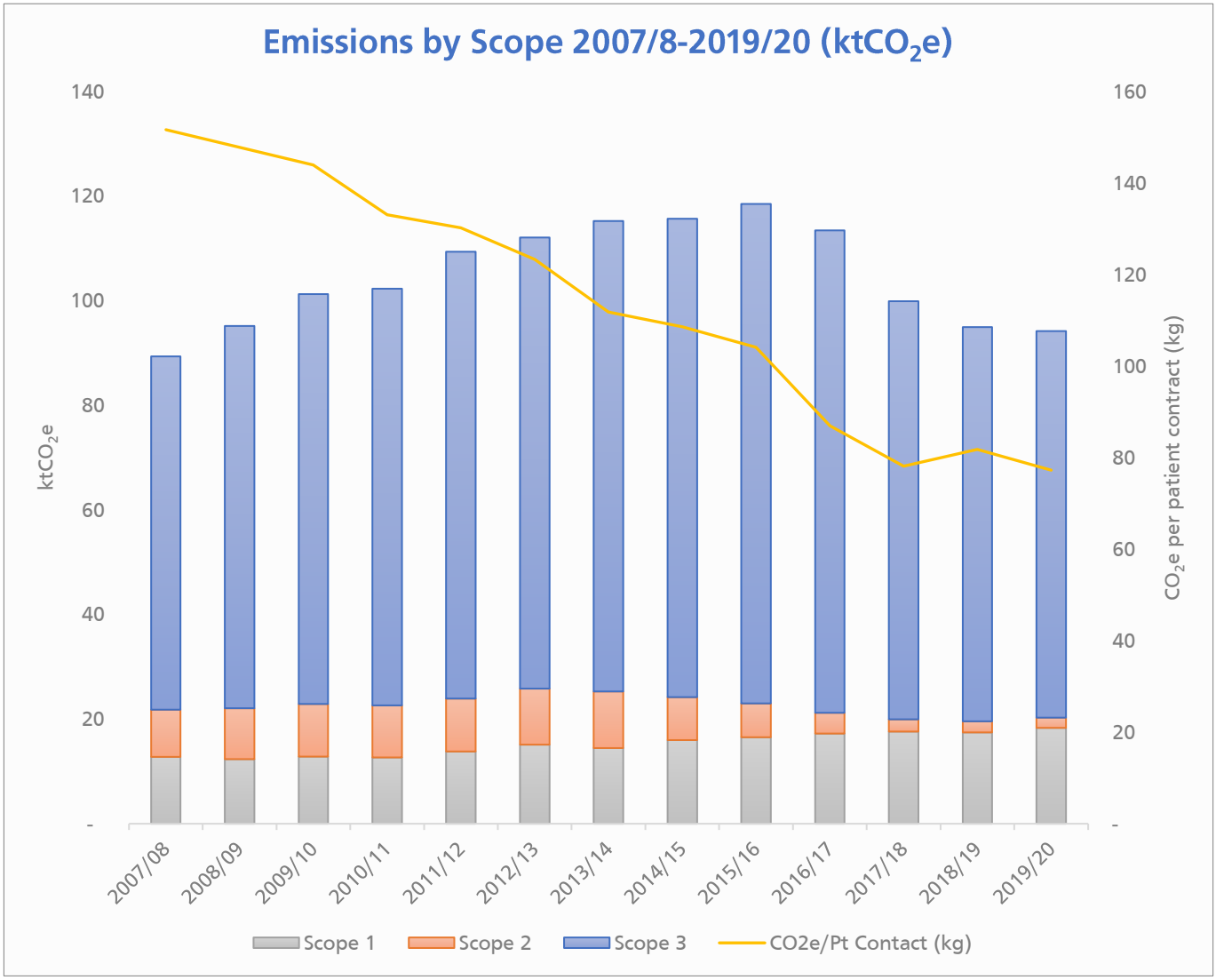


Figure 1:Total Trust CO_2 e emissions 2007/8-2019/20 by scope

Delivering A Net Zero NHS

2019/20 Carbon Footprint/Carbon Footprint Plus

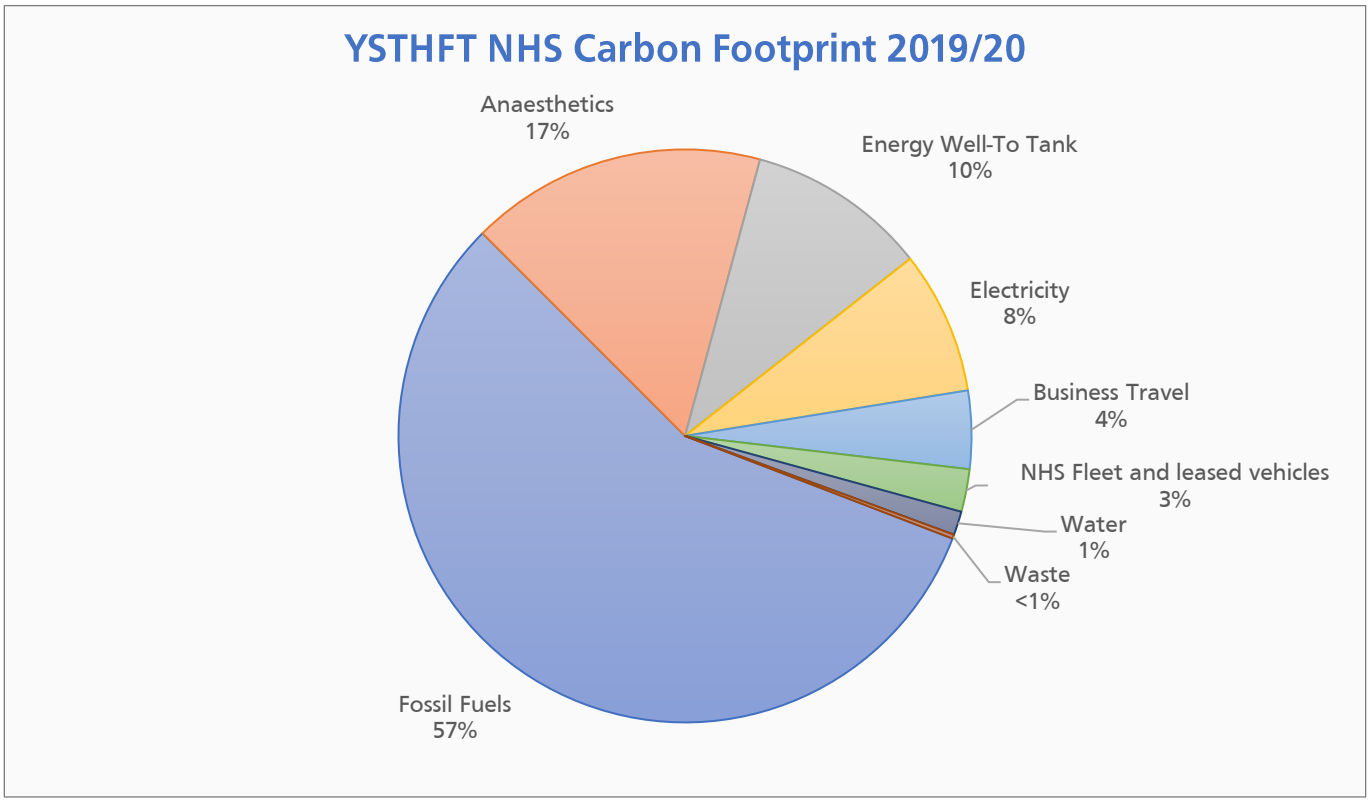


Figure 2: Trust carbon emissions for 2019/20 broken down into NHS Carbon Footprint categories

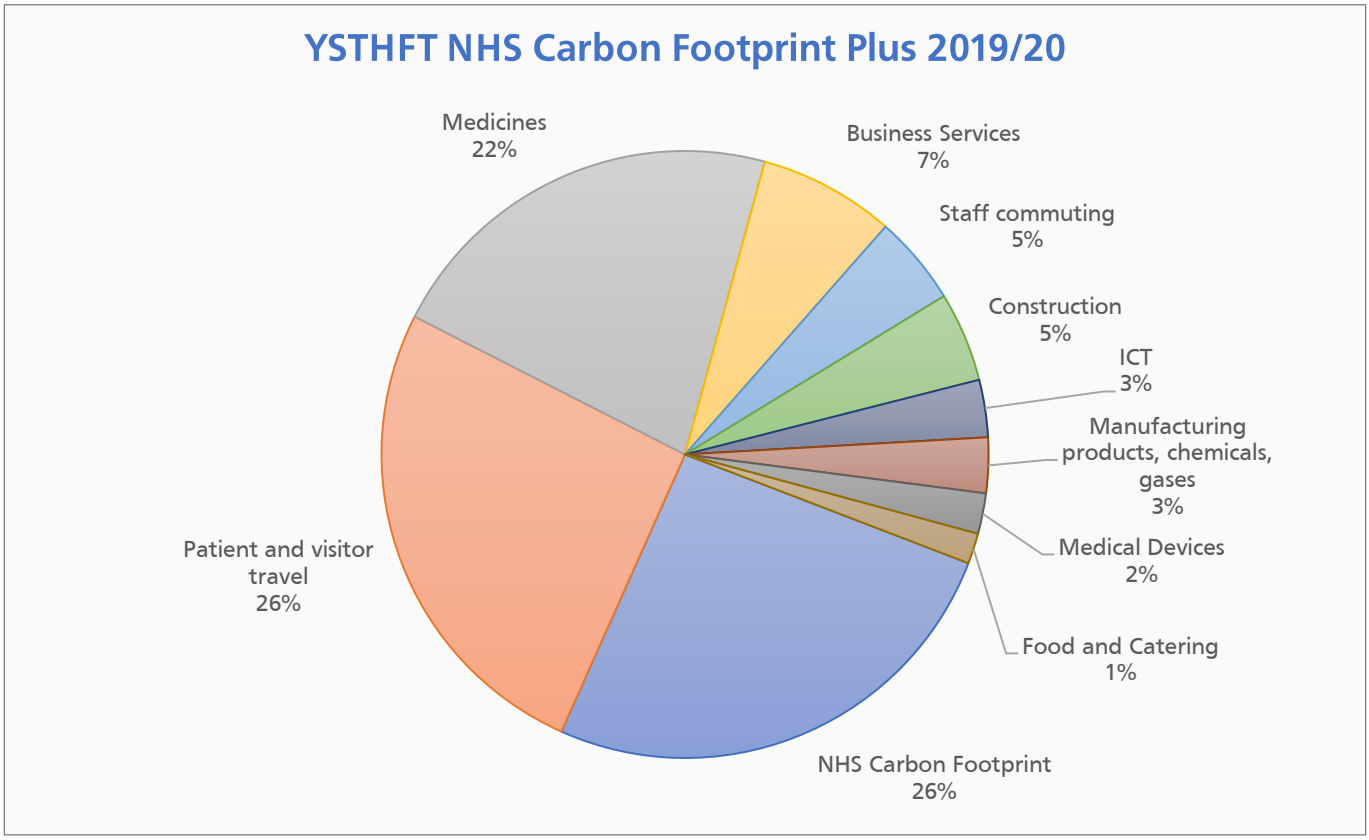


Figure 3: Trust carbon emissions for 2019/20 broken down into NHS Carbon Footprint Plus categories

Delivering A Net Zero NHS

Historic and forecast data

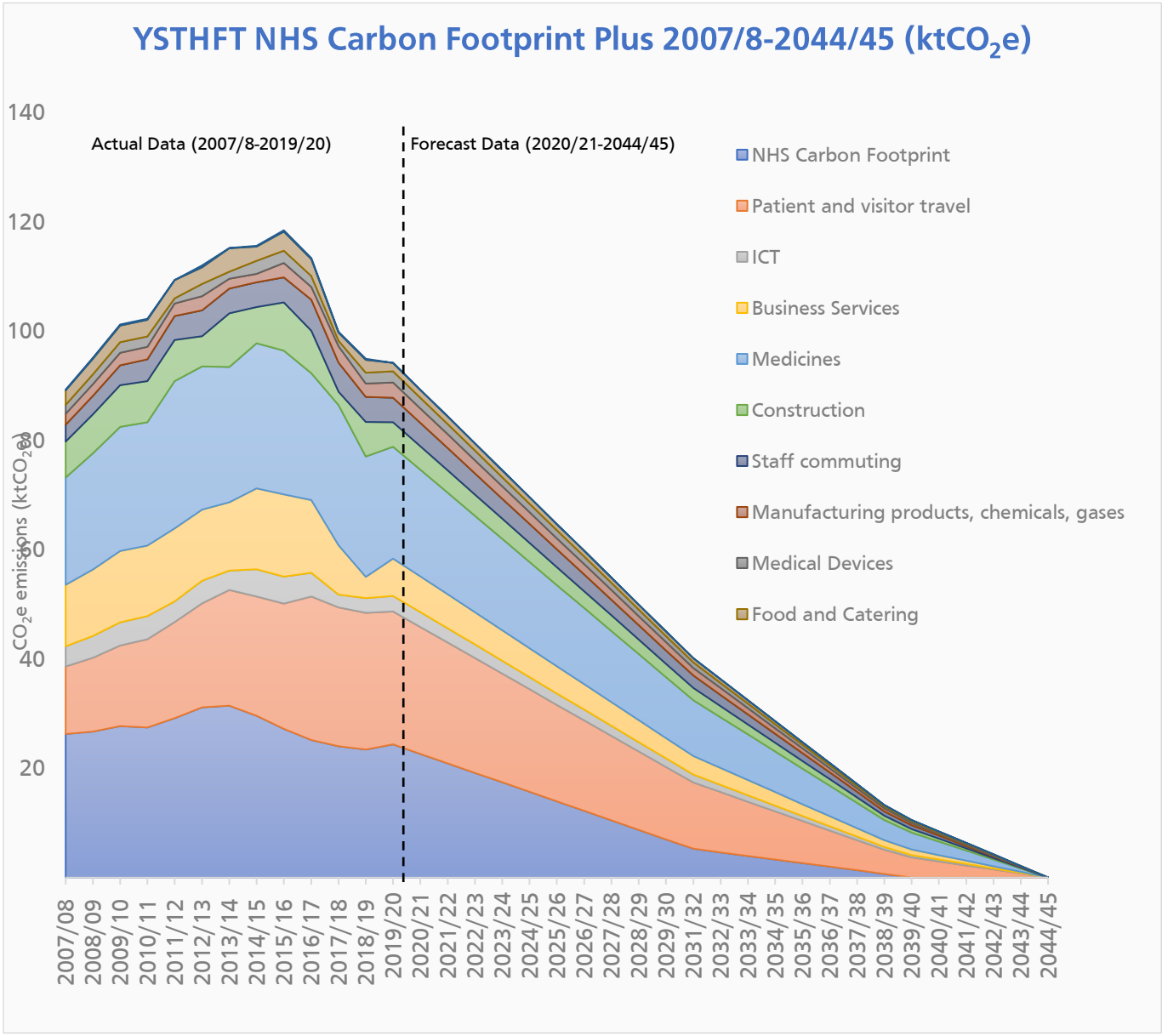


Figure 4: Historic Trust emissions aligned with the "Delivering a Net Zero NHS" Carbon Footprint Plus and projected to 2044/45

NHS Carbon Footprint and Carbon Footprint Plus Targets

- Carbon Footprint (Figure 2)
- 80% Reduction by 2032 and 100% by 2040
- Carbon Footprint Plus (Figure 3)
- 80% Reduction by 2039 and 100% by 2045

SDAT
Areas of focus

The Sustainable Development Assessment Tool (SDAT) areas of focus allow for a holistic approach to sustainability, including areas outside the scope of carbon reduction. An overview of the areas of work is provided below, whilst page 7 highlights some of our achievements in these areas over recent years. Page 8 provides a summary of the targets the Trust is working towards, in addition to the requirements of Delivering a Net Zero NHS.

Corporate Approach
The top down approach to sustainability within our organisation.

Asset Management and Utilities
The use of utilities such as gas and electricity across our estate.

Travel and Logistics
The travel of our fleet, business users, patients and visitors along with our staff commute.

Adaptation
The Trust's ability to deal with the impacts of a changing climate and associated extreme weather events.

Capital Projects
The consideration of Net Zero and sustainable development principles in new build and refurbishment projects.

Green Space and Biodiversity
The availability of green spaces for staff and visitors and the wildlife our sites support.

Sustainable Care Models
The integration of environmental sustainability into care models to improve efficiency and long term sustainability.

Our People
Ensuring staff are engaged with the sustainability agenda and encouraging staff to take ownership within their areas of influence

Sustainable Use of Resources
Reducing waste and the use of single use plastics.

Carbon/Greenhouse Gases
The total emission profile of our organisation and targets relating to Greenhouse gas reductions

Overview
Achievements

Corporate Approach
The Trust operates the Sustainable Development group, with an escalation route to the Trust Board.

Asset management and Utilities
Since April 2020, all the electricity we import from the national grid is on a 100% Green Tariff.

Travel and Logistics
Business leases limit high emission vehicles and encourage Ultra-Low emission vehicles.

Travel and Logistics
20% of the transport fleet comprised of electric vehicles and charge points have been introduced.

Travel and Logistics
York Hospital Park and Ride established. An E-Scooters trial is in progress at York, and we also operate car share and cycle to work schemes

Adaptation
Flood defences installed at Tadcaster Health Centre. Adverse weather plan updated to include data collection opportunities to inform longer term capital planning.

Capital Projects
Sustainable Design Guide introduced reinforcing the need to integrate BREAAM Excellent standards and whole life costs for all new buildings.

Green Space and Biodiversity
£200,000 charitable funding secured for Well-being gardens, with first five to be delivered in 2021/22

Sustainable Care Models
The proportion of desflurane to sevoflurane (anaesthetic gases) used in surgery reduced from 38% in 2018/19 to 9% in 2019/20

Our People
The Trust has established a Green Champions network to engage staff in sustainability and carbon reduction

Sustainable Use of Resources
Over £6,000 in avoided costs and 3 tonnes of CO_2 emissions saved by use of the “Warp It” reuse portal

Overview

Targets

Cut our business mileage by 20% (2023/24)

Work Towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs (April 2022)

Reduce face-to-face outpatient appointments by 1/3 by 2023/24 through use of virtual consultations

Phase out use of oil for primary heating (2023/24)

Reduce avoidable use of single- use plastics

Reduce use of single-use plastic food and drink containers, cups, covers and lids

Work towards ensuring that all new builds and refurbishments conform to Net Zero Standards

Provide an annual review of adverse weather impacts and adapt premises and service delivery to mitigate risks of climate change

Reduce our fleet air pollution emissions by 20% (2023/24)

Ensure that all new staff lease, salary sacrifice and pool cars purchased/leased are ULEVs or ZEVs (April 2022)

Reduce water usage and waste

Support move to less carbon intensive inhalers, where clinically appropriate

Cease use of single use plastic cutlery, plates and cups on our premises

Maximise the rate of return for walking aids

Replace lighting with LED alternatives during routine maintenance

Reduce carbon emissions from use of gas, oil and electricity through better controls and building fabrics and implementation of renewables and heat pump technology

Targets derived from the NHS Standard Contract Service Conditions 2021/2022[3], NHS Long Term Plan 2019[4], and the Greener NHS MoU requirements April 2021.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust Green Plan 2021-2026

York and Scarborough Teaching Hospitals Green Plan 2021 – 2026

1. CEO Forward

I very much welcome and support this Green Plan.

As a large, acute healthcare organisation, we are determined to deliver our contribution to national carbon reduction targets and broader sustainable development principles.

We are committed to incorporating sustainability into all that we do to ensure that our services are fit for the needs of the future without compromising on the services we provide at present.

This Green Plan sets ambitious targets and outlines the reductions in carbon emissions required to achieve our goals.

I am confident that we can face these challenges head on and emerge as a more resilient, sustainable organisation that provides quality services, continuing to put patients at the heart of everything we do.

Simon Morritt

Chief Executive Officer

"York and Scarborough Hospitals NHS Foundation Trust strives to actively encourage, promote and achieve environmental sustainability in all that it does"

Trust mission statement

2. Executive Summary

This 2021-2026 Green Plan has been developed to replace the 2017-2020 Sustainable Development Management Plan, taking account of the guidance released in 2020 on Delivering a Net Zero National Health Service (published by NHS England/Improvement in October 2020). The introduction of numerous targets in the last few months from the NHS Standard Contract, and through a Memorandum of Understanding from NHS England and Improvement, set against a back drop of the October 2020 publication of "Delivering a Net Zero National Health Service", has served to highlight the improvements needed to strengthen the Trust's plan for tackling carbon reduction. Achieving the net zero carbon target which relates to the emissions that we directly control (referred to as our NHS Carbon Footprint) through reducing our energy use, our fleet and business travel, our use of anaesthetic gases and with changes to prescribing inhalers, is to be achieved by 2040 with 80% of this delivered by 2032. For emissions that we can influence but can't directly control, the net zero target is 2045 for our NHS Carbon footprint Plus. The NHS Carbon Footprint Plus includes the embodied carbon emissions from the things we buy such as medicines and medical devices and also the carbon footprint of patient and visitor travel together with the staff commute.

This plan identifies a range of recent achievements in delivering the pathway to net zero as well as achievements against some of the new targets, such as the reduction of the use of the anaesthetic gas desflurane in favour of sevoflurane, (a lower environmental impact gas) and the increased use of technology to allow people to receive consultations at home and also work from home; but it is clear that the speed of change to transition to lower carbon alternatives needs to accelerate.

An analysis of our NHS Carbon Footprint shows that 75% of the footprint is due to our energy use with 57% of the footprint coming from our gas consumption. Fleet and business travel contributes 7% of our carbon emissions but patients and visitor travel accounts for the largest portion (26%) of the Carbon Footprint Plus. In summarising the actions required to achieve carbon and greenhouse gas reduction, there is a strong focus on energy, through better control, improvements to building fabric, installation of renewable and building to net zero standards, and also travel, through improvements of facilities for active travel and electric vehicle charging, but also noting that this is about total reduction to net zero through emerging technology, the way that we deliver services to minimise waste and procurement decisions that capture requirements to reduce the carbon impact and lead to net zero.

Whilst the later sections of the report highlight the importance of communication, tracking progress, risks and finance, it is noted that the real cost of emitting carbon is the long-term impact of the changing climate and irreversible change. We only have a short window of opportunity to stop this happening. Much of the action needed to achieve net zero results in a cost of reducing carbon emissions and this currently has to be borne by the organisation meeting the targets. It is hoped that government addresses this matter through a taxation and /or grant systems to result in financial benefits for delivering carbon savings. Whilst work must continue to deliver the required carbon savings to achieve net zero and help to solve the current climate emergency, the Trust needs to establish the most cost-effective way to achieve this without further delay.

3. Introduction

Why do we need this plan?

As an NHS organisation and a spender of public funds, we must work in a way that has a positive effect on the communities we serve. Our opportunities to make a positive impact extend beyond CO_2 reduction, and we can also help to influence our local community and workforce's health as well as our local environment.

By reducing single-occupancy car journeys, encouraging uptake of active and public travel, and reducing our business mileage, we can contribute to local air pollution reductions and increase our staff's fitness. We can also reduce our environmental impact by reducing the usage of single-use plastics where an alternative is available and ensuring that resources are used sustainably with minimal possible waste.

NHS institutions across the country are committed to the "Delivering a Net Zero NHS" strategy. Published in October 2020, these ambitious targets are outlined later in the document and form the backbone of the Trust's long-term carbon reduction strategy.

In addition to Net Zero NHS carbon reduction targets, we also must ensure that the Trust can meet sustainability-related targets within the NHS Long-Term Plan and Standard Contract. We are also committed to using the Sustainable Development Assessment Tool (SDAT), which contains many work streams which are outlined later in this document. We must take a proactive stance on carbon reduction and take advantage of new technologies and methods of working to reduce our emissions as these become available. Meeting the targets found later in this report will require holistic measures that ensure carbon reduction across the board. By collaborating with local partners and other NHS institutions, we can share best practices and ensure that we are at the vanguard of the process of becoming a Net Zero National Health Service.

Bridlington Hospital Main Entrance

4.1 Overview
About Us

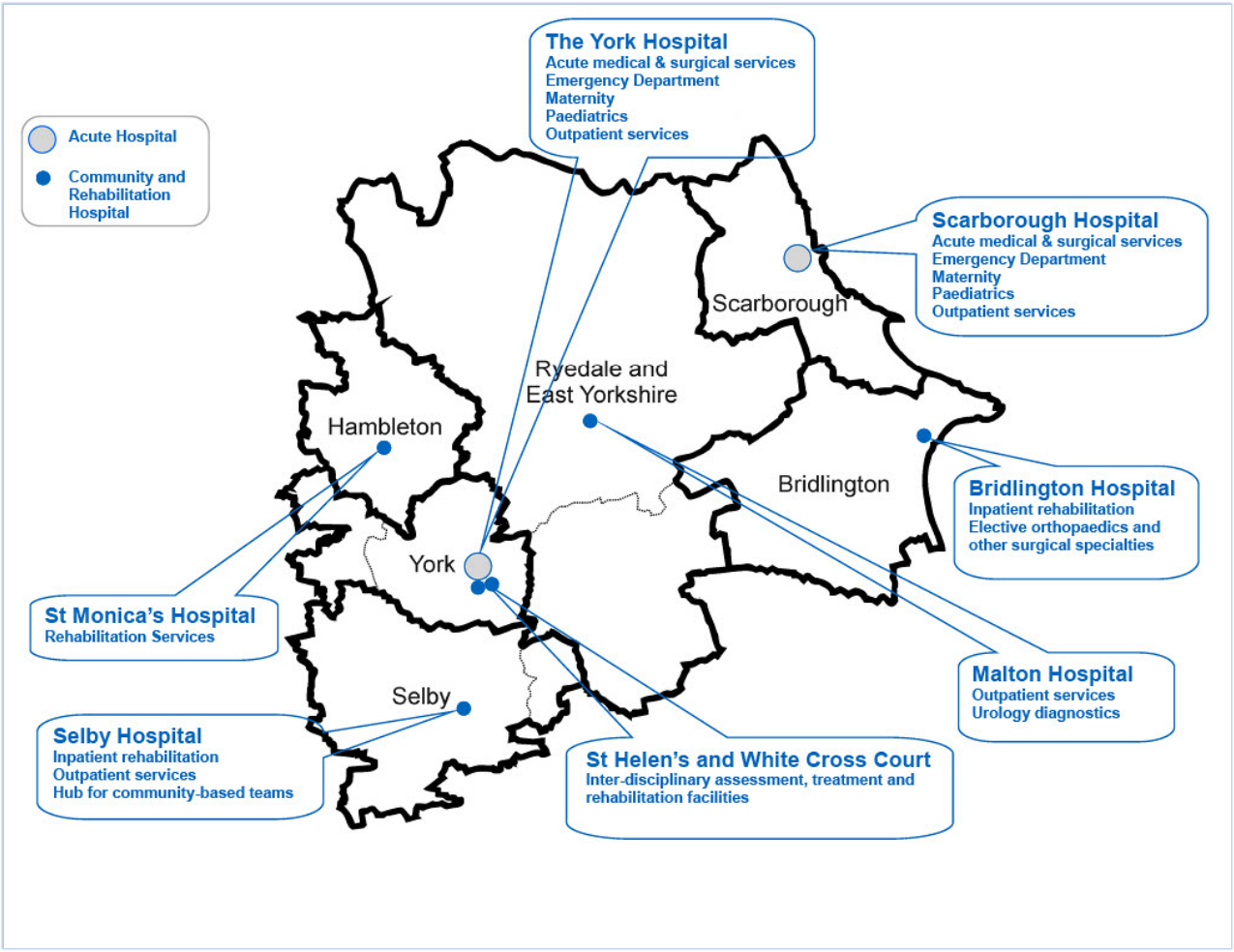
Our Hospitals

- York Hospital
- Scarborough Hospital
- Bridlington Hospital
- Malton Hospital
- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- Nelson's Court Rehabilitation Hospital (Previously St Helen's)

Our Activity

The Trust operates a wide range of inpatient, outpatient and community services across the region and provides emergency care through A&E units in York, Scarborough and Selby.

In 2019-20, the Trust had more than 1.2 million patient contacts across our sites, along with over 300,000 visits to patients in the community.



4.2 Overview
Achieving Strategic Goals

Overview

The transition to net zero is an exciting process to be a part of, and each NHS Trust will experience its own specific challenges and opportunities in achieving this goal. It is important that both are highlighted and addressed to maximise progress.

Successes

The Trust has made good progress in reducing carbon emissions from various sources, including implementing CO_2 limits on business vehicle leases, using more environmentally friendly anaesthetic gases in surgery (where appropriate), and incorporating electric vehicles into our fleet. Widening the scope of actions taken allows for increased integration of sustainability into everyday working practices and supports awareness from staff in all roles. More examples of recent successes can be found on page 11

Opportunities

While the Covid-19 pandemic has unquestionably impacted all sectors, resulting in unprecedented changes to how we live our lives, climate change and the environment remain high on the national agenda.

From an environmental perspective, the pandemic has presented new challenges such as the disposal of high volumes of PPE and decreased public transport utilisation. Still, there have also been areas where the pandemic has sped up positive change and provided inspiration for the post-Covid future. The use of videoconferencing by staff has increased tenfold since the start of the pandemic primarily because of social distancing measures and an increase in home working. We expect that after the pandemic, there will be residual impacts, including a reduction in business mileage due to staff now having a viable, tested alternative to travelling to other sites. The increase in home working enforced by the pandemic, and increasing the availability of video/telephone appointments for patients have reduced unnecessary inconvenience to patients and reduced local congestion, pollution, and carbon emissions.

We must take these and other positive by-products of Covid-19 into account as we make decisions in the future.

4.2 Overview
Achieving Strategic Goals

Challenges

With a growing, ageing population and one of the highest rates of obesity in Europe, the outlook is challenging for the Health Service. While the provision of a central NHS strategy to reach net zero is highly welcome, future strategies across all areas of the NHS must be consistent with meeting these commitments if targets are to be achieved.

York and Scarborough Teaching Hospitals provide healthcare for an area of 3,400 square miles - one of the largest of any Trust in the country. This geographical spread results in high levels of business travel between sites, one of the areas we have to address. Combined Heat and Power (CHP) generators, powered by natural gas, provide most of the Trust's electricity. While they used to provide the Trust with an annual carbon saving, the national grid's rapid decarbonisation has resulted in these CHPs being more carbon-intensive than drawing the necessary electricity from the grid. While on-site electricity production from gas benefits the Trust financially, we will not achieve the required carbon savings to meet future targets until we address this.

Historic measures to reduce carbon emissions have often had a financial co-benefit that made them viable, but there will be costs associated with meeting net zero. A Climate Change Committee study determined that a 2050 net zero target is "technically feasible but highly challenging“ [1], requiring complex, costly, and time-consuming interventions. As the NHS Carbon Footprint Plus requires Net Zero emissions by 2045 and includes emissions outside the scope of the Climate Change Act, it is logical to assume that the same will apply to these targets. We must reflect on this reality and adjust our expectations accordingly to reduce emissions at the required rate.

York Hospital Main Entrance: Over 700,000 patients are seen every year at the York site, representing around 60% of our clinical activity.

4.3 Overview
Partnership Working

Working Together

The Trust's premises are spread across a large geographical area, spanning three different CCGs and a multitude of local and regional councils, serving a registered population of approximately 800,000 people.

All of our partners are working to reach Net Zero by 2050 as per the Climate Change Act, some such as City of York Council, have gone further and set more ambitious targets, including a 2030 Net Zero target for scope 1 and 2 emissions. It is vital that we link with these partners to share best practices and ideas so that all groups can make progress towards these ambitious targets.

The Trust works with local councils to help achieve our aims, such as encouraging uptake of active and public transport to work and being involved in local schemes to cut air pollution. The Humber Coast and Vale partnership is working towards sustainability goals across the region, and the Trust is keen to be an active partner in this endeavour.

Our Partners

- NHS Vale of York CCG
- NHS North Yorkshire CCG
- NHS East Riding of Yorkshire CCG
- City of York Council
- North Yorkshire County Council
- Scarborough Borough Council
- East Riding of Yorkshire Council
- York and North Yorkshire Local Enterprise Partnership (LEP)
- Humber, Coast and Vale Partnership

4.4 Overview
Sustainability Timeline

2007 — The Trust commits to reducing its CO_2 emissions

2009 — Sustainable Development Group (SDG) Established

2012 — The Trust incorporates Scarborough and Bridlington Hospitals

2015 — The Trust publishes it's first Sustainable Development Management Plan (SDMP)

2017 — The Trust updates it's SDMP to cover the following three years

2019 — First Trust-wide Travel Plan published to encourage greater use of active and public forms of travel

2021 — Green Plan published for 2021-2026

4.5 Overview
Achievements

In recent years, the Trust has made good progress across a range of areas. Some of our highlights are shown below, aligned to the Sustainable Development Assessment Tool (SDAT) areas of focus outlined in section 7.1

We believe that the scope of our achievements demonstrates our commitment to carbon reduction and decreasing our environmental impact. We aim to further widen the range of areas that we are addressing during the lifetime of this strategy and look forward to reporting back on further successes in the future.

Corporate Approach
The Trust operates the Sustainable Development group, with an escalation route to the Trust Board.

Asset management and Utilities
Since April 2020, all the electricity we import from the national grid is on a 100% Green Tariff.

Travel and Logistics
Business leases limit high emission vehicles and encourage Ultra-Low emission vehicles.

Travel and Logistics
20% of the transport fleet (9) comprises of electric vehicles and charge points have been introduced.

Travel and Logistics
York Hospital Park and Ride established. An E-Scooters trial is in progress at York, and we also operate car share and cycle to work schemes

Adaptation
Flood defences installed at Tadcaster Health Centre. Adverse weather plan updated to include data collection opportunities to inform longer term capital planning.

Capital Projects
Sustainable Design Guide introduced reinforcing the need to integrate BREAAM Excellent standards and whole life costs for all new buildings.

4.5 Overview
Achievements

	**Green Space and Biodiversity** Scarborough Hospital car park planted and maintained to increase biodiversity.
	**Green Space and Biodiversity** £200,000 charitable funding secured for Well-being gardens, with first five to be delivered in 2021/22
	**Sustainable Care Models** The proportion of desflurane to sevoflurane (anaesthetic gases) used in surgery reduced from 38% in 2018/19 to 9% in 2019/20
	**Sustainable Care Models** Clinical prescription of greener inhalers in local care pathway in conjunction with CCGs
	**Our People** The Trust has established a Green Champions network to engage staff in sustainability and carbon reduction
	**Sustainable Use of Resources** Over £6,000 in avoided costs and 3 tonnes of CO_2 emissions saved by use of the “Warp It” reuse portal
	**Sustainable Use of Resources** Plastic Straws and stirrers are no longer used in the Trust (Except where clinically appropriate
	**Sustainable Use of Resources** Sustainability is a mandatory consideration in all new business cases and resource use and efficiency is part of all new job descriptions (since 2017)
	**Carbon/Greenhouse Gases** 20% Reduction in CO_2 emissions since 2015/16 and a 49% reduction in CO_2 emissions per patient contact since 2007/08

4.6 Overview

Targets

Cut our business mileage by 20% (2023/24)

Reduce our fleet air pollution emissions by 20% (2023/24)

Work Towards purchasing vans under 3.5 tonnes that are ULEVs or ZEVs (April 2022)

Ensure that all new staff lease, salary sacrifice and pool cars purchased/leased are ULEVs or ZEVs (April 2022)

Reduce face-to-face outpatient appointments by 1/3 by 2023/24 through use of virtual consultations

Reduce water usage and waste

Phase out use of oil for primary heating (2023/24)

Support move to less carbon intensive inhalers, where clinically appropriate

Reduce avoidable use of single- use plastics

Cease use of single use plastic cutlery, plates and cups on our premises

Reduce use of single-use plastic food and drink containers, cups, covers and lids

Maximise the rate of return for walking aids

Work towards ensuring that all new builds and refurbishments conform to Net Zero Standards

Replace lighting with LED alternatives during routine maintenance

Provide an annual review of adverse weather impacts and adapt premises and service delivery to mitigate risks of climate change

Reduce carbon emissions from use of gas, oil and electricity through better controls and building fabrics and implementation of renewables and heat pump technology

Targets derived from the NHS Standard Contract Service Conditions 2021/2022[3], NHS Long Term Plan 2019[4] and the Greener NHS MoU requirements April 2021.

4.7 Overview
Drivers For Change - General

Legislative

- Civil Contingencies Act 2004
- Climate Change Act (CCA) 2008
- Public Services (Social Values) Act 2013

Mandatory

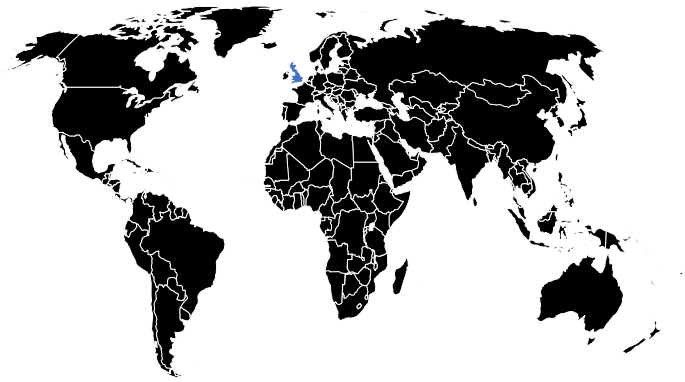
- Standard Form Contract requirements for Sustainable Development 2020
- HM Treasury's Reporting Framework
- Public Health Outcomes Framework

UK guidance

- National Policy and Planning Framework 2012
- Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013
- DEFRA Government Buying Standards for Sustainable Procurement 2016
- The Stern Review; The Economics of Climate Change 2006
- Health Protection Agency (HPA) Health Effects of Climate Change 2012
- The National Adaptation Programme; Making the country resilient to the changing Climate 2013
- DEFRA 25 Year Plan 2018
- HM Government Clean Growth Strategy 2017 (Amended 2018)

International

- International Panel on Climate Change (IPCC) AR5 2013
- United Nations (UN) Sustainable Development Goals (SDG's) 2016
- World Health Organisation (WHO) toward environmentally sustainable health systems in Europe 2016
- WHO Health 2020; European policy for health and wellbeing
- The Global Climate and Health Alliance; Mitigation and Co-benefits of Climate Change



4.8 Overview
Drivers For Change - Healthcare Specific

Drivers for Healthcare

The drivers outlined on the previous page are not specific to healthcare and the NHS. As sustainability has to be considered in a range of settings, there is a wide variety of guidance, requirements, and legislation to be mindful of - this list is not exhaustive.

In addition to more general drivers, there are healthcare-specific requirements that must be incorporated into our plan, particularly the “Delivering a Net Zero NHS” strategy released in October 2020, which includes more ambitious carbon reduction targets than legislated for by the Climate Change Act (CCA). The NHS now has a target to be Net Zero by 2045, 5 years earlier than the CCA legislates.

Health Specific Requirements

- Delivering a Net Zero NHS 2020
- NHS Standard Contract 2020/21
- NHS Long Term Plan
- Adaptation Report for the Healthcare System 2015
- The Carter Review 2016
- National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012
- Health Technical Memoranda (HTM)’s and Health Building Notes (HBN)’s
- Sustainable Transformation Partnership (STP) Plans
- NICE guideline (NG70) 2017
- The Marmot Review; Fair Society, Healthy? Lives 2010

5.1 Carbon reduction progress

CO_2e emissions 2007/8 – 2019/20

Scopes of emissions

Scope 1: Emissions that come directly from our estate - examples include gas used for heating and power generation, anaesthetic gases used in surgery and the fuel used by our vehicle fleet

Scope 2: Our only emissions in this area are from the electricity we import from the grid

Scope 3: Downstream emissions such as the carbon embedded in what we buy, our grey fleet business travel and the travel of our patients and visitors

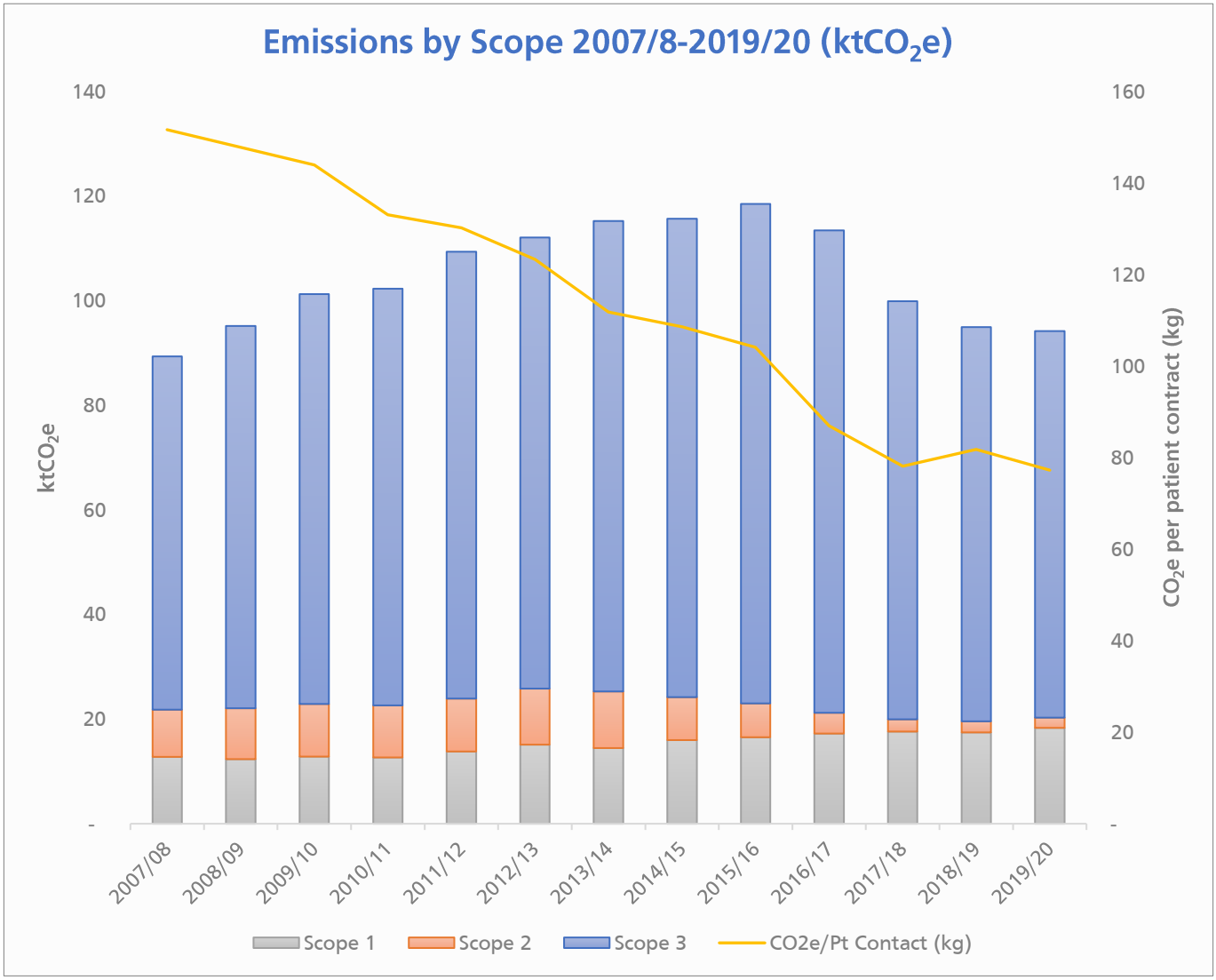


Figure 1:Total Trust CO_2 e emissions 2007/8-2019/20 by scope

5.2 Carbon reduction progress

NHS and mandatory carbon reporting data issues

Baseline

The targets set by both the Climate Change act and the "Delivering a Net Zero NHS" strategy are measured against a 1990 emission baseline. As the Trust does not have complete data going back to 1990, a 2007/8 baseline is used, as advised by the NHS Sustainable Development Unit (SDU).

A 2010 SDU report[6] showed that in 2007 NHS England CO_2e emissions were almost identical to 1990. As the Trust reports in financial years, we have aligned this to our 2007/8 emissions.

We have used this 2007/8 baseline to determine both our interim and final Net Zero NHS Carbon Footprint and Carbon Footprint Plus Targets.

Ongoing Data

We are constantly increasing the scope of both our data recording and reporting. We backdate data wherever possible, but this is not always achievable. Increases in reported emissions as sources of CO_2 are recognised and quantified or as more accurate reporting systems are developed are inevitable. As such, some historical information will not be as accurate as more recent data.

Historical data is subject to change as more information becomes available, and we will report this in the sustainability section of the Trust Annual Report.

Procurement

The Trust uses carbon factors historically provided by the SDU to calculate the CO_2 emissions embedded in what we buy. These carbon factors have not been updated for several years, meaning that changes such as decarbonisation of the grid and reductions in freight emissions are not taken into account for 2008/09 onwards. We apply Retail Price Index (RPI) adjustments to account for inflation. We are exploring options to quantify these emissions with a greater degree of accuracy in the future, which could lead to changes in our reported emissions in this area.

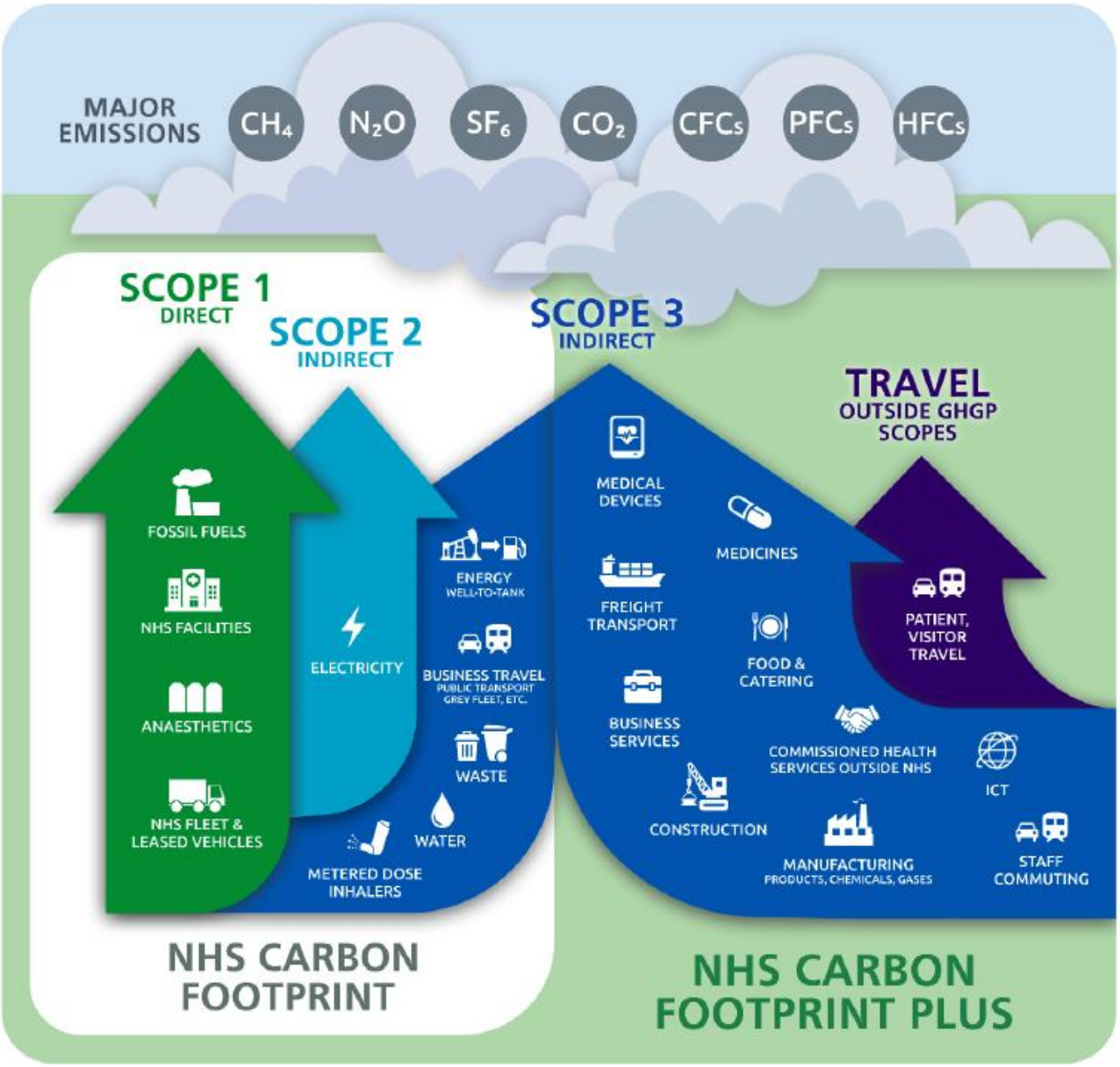
The Greener NHS is expected to provide information and advice to help Trusts reduce their procurement emissions during this strategy's lifetime and the Trust is keen to engage with this work.

6.1 Delivering A Net Zero NHS

Historic and forecast data

Overview

In October 2020, the NHS committed to becoming a Net Zero organisation by 2045 in the Delivering a Net Zero National Health Service[2] publication. The Trust has aligned its data to work towards this strategy's targets. There are two targets, one for the "NHS Carbon Footprint," which is for an 80% reduction by 2032 and a 100% reduction by 2040. The other target is the "NHS Carbon Footprint Plus," which has an expanded scope and a target of an 80% reduction by 2039 with net-zero emissions targeted for 2045, all against a 1990 baseline (2007/8 for the Trust). The components of these two targets are shown in the diagram below as presented in the strategy. The next page provides a breakdown of our 2019/20 emissions data into NHS Carbon Footprint and Carbon Footprint Plus categories.



6.2 Delivering A Net Zero NHS
2019/20 Carbon Footprint/Carbon Footprint Plus

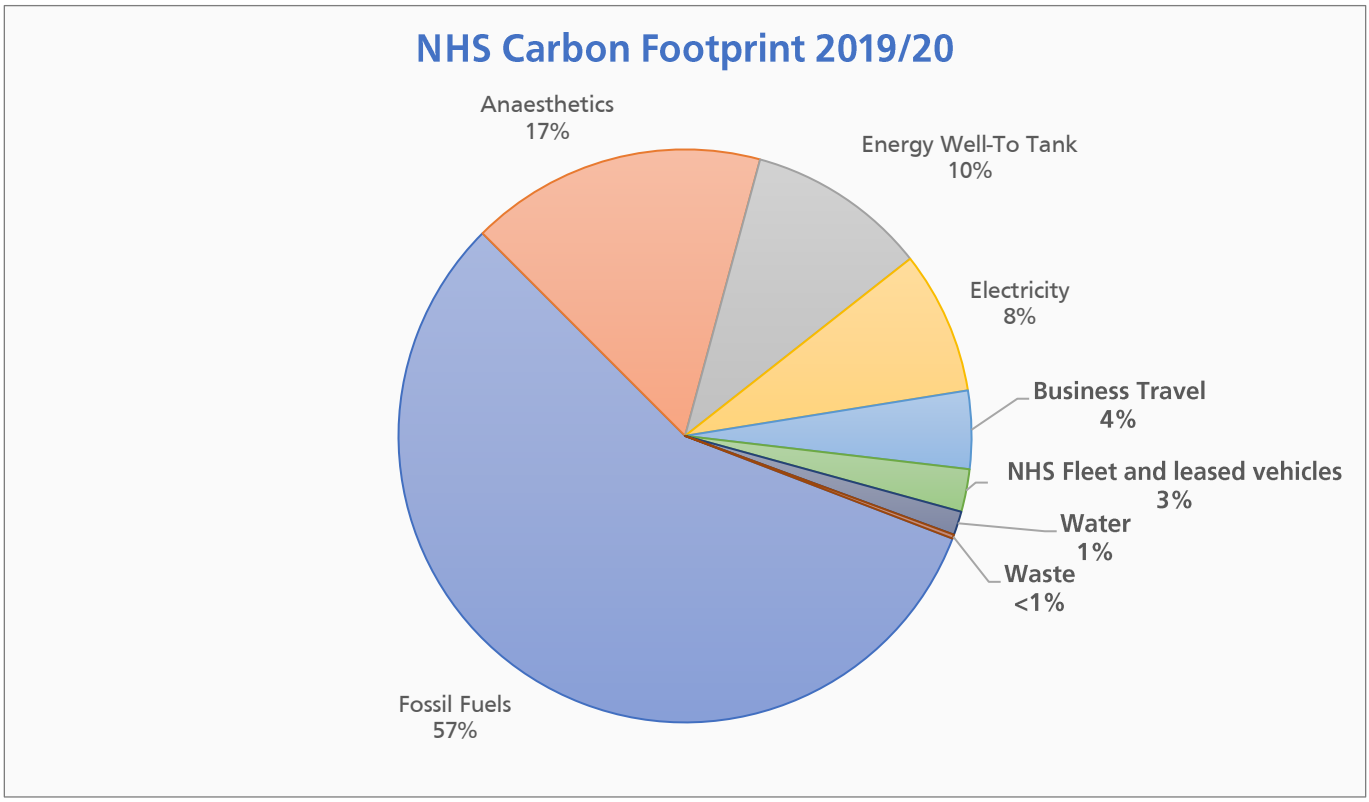


Figure 2: Trust carbon emissions for 2019/20 broken down into NHS Carbon Footprint categories

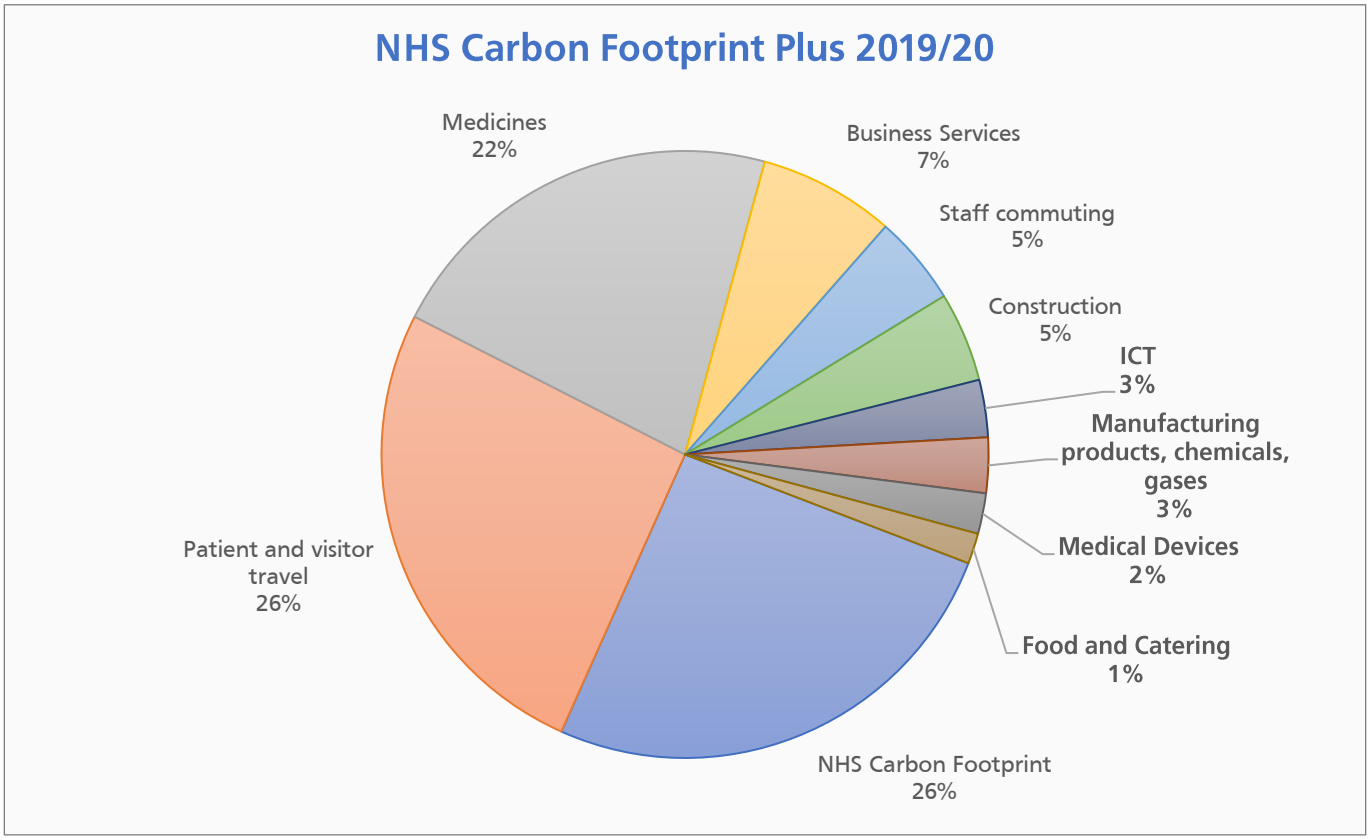


Figure 3: Trust carbon emissions for 2019/20 broken down into NHS Carbon Footprint Plus categories

6.3 Delivering A Net Zero NHS

Historic and forecast data

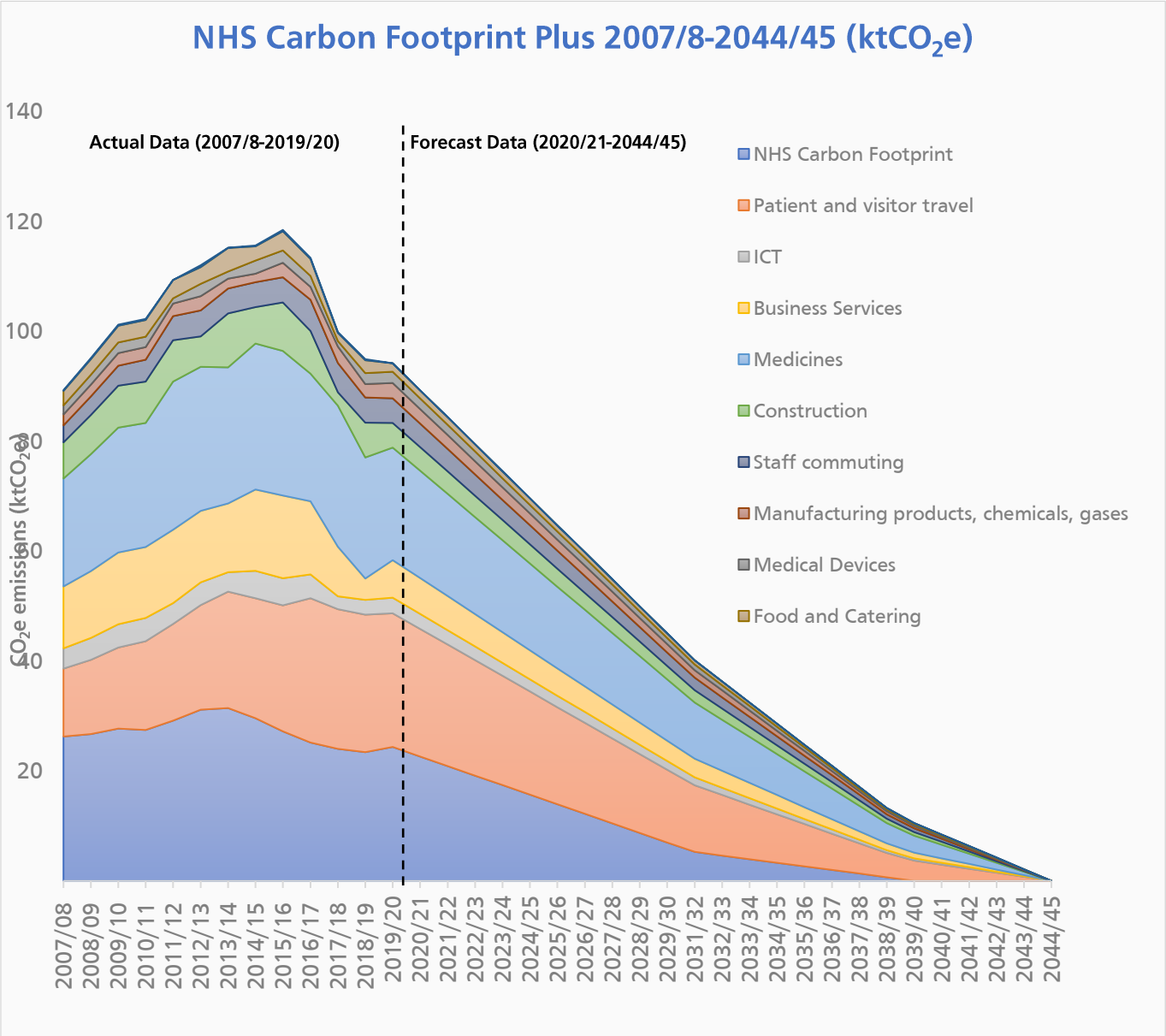


Figure 4: Historic Trust emissions aligned with the "Delivering a Net Zero NHS" strategy Carbon Footprint Plus and projected to 2044/45

Carbon Footprint Plus

The Carbon Footprint Plus includes the full scope of emissions reported by the Trust. An interim target of an 80% reduction has been set for 2039, with a 100% reduction target set for 2045. Freight shipping is included, but this is calculated as part of our procurement emissions and is not displayed separately. Percentage breakdowns of contributions from each area for the Trust are provided in figures 2 and 3 in section 6.2.

6.4 Delivering A Net Zero NHS

Carbon Footprint projections

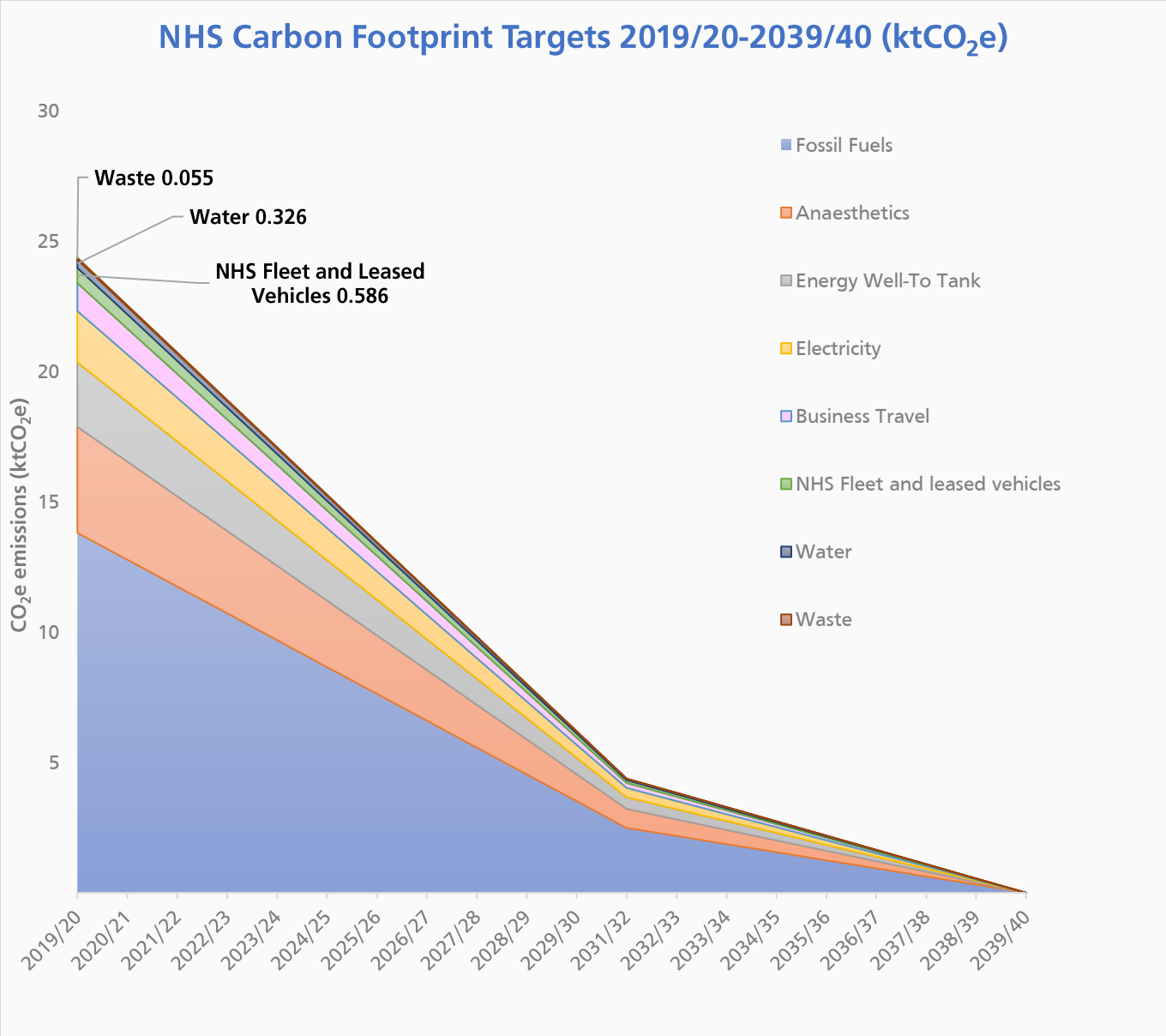


Figure 5: The emission reductions required for the Trust to meet the targets of 80% reduction by 2031/32 and 100% by 2039/40 within the scope of the NHS Carbon Footprint.

Carbon footprint Overview

The NHS Carbon Footprint includes all scope 1 and 2 emissions as well as business travel, water and waste which are classified as scope 3. These are areas that we have significant influence over and are largely produced on our estate. We have already made good progress in some of these areas, such as waste and electricity, but a rapid decrease in our use of gas and oil is essential to meeting these targets as they contribute more than 60% of our Carbon Footprint.

6.5 Delivering A Net Zero NHS

Carbon Footprint plus projections

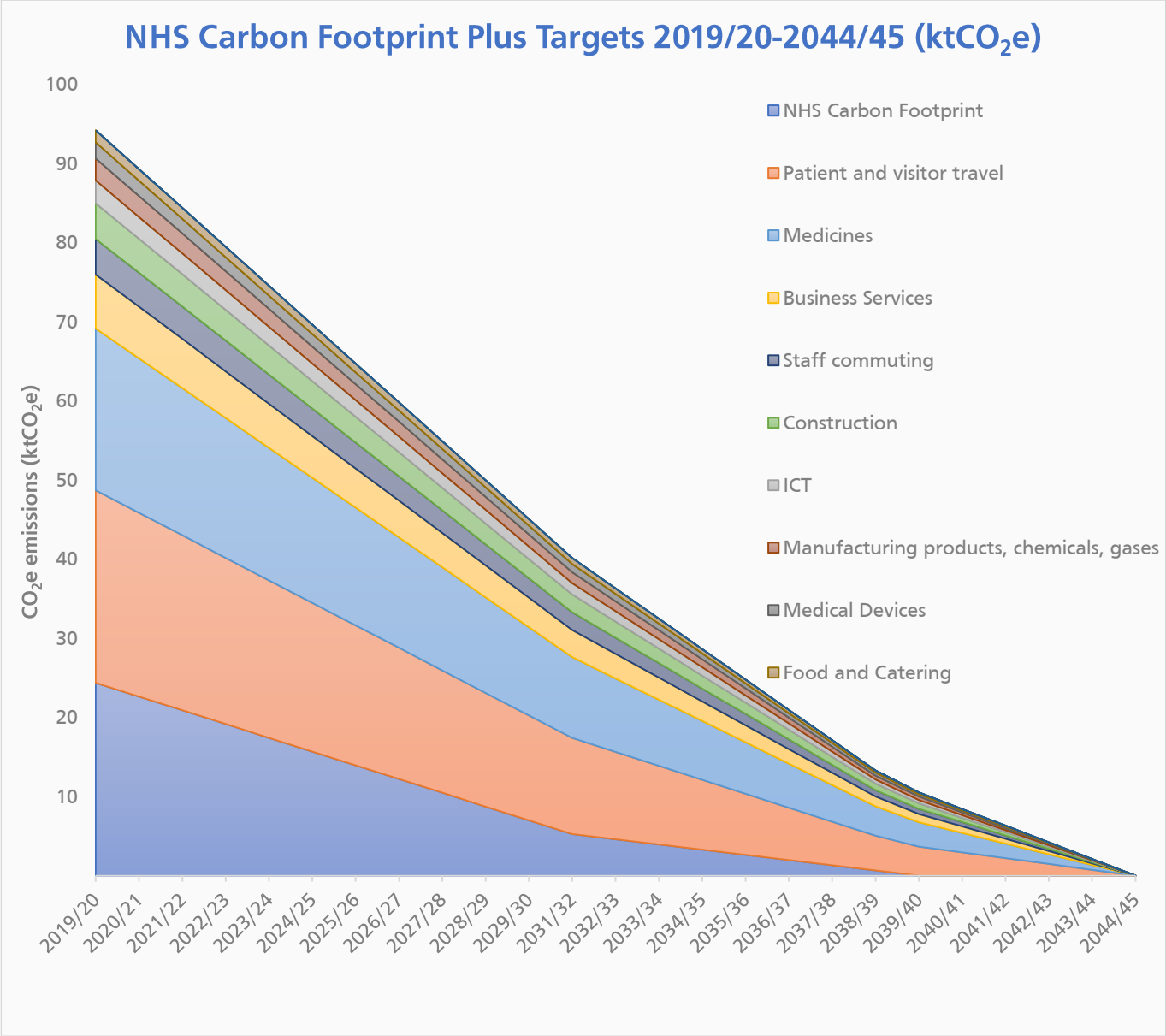


Figure 5: The emission reductions required for the Trust to meet the targets of 80% reduction by 2038/39 and 100% by 2044/45 within the scope of the NHS Carbon Footprint Plus. (Includes the NHS Carbon Footprint from Figure 4)

Footprint Plus Overview

The NHS Carbon Footprint Plus consists of Scope 3 emissions, mainly from what we buy, patient and visitor travel to Trust sites, and our staff commuting. NHS Supply Chain will undertake much of the work in decarbonising supply chains centrally, but we must ensure that we integrate sustainability into procurement frameworks at a local level. Encouraging staff to use active travel and public transport will contribute towards reductions in the emissions produced from staff commuting and this will be supported by greater availability of electric vehicles in future years for both staff and the general public.

7. The Sustainable Development Assessment Tool (SDAT)

Overview

The Sustainable Development Assessment Tool (SDAT) is used to help Trusts reach their sustainable development goals. The tool divides objectives into a group of workstreams, outlined on the next page. Each workstream has a responsible lead who reports back on progress to the sustainability team quarterly.

The SDAT covers measures that can reduce CO_2 emissions and more holistic initiatives such as improving the health of our staff and visitors, increasing access to Green Space, and mitigating the impacts of climate change.

Several NHS Long Term Plan and Standard Contract requirements are also included here within the relevant workstreams to contextualise them and demonstrate how they fit into the "bigger picture." There is inevitably slight overlap, but this is kept to a minimum.

United Nations Sustainable Development Goals

The 2030 Agenda for Sustainability Development Goals, adopted by all United Nations Member States in 2015, provides a shared blueprint for peace and prosperity for people and the planet, now and into the future. At its heart are the 17 Sustainable Development Goals (SDGs), shown below which are an urgent call for action by all countries - developed and developing - in a global partnership.

7.1 SDAT Areas of focus

7.2 SDAT 2021 Assessment score

SDAT Score 2021

In addition to reducing our carbon footprint, we have also made good progress against the qualitative SDAT scoring system. The overall score for our latest assessment was 65%, a three percent increase on our 2020 score. This is above average for comparative acute Trusts and is indicative of the measures taken across the Trust, resulting in a 16% increase in our score since 2018.

Areas that have seen the greatest increase are corporate approach, sustainable care models and asset management and utilities, where excellent progress has been made in comparison to our starting position.

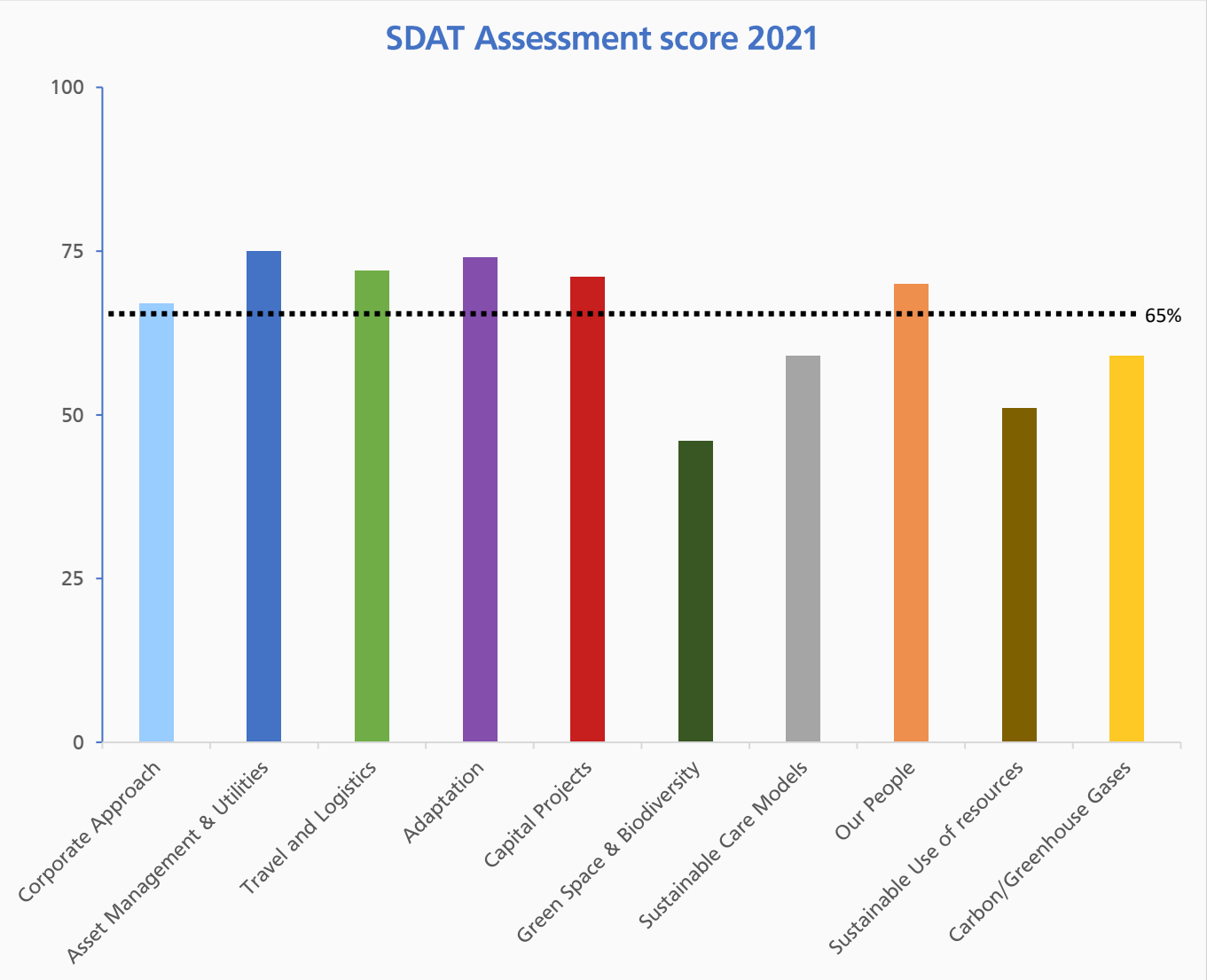


Figure 7: SDAT scores by category,

8.1 SDAT Areas of Focus
Corporate Approach

SDAT Score 2021: 67%

Overview

"All NHS organisations – including every region and integrated care system – will be required to have a board-level lead, responsible for leading on net zero and the broader greener NHS agenda" **Delivering a Net Zero NHS**

Corporate support is critical to embedding sustainability into the culture of an organisation. Senior staff must be engaged in and accountable for delivering the targets in our Green Plan, with policies, procedures, and business case processes that reflect this. The Trust has already made progress in this area by establishing the Sustainable Development Group (SDG) and asking senior staff to be "Sustainability Champions" and cascade sustainability-related information to their teams. An Energy Reduction Programme Board has been established to identify areas where energy reduction can be achieved.

The Trust has also has a growing group of Green Champions, currently around 80 staff have signed up, and we hope to involve more staff in the future. We must keep our staff engaged and up to date with our progress and ways they can contribute to making the Trust more sustainable.

Scarborough Hospital is the Trust's second largest site. The Trust has been granted funding to provide a new Emergency Department. This project is in the planning stages and provides the Trust with the opportunity to produce a flagship, net zero department providing ongoing carbon and energy savings.

8.1 SDAT Areas of Focus
Corporate Approach

SDAT Score 2021: 67%

Where do we want to be?

- Sustainability integrated throughout the organisation
- Achieve an SDAT score of 75% or higher by 2025
- Engaged Green Champions network throughout the Trust
- Senior Support for Sustainability and the Net Zero Strategy

How will we get there?

- Increase distribution of relevant sustainability information
- Develop and provide an easily accessible repository of sustainability related information for staff
- Through strategic use of groups such as the SDG to engage and motivate key staff
- Appointment of a Trust board level Sustainability lead

How will we measure our progress?

- Sustainability survey to be undertaken every three years
- Review of SDAT scores
- Number of Green Champions across the Trust
- Inclusion of sustainability in the Trust's organisation values, strategy and processes

8.2 SDAT Areas of Focus
Asset Management and Utilities

SDAT Score 2021: 75%

Overview

"A wide range of interventions focused on air conditioning and cooling, building fabric, space heating, ventilation and hot water could all be rolled out throughout the secondary care estate over the next 5 to 10 years, saving some £250 million per year"
Delivering A Net Zero NHS

The Trust operates multiple properties across the North Yorkshire Region, with a range of functions, ages and energy efficiency scores. The Trust's aim is to decrease the use of gas, electricity, and water across the estate despite these challenges, with increased energy sub-metering and monitoring across the Trust playing essential parts in this process.

By developing an understanding of localised energy and water use throughout the Trust, more targeted and measurable initiatives can be devised and accurately quantified.

LED lighting will contribute to reductions in electricity demand as will procurement decisions we make regarding energy-intensive equipment.

We must reduce our gas consumption. While efficiency improvements can be achieved through measures such as purchasing more efficient boilers and installing insulation, gas will ultimately need to be phased out in favour of less carbon intensive energy sources such as on-site renewables, and increased electricity imports from the national grid. This is a challenge faced by many Trusts, and while it is unlikely that the Trust will completely phase out gas within the lifetime of this strategy, progress needs to be made to ensure that we meet Net Zero NHS strategy targets.

St. Monica's hospital is the Trust's smallest community hospital with 12 inpatient beds. A new, energy efficient boiler has recently been installed and is expected to deliver a substantial reduction in gas use at the site over the coming years.

8.2 SDAT Areas of Focus

Asset Management and Utilities

SDAT Score 2021: 75%

Where do we want to be?

- Year on year reduction in utilities consumption on a “per patient” basis
- More energy efficient equipment on site.
- To be generating our own on-site, renewable energy
- On target to meet CO_2 reductions required for the Delivering a Net Zero NHS Strategy
- Phase out use of oil for primary heating (2023/24)

How will we get there?

- Increased metering and monitoring of utilities
- Develop targeted utility reduction plans based on monitoring data
- Include lifecycle costs when purchasing new equipment
- Work to get funding for improving energy control, building fabric and installing renewable technologies at the Trust
- Engagement with staff
- Facilitating home working where possible

How will we measure our progress?

- Reviews of the Trust Utility dashboard
- Estates Returns Information Collection (ERIC) Trust Annual Reports
- Sustainable Resource Planning (SRP) Reports
- Reviews of energy efficiency weighting in new equipment tender documents

8.3 SDAT Areas of Focus
Travel and Logistics

SDAT Score 2021: 72%

Overview

"Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS" **Delivering a 'Net Zero' National Health Service**

Travel to and from Trust sites impacts both our hospitals and the local community as a whole. We have a responsibility to reduce our contribution to local air pollution and CO_2 emissions.

The Trust currently has nine electric vehicles as part of its fleet and plans to gradually add more electric vehicles in line with and above NHS Long Term plan targets. The Trust already has a travel plan and a business travel hierarchy encouraging active and public transport. We have secure cycle storage, a fleet of designated low emission pool cars, and a Hospital Park and Ride service that serves the York site.

As part of the NHS Carbon Footprint Plus, we are required to consider the transport emissions produced due to our day-to-day activities and those of our patients and visitors, along with the commuting undertaken by our staff. Increasing the provision of electric vehicle charging infrastructure is a key objective for the Trust in supporting the transition away from vehicles using fossil fuels.

York Hospital Park and Ride

The Hospital buses provide a frequent service from a local Park and Ride site to York Hospital. The service has been well received by users and provides a viable alternative to parking on site for staff and visitors. By reducing single-occupancy vehicle journeys, the service has the opportunity to reduce local air pollution and CO_2 emissions and reduce congestion.

8.3 SDAT Areas of Focus

Travel and Logistics

SDAT Score 2021: 72%

Where do we want to be?

- Fleet air pollution emissions reduced by 20% by 2023/24
- Business mileage reduced by 20% by 2023/24
- Ensure that all new staff lease, salary sacrifice and pool cars purchased/leased are ULEVs or ZEVs (April 2022) and work towards purchasing vans meeting these requirements
- Year-on-year increase in the proportion of staff commuting via active/public transport
- At least 90% of Trust fleet to use low emissions (Including 25% ultra low) by 2028/29

How will we get there?

- Increased charging infrastructure across the Trust to support electrification
- All new vehicles to conform to ULEV standards
- Increased uptake of videoconferencing to reduce site to site business travel
- Increased use of patient video/telephone outpatient appointments (where appropriate)
- Review and reduce business lease and fleet lease CO_2 limit for all new/ replacement vehicles
- Increased provision of cycle storage, shower and lockers supported by incentivisation of bike purchases through staff benefits programs
- Continue to work with partners such as City of York Council to promote sustainable travel

How will we measure our progress?

- Monitoring of the composition of our fleet and our fuel use/mileage
- Monitoring of outpatient appointments and use of videoconferencing
- Patient and visitor travel surveys, and staff surveys at least once every three years.

8.4 SDAT Areas of Focus
Adaptation

SDAT Score 2021: 74%

Overview

"A net zero NHS is an essential component of the response to climate change. However, the NHS must also adapt to the impacts of climate change that are already occurring today, and those that cannot be avoided" **Delivering a 'Net Zero' National Health Service**

As the climate changes and the likelihood of extreme weather events (in particular temperature events and flooding) increases, the Trust has to take action to protect staff and service users from the adverse impacts of Climate Change. Consideration of extreme weather and Trust resilience to it are essential if services are to be maintained.

The Trust already has detailed action plans for various scenarios that could impact service delivery, such as flooding and heatwave events. The mixed age range of our estate results in some areas being more prone to overheating. Work continues to improve temperature monitoring across the Trust to identify these areas and make improvements where possible.

A recent assessment of Tadcaster Health Centre led to the installation of flood defences to protect the site and increase resilience for services provided. Similar actions may need to be taken in the future to protect staff and patients and to ensure business continuity, and we will continue to undertake site assessments to identify areas of opportunity.

In 2021, a new Adverse Weather Plan was agreed to provide for an annual review of data collected for inclusion in an annual report to inform future Capital, Estate, and Maintenance Planning programs of requirements to adapt to the changing climate.

White Cross Court is one of our smaller sites and provides a range of rehabilitation services

8.4 SDAT Areas of Focus
Adaptation

SDAT Score 2021: 74%

Where do we want to be?

- Trust premises adapted to mitigate risks associated with climate change
- Be able to demonstrate that our buildings and services are fit for purpose in the context of a changing climate
- Further steps taken to ensure business continuity maintained during extreme weather events such as floods and heatwaves
- Provide an annual review of adverse weather impacts and adapt premises and service delivery to mitigate risks of climate change

How will we get there?

- Increased temperature monitoring across the Trust to identify areas where overheating may be an issue
- Detailed heatwave plans incorporating monitoring information
- Work with major suppliers to understand their resilience and contingency strategies
- Ensuring that new buildings are built to BREEAM excellent/Net Zero standards
- Retrofitting existing buildings where possible
- Risk Assessments based on previous climate impacts/adverse weather monitoring

How will we measure our progress?

- Temperature monitoring of key areas
- Number of overheating events relative to overheating days
- All new builds to be certified as BREEAM Excellent/Net Zero with extensions certified as BREEAM Very Good.
- Routine testing of business continuity plans

8.5 SDAT Areas of Focus
Capital Projects

SDAT Score 2021: 71%

Overview

"Delivering a net zero health service will require work to ensure new hospitals and buildings are net zero compatible, as well as improvements to the existing estate"
Delivering a Net Zero NHS

Set against the complexity of retrofitting a mixed-age estate, capital projects provide a refreshing opportunity to influence building efficiency at the design, build, and commissioning stages. It is therefore essential that sustainability and carbon reduction be factored into capital projects throughout the process.

Ensuring buildings are both designed and built with consideration to energy and water efficiency and integration of renewable technologies can achieve significant long-term financial and carbon savings. The Trust will work towards ensuring all new build and refurbishment projects conforms to net zero standard.

The new endoscopy unit, opened to patients in 2019, this modern unit has increased capacity and incorporates electrical submetering to measure energy use

8.5 SDAT Areas of Focus
Capital Projects

SDAT Score 2021: 71%

Where do we want to be?

- Projected energy and carbon performance delivered within projects
- All new builds to conform to BREEAM standards
- Work towards ensuring that all new builds and refurbishments conform to Net Zero Standards
- Renewable/low carbon technologies such as solar panels and ground/air heat pumps included in new builds

How will we get there?

- Nominating a capital projects BREEAM lead
- Ensuring that the BREEAM process is followed carefully to ensure BREEAM Excellent is achieved
- Soft landings approach to the transition from construction to occupation
- Electrical submetering in new builds to measure against projected performance
- Sustainability and carbon reduction factored into all projects
- Low carbon heating to be a tender requirement for new builds

How will we measure our progress?

- Carbon monitoring data from new builds
- BREEAM Assessments
- Monitoring of renewable energy sources through ERIC data

8.6 SDAT Areas of Focus
Green Space and Biodiversity

SDAT Score 2021: 46%

Overview

"Increasing green space and trees on NHS sites also provides opportunity for improving air quality, supporting mental health and social prescribing. Since 2009, the NHS Forest has planted over 65,000 trees across 180 NHS sites, increasing green space, improving air quality and mental health, and capturing carbon." **Delivering a Net Zero NHS**

Supporting access to green space has benefits for mental and physical wellbeing and leads to improved health outcomes. The Trust aims to provide accessible Green Space for staff and patients where at all possible.

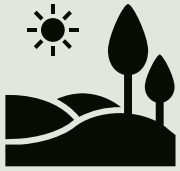
In the past, where sites have been developed, consideration has been given to making the best use of green space, including Scarborough Hospital car park, which has areas developed to encourage wildlife.

Some of our sites, such as Scarborough, have lots of green spaces, and these are well utilised by staff and patients, particularly in the summer months. Buildings largely occupy the York site, but creative use of spaces such as the formation of courtyard gardens have provided calm areas for staff and patients. There are five more wellbeing gardens planned for 2021/22 following a charitable donation of £200,000 from the York and Scarborough Teaching Hospitals Charity. In addition to the benefit of increased outdoor space, there will also be the opportunity to provide certain rehabilitation services within the wellbeing gardens.

8.6 SDAT Areas of Focus
Green Space and Biodiversity

SDAT Score 2021: 46%

Where do we want to be?

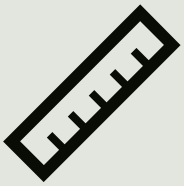


- Board approved Biodiversity Action Plan published
- More green space available for staff and visitors to enjoy
- Biodiversity considered as part of new builds
- Local community engaged with green spaces
- Tree planting to support carbon off-setting

How will we get there?

- Establish and maintain resources to develop and deliver a biodiversity action plan for the Trust
- Applying for funding to create and improve green spaces, working inter-departmentally to agree best use of space
- Ensure that Ecology/Biodiversity is considered as part of the BREEAM assessment for new builds
- Continue to ensure that volunteers are equipped and supported in their roles

How will we measure our progress?



- Biodiversity Action Plan to be published within the lifetime of this strategy
- Monitoring the area of accessible green space to ensure space is being utilised
- BREEAM assessment Ecology/Biodiversity points scored on new builds
- Numbers of volunteers working on green spaces
- Funding secured for development or improvement of green paces

8.7 SDAT Areas of Focus
Sustainable Care Models

SDAT Score 2021: 59%

Overview

"Quality services and systems include sustainability as a fundamental principle. This means minimising environmental impacts, enhancing health and building resilience with individuals and their communities" **Sustainable, Resilient, Healthy People and Places PHE**

Sustainable Care Models provide the opportunity to increase resilience, performance and sustainability within the Trust. By optimising the location of care, working towards earlier and faster diagnoses, and encouraging the use of virtual appointments (where appropriate), we can positively impact the communities we serve and reduce our environmental impact. T

he Trust has been working on two patient video conferencing trials to reduce unnecessary travel to site by patients. Accelerated by the Covid-19 Pandemic, thousands of patients now have remote appointments every month. Patients can avoid long journeys to hospital, and the avoided vehicular trips reduce local air pollution and congestion. Environmental and carbon impact calculations have been conducted for specific care models, which will continue over the coming years.

8.7 SDAT Areas of Focus
Sustainable Care Models

SDAT Score 2021: 59%

Where do we want to be?

- In-person Outpatient appointments reduced by 1/3 by 2023/24
- Increase return of walking aids to the Trust
- Reduced metered dose inhaler use (2% reduction in emissions by March 2022)
- Direct financial and environmental co-benefits of emerging and existing care models quantified

How will we get there?

- Expanding the rollout of virtual appointments for patients (where appropriate)
- Increase in patient centred care pathways
- Equipment coordinator employed to streamline the process of issuing and delivering equipment.
- Improving links with local Councils and providers to further enhance accurate data and actions to enhance increase return rates of walking aids.
- Preferential use of dry powder inhalers (DPI's) over metered-dose inhalers (where clinically appropriate)
- Conducting further environmental and carbon calculations for care models

How will we measure our progress?

- Monitoring of outpatient appointments across the Trust
- Monitoring return rates of walking aids and other applicable equipment
- Monitor prescriptions of MDI's and DPI's
- Sustainability assessments for new and existing care models

8.8 SDAT Areas of Focus

Our People

SDAT Score 2021: 70%

Overview

Staff wellbeing is essential to an effective, resilient workforce. It is important that as a Trust we provide staff with resources to help take care of their own physical and mental wellbeing, as well as being flexible to the needs of staff where it fits within the service.

NHS Health Checks are offered to all staff over 40 years of age, with advice tailored to the individual. In addition, positive management behaviours training has been introduced, particularly in supporting mental wellbeing and staff with mental ill-health.

Concerning physical activity/sedentary behaviour, the Trust is continuing to widen and improve the offers around physical activity through its Staff Benefits program. Health support has progressed virtually, with health checks, virtual activity sessions and Weight Management, Eating well, and Being Active workshops all moving on-line and being more easily accessible.

There is a staff cycle scheme/salary sacrifice promotion that has good levels of uptake. A cycle mileage rate is also available for those who cycle while at work.

A range of healthy food options are available at Trust eateries, and work has been done to reduce the availability of high sugar foods and beverages while providing healthier alternatives where possible.

The Trust has continued to expand the suite of support for all staff during the last year, a lot of this support has been in response to the added challenges that the global pandemic has brought. Enhanced support both locally and nationally has focussed on maintaining wellness in addition to identifying employee's level of individual risk factors in relation to Covid-19

8.8 SDAT Areas of Focus

Our People

SDAT Score 2021: 70%

Where do we want to be?

- Improved health and wellbeing of our workforce
- Increase in home and flexible working
- Workforce engaged in creating a sustainable environment

How will we get there?

- Further increase the provision of healthy eating options in Trust catering outlets and provide nutritional information to customers
- Providing offers on discounted gym membership to staff
- Continuing to offer discounts on cycling equipment to encourage active travel
- Ensuring that reasonable demands for home and flexible working which fit within the needs of the service are considered
- Continued engagement with Trust Green Champions

How will we measure our progress?

- Staff benefits program availability and uptake
- Establish a baseline and monitor levels of staff who utilise home/flexible working
- Sickness absence rates
- Trust Green Champion numbers

8.9 SDAT Areas of Focus
Sustainable Use of Resources

SDAT Score 2021: 51%

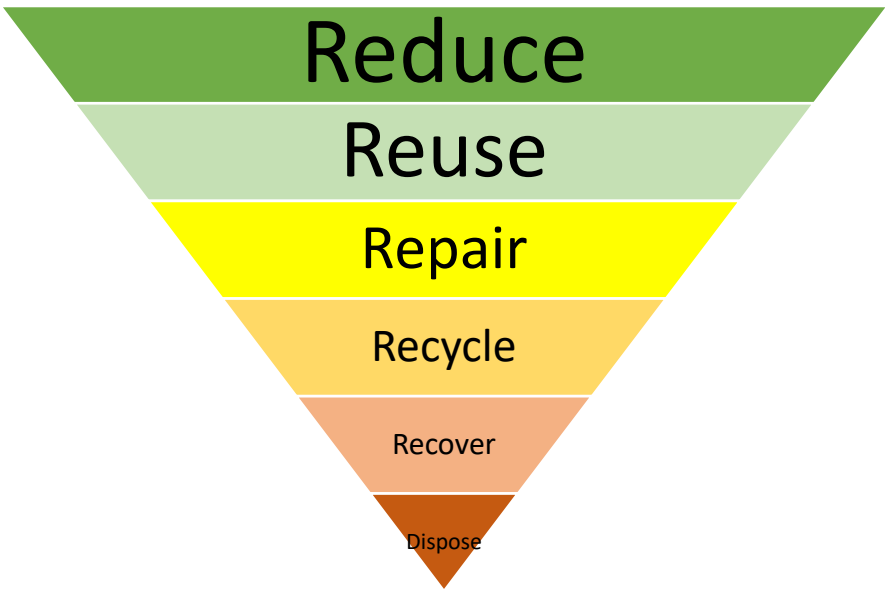
Overview

"Quality services and systems include sustainability as a fundamental principle. This means minimising environmental impacts, enhancing health and building resilience with individuals and their communities" **Sustainable, Resilient, Healthy People and Places PHE**

Significant amounts of waste are produced as a result of our clinical activities. Minimising waste and where waste is necessary, ensuring that it is disposed of in the correct waste stream are key to reducing our environmental impact. Segregation at the point of source is essential and requires engagement with staff working across different areas for maximum results.

By applying the waste hierarchy, rethinking traditional waste models, and working closely with our staff and supply chain, we can reduce the environmental impact of our waste.

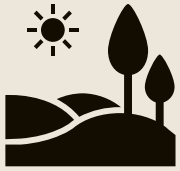
Significant progress has already been made in this area, with emissions from waste falling by more than 80% since 2015/16. Our recycling rate in 2019/20 was 23%, and less than one percent of our waste was sent to landfill. Our incinerated domestic waste contributes to a waste-to-energy plant that powers upwards of 40,000 homes in the region.



8.9 SDAT Areas of Focus
Sustainable Use of Resources

SDAT Score 2021: 51%

Where do we want to be?



- Improved waste segregation at point of source and increased recycling rates
- Continued decrease in the use of energy intensive disposal methods such as landfill and incineration without energy recovery.
- Increased reuse of equipment throughout the Trust
- Reduced food waste
- Reduction in the avoidable use of single use plastics

How will we get there?

- Waste segregation training for staff
- Increased provision of educational information relating to sustainable use of resources
- Maximise use of the Trust Warp-It portal to reduce waste and unnecessary procurement
- Obtain a baseline of ward food waste levels and implement a plan to reduce this level
- Replacing single use plastics with compostable/more environmentally friendly alternatives as these become available

How will we measure our progress?

- Monitoring of training provided to staff on waste segregation
- ERIC waste stream volumes
- Monitoring of CO_2 and financial savings from the Warp It system
- Food waste baseline and progress reports
- Annual reporting of single use plastic use as per the plastics pledge

8.10 SDAT Areas of Focus
Carbon/Greenhouse Gases

SDAT Score 2021: 59%

Overview

"Delivering 100% LED lighting could be achieved with an additional non-recurrent investment of £492 million, which would be paid back over a 3.7-year period, providing an estimated net saving of over £3.0 billion during the next three decades (across the NHS)" **Delivering a Net Zero National Health Service**

The Trust aims for continual reductions in gas and electricity demand in line with the NHS Net Zero Strategy and also monitors this on a per-patient basis. The Trust has purchased a Green Energy Tariff for all grid electricity imports which, while not directly attributable to the Trust as CO_2 savings, will increase the proportion of the grid that is zero carbon.

We must explore opportunities for renewable technology across the estate. There are possibilities for solar panels at multiple sites, and there is potential for more efficient heating methods such as ground and air heat pumps. LED upgrades will deliver energy savings over time as older style bulbs are replaced during routine maintenance.

8.10 SDAT Areas of Focus
Carbon/Greenhouse Gases

SDAT Score 2021: 59%

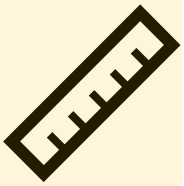
Where do we want to be?

- Reduce greenhouse gas emissions in line with the Net Zero NHS Strategy
- Year on year reductions in gas and electricity demand
- Reduced carbon intensity per patient contact
- Increased active and zero emission travel
- Lower emissions from use of anaesthetic gases and inhalers

How will we get there?

- Through the measures outlined in previous sections
- By ensuring that new, emergent technologies are factored into decision making
- Engaging with staff to save energy
- Working with procurement to ensure that energy use and carbon emissions are appropriately weighted in tender documents
- Building fabric upgrades to reduce heat loss
- Increased submetering to provide greater detail on where energy is being used
- Improving electric vehicles charging facilities and facilities for active travel
- Promoting more environmental alternatives for anaesthetic gases and inhalers

How will we measure our progress?



- Annual reports
- ERIC data
- SRP submissions
- Trust Carbon Dashboard

9. Communications and Tracking Progress

Communications

As an essential part of driving change throughout our organisation, we take a considered approach to sustainability communications. By communicating what we are doing both within and outside the organisation, we can engage staff with key priorities and ensure sustainability is part of the conversation.

We communicate sustainability information regularly through various channels, including our weekly and monthly staff communications and a group of Green and Sustainability Champions.

We aim to provide a resource of accessible sustainability information for staff on our Trust Intranet site, complete with a waste guide and advice on reducing utility consumption/carbon emissions.

Tracking progress

We will be measuring the progress of this strategy using a range of qualitative and quantitative methods including:

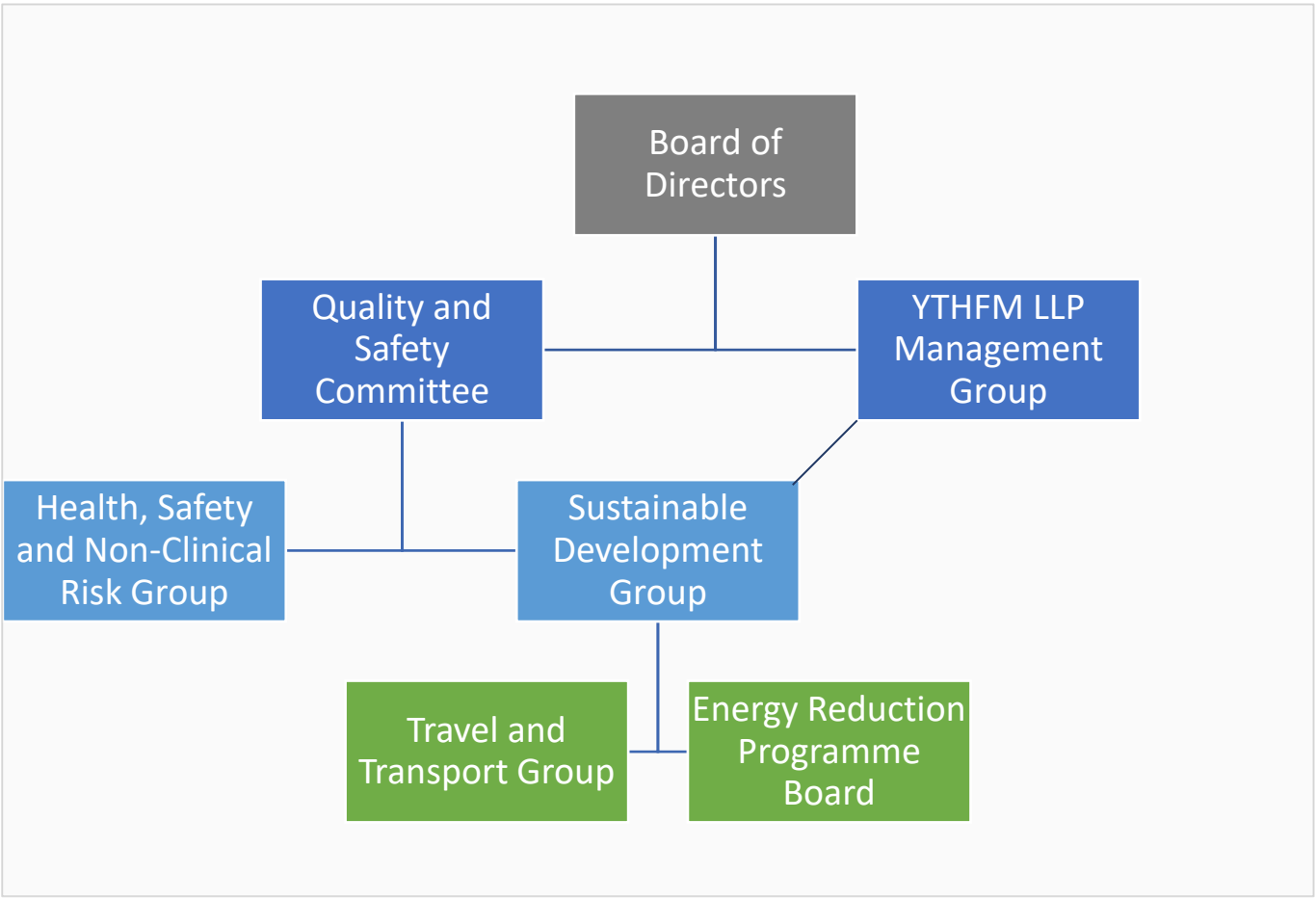
- Our annual SDAT Scores – We are aiming for an overall percentage of 75%+ by 2026
- Consumption of Utilities - We aim to improve our reporting ability, access to real time data and invest in sub-metering throughout the lifetime of this plan.
- Travel data
- Waste Volumes
- Anaesthetic gas use
- Organisational carbon footprint as measured and reported annually in line with sector guidance

10. Governance

Governance

The Trust has operated a Sustainable Development Group (SDG) since 2009. The group, which meets every quarter, includes key staff from various departments and facilitates interdepartmental work on sustainability projects. The Travel and Transport Group and Energy Reduction Programme Board were established to provide more specific workstreams and feed into the SDG.

The SDG can escalate items to both the Quality and Safety Committee and the YTHFM LLP Management group, who in turn can bring items to the attention of the Board of Directors



11. Reporting

Reporting

The reporting of the Trust's sustainability performance is provided through multiple systems at an operational, organisational and national level. As a responsible organisation we adopt an open and transparent approach to the information collected, making it available to all and have a duty to provide information that is accurate and is recorded within the systems below;

Monthly

- Data collection from utilities, waste and transport used to identify levels and trends.
- Reports and monthly figures reviewed at the Energy Reduction Working Group (ERWG).

Quarterly

- Internal reports produced by the Sustainability Group, Travel and Transport Group, Premise Assurance Model Group and Board Sustainability Lead. These are summarised and presented to the Quality and Safety committee who escalate key issues to the Trust Board of Directors.

Annual

- Internal report produced on Carbon and Cost Reduction programme.
- ERIC (Estates Return Information Collection)
- Complete SDAT assessment to identify sustainability development work, measuring progress and enabling the Trust to make plans for the future from the previous year's actions.
- Complete SDU Sustainability Reporting Portal which informs the sustainability section of the Trust's Annual Report and calculates the Trust's carbon emissions (Scope 1, 2 and 3).
- Sustainability report identifying progress against the Green Plan and highlighting the main activities delivered throughout the year.

12. Risk

Risk

Risks to the delivery of our Green plan are identified through a series of committees and groups illustrated within our Governance structure. Escalation of risks is conducted through the Sustainability Development Group and placed onto the Nursing Directorate Risk Register, where depending on the severity of the risk is progressed up to the Quality and Safety Committee and Emergency Planning Steering Group (EPSG) and then to the Trust Board.

The register reviewed by the Sustainable Development Group on a quarterly basis include the following key risks:

1. Risks of changing climate – increasing costs and impact of adverse weather and climate change which includes heat waves and overheating buildings increasing deaths from air pollution, increasing likelihood of flooding events, disruption to services and communities and longer-term changing disease patterns.

2. Specific risk of overheating putting patients and vulnerable groups of visitors and staff.

3. Risk of failure to achieve air quality/transport targets from NHS Long Term Plan and NHS standard contract 2020/21 which requires Trusts to:

a) Cut business mileages and fleet air pollutant emissions by 20% by 2023/23

b) Achieve at least 90% of the NHS fleet using low-emissions of which at least 25% are ultra-low emission vehicles by 2028.

4. Risk of failure to reduce the carbon impacts from the use, or atmospheric release, of environmentally damaging fluorinated gases used as anaesthetic agents and as propellants in inhalers, including by appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 10% by volume, through clinically appropriate prescribing of lower greenhouse gas emitting inhalers, and the appropriate disposal of inhalers

13. Finance

Finance

Sustainable development schemes and activities will provide multiple benefits for the Trust over the coming years. As patient numbers, utilities and transport costs rise there will be a focused approach towards reducing costs and improving services, through changing working practices and identifying beneficial cost reduction schemes.

Financial constraints within the Trust require sustainability improvements to either find external funding, partnership working or go through the Trusts business cases (BC) process, indicating the benefits of the improvement, costs, return on investment and effects on the environment, which is viewed by the BC panel. The Trusts charitable funds are available if the improvement fits in with the criteria for accessing the funds.

The Sustainability team seek to minimise and reduce financial burdens whilst at the same time, seeking to achieve a balance between carbon and cost savings. It is increasingly difficult to achieve financial pay backs of five years or less, and greater levels of investment are now needed to achieve carbon reduction in line with Net Zero NHS targets. The Trust works with local, regional and national organisations to seek technical and financial support.

Utilities are procured through a tendering process to deliver the best value for money, provide energy from renewable sources and capture data that monitors and records information to identify high usage areas. This allows the Trust to identify areas where improvements can be made and alternative options for delivery considered.

Refurbishment to our estate provides an opportunity to invest in equipment and buildings that incorporate whole life cycle materials, heating and ventilation that can cope with the predicted changes in climate change and reduce our carbon impact on the environment.

Recently funding has been secured for submetering and telemetry for the York Hospital site. Further work is planned to develop a capital investment programme to contribute to the achievement of carbon reduction targets.

The predicted global impacts of an increase of greater than two degrees Celsius have been widely modelled and documented. Only a short window of time is available to reduce emissions to a level that can prevent potentially irreversible changes to the climate.

There will likely be grants and government schemes to help support the financial aspect of the transition to net zero, but the organisation meeting the targets will also have to bear some of the costs themselves. The Trust must establish the most cost-effective way to deliver the required works to meet net-zero and contribute to the global effort to solve the climate emergency.

Appendix 1: Glossary

Air Pollution: Levels of pollutants in the air such as Particulate Matter, Nitrogen Dioxide (NO_2) and Sulphur Dioxide (SO_2). This is measured on the Air Quality Index, which has a scale of 1-10. Air pollution can negatively impact health outcomes for local communities

BREEAM (Building Research Establishment Environmental Assessment Method): A method of assessing, rating and certifying the environmental, social and economic sustainability of buildings

Carbon Footprint: The total amount of greenhouse gases produced to directly and indirectly support human activities, usually expressed in equivalent tonnes of carbon dioxide (CO_2e)

Climate change: A long term shift in weather patterns and average temperatures, caused by the emission of Carbon Dioxide and other Greenhouse gases into the atmosphere

Climate change adaptation: Changes made to allow for future weather patterns. Examples include storm drains to help cope with increased flooding and improved quality road surfaces to withstand higher temperatures

CO_2e – Carbon Dioxide Equivalent: Whilst CO_2 is the most common greenhouse gas, other gases contribute to climate change, often at much higher levels per tonne. One tonne of methane has the global warming potential of 25 tonnes of CO_2. Whilst one tonne of desflurane (A potent anaesthetic gas) is equivalent to over 2000 tonnes of CO_2. The CO_2e figure allows us to factor in the impact of these other gases within our overall carbon footprint

Combined Heat and Power (CHP): The generation of electricity (usually through consumption of natural gas) with the heat utilised as a by-product

Electric Vehicle (EV's): Vehicles driven by an electric motor. EV's have zero tailpipe emissions (CO_2/air pollutants) and do not contribute to local air pollution

Estates Return Information Collection (ERIC): A central reporting portal where NHS organisations report key information (such as waste and utilities usage)

Greenhouse Gases (GHGs): Gases that reduce the amount of infrared radiation that can escape through the atmosphere, thereby contributing to Global Warming. Examples include CO_2, Methane and (in the healthcare sector), anaesthetic gases

Appendix 1: Glossary

Hybrid Vehicle: A vehicle that uses conventional fuels, assisted by electric motors

KPI: Key performance indicator

Low Emission Vehicle (LEV): Vehicles that meet current 'Euro Standards'. Euro 3 for motorcycles, mopeds, motorised tricycles and quadricycles; Euro 4 for petrol cars, vans, minibuses and other specialist vehicles; Euro 6 for diesel cars, vans and minibuses and other specialist vehicles; Euro VI for lorries, buses and coaches and other specialist heavy vehicles (Correct as of July 2020)

Net Zero: The point where total CO_2e emissions minus offset emissions is less than or equal to zero

Patient Contacts: The number of patients that visit the Trust in a given time

Payback Period: The length of time required for the cost of an investment to be recovered

Sustainable Development Assessment Tool (SDAT): The SDU's Sustainable Development Assessment Tool (SDAT) is designed to help Health and Social Care organisations assess progress in sustainable development and identify how local action is contributing to the UN Sustainable Development Goals

Travel Plan: A package of actions put in place by an employer to encourage staff to use alternatives to travelling alone in their cars, both for environmental and health benefits

Ultra-low emission vehicle (ULEV): Vehicles that emit tailpipe emissions of less than 50g CO_2/km. Electric vehicles (including battery electric, plug-in hybrid electric or hydrogen fuel cell) all meet these criteria

Warp It: A material reuse portal, which assists the Trust in redistributing assets such as furniture

Whole-life Costing: Sometimes called 'life-cycle cost', this approach assesses the absolute cost of a product or service over the course of its lifetime, from its conception through to its end of life, taking into account purchase, maintenance and repair, training, utilities and disposal

Zero emissions vehicle (ZEVs) Fully electric vehicles that produce zero tailpipe emissions

Appendix 2: References

1. Committee on Climate Change, *Net Zero: The UK's contribution to stopping global warming,* 2 May 2019 www.theccc.org.uk/publication/net-zero-the-uks-contribution-to-stopping-global-warming/

2. Delivering a Net Zero National Health service https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

3. NHS Standard Contract Service Conditions 2021/22 https://www.england.nhs.uk/publication/nhs-standard-contract-service-conditions-full-length/

4. NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

5. NHS Operational and contracting guidance 2021/22 https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

6. Sustainable Development Unit NHS Carbon Reduction Strategy Update 2010 – Document can no longer be accessed online (the Trust holds a copy on record)

Minutes
Resources Assurance Committee
21 September 2021

Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (ABert), Polly McMeekin (PM), Dylan Roberts (DR), Penny Gillyard (PG), Michael Taylor (MT), Jim Dillon (JD), Cheryl Gaynor (for minutes), Adrian Shakeshaft (AS), Bobby Anwar (BA)

Apologies for Absence:

No apologies received.

Welcome and Introductions

LM welcomed Mike Taylor to the meeting as the new Associate Director of Corporate Governance.

It was noted and agreed that the meeting was recorded for the purpose of the minutes and would be destroyed following the approval of the minutes.

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 20 July 2021

The minutes of the last meeting held on 20 July 2021 were agreed as a correct record.

Matters arising from the minutes

Action log updates:

Action 89: LM wanted to discuss in more detail, meeting had been arranged for 21 September. Post meeting note – action now closed.

Action 88: Research and development quarterly update. PM advised the research quarterly update will come to the October meeting.

Action 87: Quarterly report to be received for the October meeting.

Action 85 (Information Governance Register): DR advised that although there were some aspects covered in the report on the agenda, he had asked Rebecca Bradley to, as well as the plan and quarterly progress report, incorporate some of this into an overall corporate governance plan. Unfortunately there were limited resources and it was proposed that this be brought to the Committee in October. LM noted that she had attended the Group Audit Committee and there were a number of items on this picked up by the Audit Committee on information governance therefore the plan in October was appreciated.

Action 84 (VIU Scheme): AB noted the capital planning team were currently working with Kier through the construction part as well as Yorkshire Water to evaluate options. A paper will be presented to the Executive Committee in the first instance to discuss next steps and a decision at the Board of Directors meeting to be held in October.

Action 83 (Grounds maintenance): PG reported the need to timetable the TBC's for the LLP as part of the quarterly updates. Completion date to be October meeting.

Action 82: PG reported that a discussion had taken place and the vaccination hubs were currently being set up. She noted that it was a little more complicated for the LLP with the Covid and the Flu vaccine taking place at the same time but there was a meeting planned with the Flu Vaccination co-ordinator to increase the uptake within the LLP. As a result of the discussions now taken place, this action is now closed. PG advised that there was a plan that required to be discussed with the vaccination planning manager as the initial plan was solely focussing on flu but now included the combined Covid vaccine. LM suggested that the action remained open until a clear view of the plan was confirmed and linking in with PM.

Action 81 (Workforce Task and Finish Group) - PG noted that this was an update report what would be presented from Malcolm Veigas as the Chair of the Absence Task and Finish Group and could be presented to the October meeting.

Action 80 (New Starter Programme): closed and on the agenda.

Action 79 (CAFM): Update in November as there was additional time required for completion.

Action 78 – closed and on the agenda.

Action 77 (Essential Services Programme): DR advised that this was more of a long term plan where we are building the Trusts future architectural model and obtaining external support to achieve and develop this. Likely to be December/January time to update. LM suggested that it would be good to have an update and to look at the road map when developed in February/March 2022

Action 60 (Asset Management Update): PG advised that Mark Steed had completed some work around this and as part of the Governance process it would need to be presented to the Management group in the first instance before presented to the Resources Assurance Committee in November 2021.

WRES & WDES Standards report

PM advised that there were two reports in the pack (Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) which together held a combined action plan. PM advised that these were nationally mandated reports with data that the Trust was required to submit in August with the action plan followed up and published at the end of September.

WRES

PM reported that there were nine indicators and five of which related to staff data that was pulled from snapshots of comparison for March 2020 and March 2021 or of the 12 months up to the 31st March 2021. There were four which related to the 2020 staff survey report.

PM highlighted page 24 of the report which detailed what essentially was the snapshot date of what the Trusts workforce profile looked like by grade, PM noted that it was visually clear to see there was a significant lack of diversity from Agenda for Change upwards and including Board level positions. PM reported that the Trust had seen deterioration in recruitment activity over the last 12 months to the end of March 2021 reporting that white individuals were 2.61% more likely to be appointed compared with 1.76% the previous year and advised that the international recruitment data was specifically excluded from this.

PM advised there the Trust has some good areas of practice - in the last 12 months there had been the Race Equality Network setup which had over 25 members and a monthly meeting schedule. There had also been some budget allocation agreed to support the networks to be able to promote themselves and also to promote some of the initiatives they were looking to drive forward. However, it was important that the Trust didn't drive their agenda as it was a staff network and was led by staff. The Trust had engaged with the network to advise and provide a steer as to what the action plans should look like, and needed to hold the Trust slightly to account on the delivery of those actions. PM advised that a few of the Executives including herself had attended the Race Equality Network meeting to speak to the members and there are guest speakers invited to attend frequently. JD queried what the view was in terms of the Network and what the feedback from them was in terms of how they felt that the group had been and was it effective. PM advised that there were some tensions about what was the strategy and what should the Trust be influencing. It was important that the right members were attracted to the network with staff of different groups and different levels. It was chaired by a relatively senior member of staff in the organisation (Band 8B Deputy Care Group Manager in Care Group 3) and the Vice Chair was a member of the HR department. Malcolm Veigas from the LLP was also an active member of the Race Equality Network and was bringing a lot of valuable input from an LLP perspective.

PM also advised that The Trust had established a reverse mentoring programme with 18 mentoring partnerships between senior managers and BAME staff. It was noted that evidence from other Trusts suggested that the reverse mentoring really helped with the talent management and progression into more senior roles so there was hope to see this evidenced in the data (such as on page 24) beginning to adjust over time. PM advised that the point of BAME being included in the People Plan was that it was generally accepted that the NHS had a lack of diversity in more senior roles. She also advised that Medical Non-training and training grades were seeing real diversity coming through but

this was unfortunately not seen tipping to consultant level. This was something that was being picked up with the Care Groups. PM highlighted that there was felt to be a cultural perception around the recruitment of a consultant non UK trained and was a bit of a barrier to that.

JD highlighted that given where we have been in the last couple of years, the lack of movement and such, was the Trust was less able to attract overseas candidates. PM advised that she had recently raised this with Corporate Directors as a concern with seeing the UK Border Agency and the whole Government Policy on immigration if you recruit outside of the UK, comes with a significant skills charge, visa application process, right to work, certificate of sponsorship. She also advised that the skills charge was up to £3,500 for a 3 year contract and for some roles the Trust required to fund this however for other roles when the Trust us able to recruit domestically, the government strategy was that you only recruit to those who are able to work in the UK imminently.

LM highlighted page 25 of the report and the issues around bullying, harassment, disciplinary and also discrimination cases on BAME staff and wanted to understand what were the root causes. She noted that the Trust has had bullying and harassment raised across the Trust generally but the fact it was picked up with higher numbers for BAME staff was concerning. PM advised that the more people employed who were BAME, consequently the more this would weight against the organisation in something such as the staff survey. Feedback from international nurses, one came forward to speak) about how welcomed or rather not welcomed they were into their placement. For example, when white British individuals were moved from ward to ward (shift deployment) the feedback was that they were just not welcomed so it should be considered how much of it was attached to colour and race verses 'your just not in our team' culture. Which consequently then feeds into some of the cultural work around the values and behaviours of the Trust and the just culture implementation, all about what the Trust will tolerate and what it won't and encouraging staff to speak up rather than just reporting in the staff surveys. LM questioned whether there was assurance from a plan perspective and noted that the appendices were all 2022 to be completed, specifically around culture and wanted to understand how this linked with the clever together piece. LM raised the question how much the Trust was really being proactive with strong ethnic communities in the regions such as Bradford, Leeds or Manchester and wider linking with their WRES Networks developing collaboration. PM advised that the networks all fed up to an ICS network and so the Trust's Race Equality Network reported up to the ICS and looked East of the Country and not West. PM assured that Hull was a very advanced and established BAME network and had achieved some really positive things which the Trust had learnt in developing the action plan through picking some of their best points. PM also advised that although the LLP are excluded from the report, there will be another produced but overall the general picture was similar.

<u>WDES</u>

PM reported statistics across the population reported about 18% of England's population regarded themselves as having a disability. It was important to note that it was not mandated that people report it and those that feel that they have a disability that ultimately impacts on their life. More recent Trust data, because of the experience of covid suggests that closer to the 20% mark. Those that had started and not reported it, if they were asked again having lived through covid, they might then feel that their condition has in fact impacted their life over the last 18 months. What has been seen through recruitment was

that recruitment of individuals with disabilities had improved. The Trust had managed to maintain its disability confidence status and part of that was because of offering a guaranteed interviews scheme i.e. if an individual meets the criteria on the personal specification they are guaranteed an interview. PM also noted that in the 2nd year in a row the Trust had managed to have a consistent reduction in the number of disabled individuals entering staff capability process and 77% of staff from the staff survey have said that the Trust had made reasonable adjustments against a national average of 75% so just above national. However, there had been a number of staff who had noted that they had a long term condition and had reported a poor experience of working in the organisation. One of the actions that was similar to the Race Equality Network was in June 2021 the Trust had the enable network. Although PM reported that it felt that the network had less visibility because of the focus around the race network and also the focus across the NHS being about race. That said, statistically evidence suggests that the Trust does support staff who do have a disability.

JD noted that as time goes on a status and respect of that changes over time and at the point of recruitment people were potentially more reluctant to disclose their disability and it was pleasing to hear that there was often a disclosure opportunity. PM advised that although there isn't a routine disclosure opportunity, it had evolved through Covid and in line with information and evidence about Covid and the effectiveness of the vaccine in certain areas. Where it was good to strengthen was to write an open letter that went into a new starter pack which described that there was a request for this information/disclosure, an explanation as to why they were being asked for this data and to really encourage them to disclose that. There was also the Trust's ESR Self Service System where staff were able to update their records at any time. PM highlighted that it could be seen as sensitive so looking at all protective characteristics rather than focussing on disability or race was probably the way forward.

The Committee also discussed concerns regarding bullying, harassment, and discrimination issues highlighted in the WDES report and welcomed the plan to have a root and branch review of these issues for both the WRES and WDES and feedback to the Committee.

AB noted that in the case of bullying and harassment, there was reference to a communication campaign but perhaps was more about declaring an individual had a disability and being open and positive about that. AB suggested from the action plan that there was a point where an external facing communications campaign could be considered that clearly staff would read which does make the point that the Trust will not tolerate this. PM advised that there was some targeted communications regarding generally not tolerating violence or aggression which was targeted at staff escalating when incidents occur because of an increase in incidents across the NHS. However, PM noted that there was a need to explicitly draw it out a bit more. LM asked for the WRES and DES reports to be brought to the Board for discussion as part of a wider culture debate and how we better communicate issues and improvements as a Trust both in the short term and strategically. **PM agreed to work with Director of Communications Lucy Brown on developing a communications campaign to link with the values and behaviours plans to be brought to Board.**

People Plan Update

PM advised that the report was a 6 month update and real progression had been made on 18 of the actions. There were 110 actions in total however many of them were not for the Trust to deliver but for HEE, NHSE&I, ICS etc. The main progressions to note were being made across the health and wellbeing, flexible working, equality and diversity, recruitment and retaining staff.

LM noted her thanks for the update and the easier reading of the report. The action plan was colour coded for ease and LM highlighted that the grey colour was another organisation requiring to deliver either the entire action or in part with the Trust and wondered if there were any elements of grey that as a Trust we could work towards and how further information could be obtained on those grey areas as they pose a risk..

LM suggested that the format includes an executive summary where there are updates of any statuses that have changed and a description of how it is project managed and tracked.. There was clearly a lot of work happening and it was felt that an executive summary would bring this out.

LM queried any plans for taking forward the Clever Together work (namely the Values and Behaviours Implementation) and PM advised that the Clever Together would be taking a step back as the external organisation with a remaining minimal licence to use their platform analysis. The Values and Implementation plan had been paused due to operational pressures. PM noted that an overall action plan of what this looks like could be drawn up which could include the detail of things such as training session that were arranged however a lot of the work was intangible and non-corporately managed relying on the ambassadors and sponsors to challenge unacceptable behaviour or to reinforce it in their particular area. The work was driven through things like the staff survey action plan but wouldn't necessarily be corporately held which was deliberate.

The Committee received and noted the report.

PM to develop a Values and Behaviours Implementation action plan.

Integrated Business Report – Workforce

PM highlighted page 17 of the IBR report that there were over 3100 recruitment campaigns completed over the last 12 months and when comparing August 2021 with August 2020, the Trust has over 84 full time registered nurses more than employed in Aug 2020. There was a further 60 that would have joined by the November and with the Trusts international nurse recruitment campaign it would contribute a further 90 before the end of the financial year. PM also highlighted that there were also a further 24 full time equivalent (FTE) doctors over the same period and despite it not feeling like it, the establishment was more robust than 12 months prior. PM noted that the main challenge felt to have been on staff unavailability during July and August and was really challenging. For the 4 weeks to the 15th August the Trust looked at nurse rostering as the main focal area of the challenging gap. PM advised that the Trust used HealthRoster 'Allocate' as the main eRostering provider across the NHS, the benefit of which was that part of the package included a module named 'insight' which provided high level data which can be filtered by care group and by Trust and enabled the opportunity to compare with other

Trusts (of which there are around 200 on using the same software). PM noted that up until the 15th August the Trust staff sickness was up to 7.1% compared with a national average of 6.8%. For the Trust code 'unavailability' which was slightly higher nationally 1.6% and the Trust was 4.7% - PM noted that some of this may have been due to coding and was questionable as to whether there were too many options available to code to and should it be more restricted. PM advised that she was working with Emma George and the Chief Nurse Team to complete work on this because this comparison benchmark in itself was really helpful to have. PM also noted that there was a daily SitRep (Situation Reports) available which currently stood at 5.7% for sickness absence.

JD stated that despite the last 12-18 months the Trust has really tried to get the staff welfare balance right and queried how much the absence or unavailability was down to that. PM advised that what was a compound to the situation was the season of annual leave and what had been advised and encouraged was that any annual leave booked should have been taken. PM went on to advise that annual leave was 18.7% which wasn't out of kilter for that time of year (August). As a general rule the Trust encourages roster managers to maintain 14-16% leave at any one time so when assessing what the percentage was for August, the fact it was below 19% it wasn't a hugely out. PM highlighted that there had since been a significant reduction in leave in September and the Trust as a whole has positively felt that difference and feels better staffed. PM advised that this had also translated into the temporary staffing demand for example, in August there was an ask for 659 FTE – 449 were covered by the bank, unfortunately agency were only able to fill approximately 11% (all detailed on page 17 of IBR report) Agency filled 90 FTE and there were 210 shifts (32%) of demand going unfilled and in July up at 56% was unfilled. This unfilled demand was to be a discussed with the Quality Assurance Committee. PM noted that the Trust incentivised the bank and that brought the unfilled numbers down slightly but arguable not enough. One of the outcomes that was picked up was that a lot of the bank staff were also Trust staff so if they were unwell, unavailable or on holiday, they are also unwell, unavailable or on holiday for bank. Consequently there was a Workforce Resilience Model being developed which was based on staff absence. If absence by staff group was doing a particular increase, factoring in what the vacancy rate was against the establishment on annual leave etc. the model looks to address what triggers did the Trust need to implement i.e. incentives for staff, step downs, deployments of service, what does the Trust need to do and in what kind of measured and proactive way going forward rather than it being reactive.

JD questioned what the incentive was for those staff not on bank who wouldn't have received an enhancement payment but working the same shift. PM advised that it was suggested that the Trust was keen not to incentivise staff resigning and just going on the bank because they feel they will always find a shift because there is clearly an awareness of the demand and was why there was a need for a toolkit approach to base incentives. PM clarified that there was a considerable amount of information gathering underway from the bed managers to find out what works for staff.

LM enquired around what the Trust plan for the Covid and flu vaccination was. PM advised that this was continuously moving and the booster had now been signed off and the co-administration had been approved. Looking at the vaccination compliance the Trust wide figure was 85% for the double vaccine uptake. Last year the Trust had a slight improvement in position for the flu vaccine at 73% therefore co-administration was favoured as it was felt it was better for the individual staff member going for their vaccination to have them at the same time whilst also being quicker to manage. Primary

care was working on the same basis and had consequently paused the rollout of flu vaccination. PM also advised that the Trust had begun to roll out the flu vaccination and were going out onto the wards and vaccinating staff on the wards but had also paused to now co-administer. The rules around this were that individuals could not have their booster Covid vaccine within 6 months of their second dose. As a result of this, the Trust couldn't really proceed before the 30th September and the fastest would be in 5 weeks because that was the pro plan that the Trust delivered the second vaccination on. To manage the co-administration the Trust had arranged to hold 3 clinic days per week per site starting from 30th September where there would then be a programme of work and pause at the end of October when there would then be a wait for our next and final delivery of the flu vaccine. Although the Trust was prioritising frontline staff, booking of the vaccine was through the 'Aire Logic' booking system and if individuals would prefer to have both vaccines, they have the choice when they make their booking. JD raised his concerns around how this campaign and clinics were being resources. PM advised that it was challenging because the Trust was also vaccinating Tees Esk and Wear Valley therefore they were also providing two or three vaccinators. The Trust was also looking at Care Group 6 and 3 to help with vaccinators as well as Chief Nurse Team and others from the bank that came to work in the Covid vaccination hub previously.

PM advised that there were no changes to the Board Assurance Framework. The Committee noted the report and comprehensive updates.

Digital and Information Services Report

DR described some of the Chief Technology Officer Function Wins highlighted in the report and noted he was pleased about the progress. As a result of resolving some of the long winded issues, the impact on the service desk with the number of faults and issues they were getting had significantly reduced. However, DR highlighted that he was conscious that these were summer figures and ideally there was a need to have at least 3/4 months of consistently lower figures to really evidence improvement from the new disciplines around some of the operational work. DR reported in terms of plans to develop the skill set, he was progressing work with the help of colleagues from HR with a restructure of the service which was around bringing in some particular specialist skills that the Trust didn't currently have. For example the Trust was moving to The Cloud but there was currently none or limited specialist skills around that. DR highlighted the risk that it was hoped that the restructure cost implications were funded however they were reliant on funding bids being agreed which were to happen as part of the wider budget in the coming months.

In relation to the Chief Technology Officer Function Wins, LM highlighted that the DIS had implemented the proposed operating model and associated organisation, including the introduction of a CTO owning all services, operations and transformation across core IT services and asked that it be considered if the PMO developed a clear benefits analysis of what was being delivered (including monetary values) and then communicating a summary.

The Committee noted the updates and assurances.

New NHSX Policies launched on Digital

DR reported that NHSX had issued three sets of new policy face documents. One was a document which described 'What good looked like' in terms of the expectation of what the Trusts digital strategy should look to achieve. 'Who pays for what' and the 'Unified Tech Fund' were the other two. DR described that they were all interrelated and what had to be recognised was that anything that was progressing needed to be aligned to 'What good looks like' and the sign-off be aligned to 'Who pays for what'. The emphasis of what good looks like was to ensure that the Trust was providing safe services and the key thing about it was the expectation that digital should be delivered across the ICS footprint. The 'Unified Tech Fund' had been identified to pull together different funding schemes (9 or 10 of them) but was positively clearer to understand what the Trust could or couldn't bid for. In terms of bidding, DR advised that the Trust was bidding for as much possible over the coming 4 or 5 weeks. However, DR highlighted that the Unified Tech Fund would not pay out for any backlog maintenance. Despite this the Trust was progressing as in order to close that finance gap there were plans to apply for emergency capital allocation and DR was working closely with the Finance Team to look to reallocate capital allocations to fund that. LM highlighted her concern around the funding and emphasised the need for assurance around mitigating any risk if the funding was not achieved.

LM noted that it was great to read in the report about the delivery of the dictation system however, she felt that it would be good to bring out as a result of the delay, an understanding of what that had cost the organisation. LM also noted that there was clearly a case for change but there was a need to understand the cost benefit analysis.

The Committee noted the updates and assurances.

The different types of cyber-attack and how we mitigate against them, including an update on the cyber incident desktop exercise

AS joined the Committee to present the item. He reported that the Trust had recognised the risk of a cyber-attack as one of the most significant risks to the organisation and could take many forms. He highlighted that the report provided some information and assurance around what the Trust was doing to actively mitigate the risks and some thought as to what else the Trust could be doing. AS advised that a significant amount of the risk mitigation was down to user education being important and consequently the Trust had updated key areas of opportunity to educate such as statutory and mandatory training. The Trust was also utilising more National Cyber Security Centre recommended modules and also working closely with Rebecca Bradley, Head of Information Governance on email roadshows, screensavers etc. AS advised that there was also a number of things that could be done with spam filters and highlighted that the report described two levels of spam filter and when we move to NHS mail that will be further secured. Inevitably both will work and at home people will be at risk from things like phishing and AS advised that the best defence was the constant reinforcement of messages to not click on unusual links. AS described that a lot of the Trusts mitigation was around multifactor authentication and privileged access management so if someone had a weak password, even if there were no administrative privileges, by giving a hacker the chance to get hold of that password they could then potentially attempt and get onto the next level. Mitigations were again around user education. There was also the standard cyber work that was generally thought of such as anti-virus/malware protection. AS highlighted that the privilege of working with

NHSX and NHS Digital was that there was a lot of support that is freely accessible such as the Trusts Windows 10 agreement, using windows defender and Microsoft ATP and BitLocker for encryption of data.

JD enquired whether there had been any near misses and whether any lessons had been learnt. AS clarified that there had not been any near misses and one of the reasons was that the Trust had strengthened its patching policy to ensure that the vast bulk of documents were patched within 14 days. As a good consequence of user education, individuals were a lot more proactive about contacting the service desk if they thought that they had clocked on a spam email. As soon as a call is made the process in place immediately goes into action and the users account is frozen, the PC is taken off the network and scanned. AS assured the committee that the lack of near misses was as a result of improved processes followed by additional processes around communicating information, the Trust was also signed up to associations such as the Cyber Associates Network, there was also the cyber alert system should any kind of security threat come out, a message would be received and the Trust was mandated to respond within 24 hours to acknowledge and confirm any actions completed. AB enquired if there was any data available which described the number of attacks that the Trust had as there was an understanding that the Trust was continuously being attacked but nothing was getting through. AS advised that as part of the toolkit the Trust is asked to provide the number of attempts and blocks and this information was obtained from the email system. There were also firewall logs that were available to see however, a lot of the threats are blocked before they even reach the Trust because of the layers of cyber protection. NHS Digital had also added a boundary section and this was in addition to the Trusts own firewalls. This was a similar picture with emails before they reach the Trust system.

LM thanked AS for the report. She highlighted the appendices which listed a number of items but was not really assured there was a clear plan to address certain elements. LM expressed that it was important to get assurance for of the delivery implementation plans. She acknowledged that there was clearly a lot of activity but some of the actions were well over a year old and this was concerning so assurance was key in understanding the Trust was on top of the plan and that risks were being mitigated. The Trust was looking to work with Co-Stratify and also partnering up with a 3rd party organisation to help to achieve a lot of the actions and as part of this the AS was looking to develop a roadmap and the plan which would then allow to report on progress against the plan. LM requested on the back of this that the **committee receives a regular monthly update to assure the committee that the plan was on track and in particular to see a plan by the next committee meeting.**

DR advised that fundamentally the starting point was to prioritise some of the cyber security such as the data security protection toolkit actions and were the ones that NHS digital were working with the Trust on so it was important to continue to utilise their services. **It was it was agreed that the Data Security Protection Toolkit requirements were the priority actions DIS would address along with any other high priorities set in the delivery plan.**

AS highlighted the audit and cyber toolkit described in Appendix 2 of the report which was the table top exercise, going through the cyber incidences processes and looked to refine those. The table top exercise was due in October with one of the outcomes reporting what went well, what didn't and what the actions coming from that was, this was also to include dates to ensure that it tied closely with the cyber action plan in general. LM expressed her disappointed on the table top exercise as it was overdue for review. As a result of it not

being, LM requested that it was considered urgently as this would provide a full view of what was working well and what wasn't and where the gaps were. MT noted that there was an opportunity to also strengthen the Board Assurance Framework (BAF) around this clearly from some of the things around the direct of controls around education which would help substantially and then some of the NHS X assurances. MT advised that he would work with DR and BA to action.

BA reported to the Committee that there had been no discussion around key controls and understanding what the mitigations were that had the greatest impact on reducing that risk as not all controls were equal in terms of the impact they had. BA advised that was working with DR on drawing out those key controls and understanding the impact not only on the Corporate Risk Register but also more importantly on the BAF as well.

There was nothing of note to update the BAF.

LM summarised the concerns raised around the lack of delivery of the plan with dates and noted that this must correlate with the asks of the Group Audit Committee too and was agreed that the Data Security Protection Toolkit requirements were the priority actions that the DIS were addressing along with any other priorities sent in the delivery plan. LM also summarised that **the Committee required assurance on the desktop exercise noting its lateness and having been tested with relevant clinical and business stakeholders, it was to be reported back again along with a cyber update to the next meeting of the committee.**

Demonstration of some of the CPD system developments that integrate care across the system

Kevin Beatson, Head of Systems Development and Daniel Holdsworth, Lead Developer joined the committee to provide a demonstration that brought to life some key areas of work on CPD (Core Patient Database) interoperability which included:

- GP Connect
- Ambulance Transfer of Care
- Request for Expert Input; and
- ePACCS (Elective Palliative Care Coordination Services).

JD commented on how fantastic these developments were for the patients and the Trust. LM concurred and requested that further information be issued offline to the Committee members and that these great developments are presented to the Board. **DR suggested that a short video of the presentation which articulates the benefits being delivered be developed and then shared with the Resources Assurance Committee** to obtain feedback with a view to then present it to the full Board of Directors.. It was also suggested that a clinician be brought in and if possible a member from the Yorkshire Ambulance Service to provide other perspectives of the systems.

Half year review of the Capital Programme and Priorities for the remainder of 2021/22

AB reported that there had been an ask of all staff to understand what was a priority and developing a list of needs before the end of March. The report showed that using non-recurrent revenue, leasing equipment and capital funding covered everything one way or another. There were a couple of contentious issues, the Trust was bringing forward £1m to support the essential services programme this year so taking the DIS team right up to the limit of what they could realistically spend in the timeline. LM queried the risk of bringing forward the funding because it was not just DIS as there were a few areas mentioned, could this be spent in 6 months. AB assured the Committee that DR and his team were optimistic that they would spend in line with what was presented in the report however, that was the maximum and the same for the backlog maintenance. He also advised that the biggest element was the lease of equipment and the capital value of that was £4.9m included as part of the Total Value of Urgent and Critical Capital Items in table 2 of the report and described in the appendix to the report. This was subject to the Trust being able to source, which there was nothing to suggest that this could not happen. The procurement team was working with the various care groups and there was confidence around the delivery of the backlog maintenance.

AB advised that there were no changes to the BAF.

The Committee noted the current position at the half-year point with regard to the Trust's Capital Programme and reviewed the prioritisation schedule and agreed the described allocations.

Integrated Business Report – Finance

AB reported that the surplus was reducing and the Trust was currently standing at a £3m surplus with the forecast for the end of month 6, it was believed that the Trust would deliver a balanced income and expenditure account.

The Committee noted the report.

New Start Programme – Interim Report

PG highlighted that the report provided an interim update on the new start programme action plan. Some of the challenges that had come through were about the timescales being a little too ambitious. She advised that it was anticipated where there may have been slippage or where may be specific time required in relation to the procurement of a new CAFM system. It was thought that this would need some additional time to have ensured that the implementation of the system went well. It was known that the procurement timetable was on track and was pleasing to report that the business case for the interim upgrade of CAFM was complete. PG also highlighted that the 3 KPI's that were previously unable to be reported on were now being reported and were going forward to the Management group as part of the compliance report. In terms of the soft services facilities management, despite this not being part of the original business, a trial was being completed to see if there was ability to report on the remaining KPI's. PG reported that a lot of the areas with the new start programme remained on track with a lot of really good work being done on the programme. To help in terms of challenging and robustness of the plan a Programme Board had been set up and were using the principles around project management. The first Programme Board was in October.

LM noted that it would have been good to see the report as previously with a summary and would have also been good to see updates against that summary just from a point of view of understanding progress. LM queried the report on the CAFM system and noted that at the last meeting there was concern that it was going to be April and now being pushed back further – this was a concern that this was a further delay and although there was no desire to rush from a quality perspective, it was something that the Trust had been waiting for a while from the LLP. She asked that some understanding of what the cost was to the organisation of delaying this for several months i.e. the cost in benefits. For assurance, a good understanding of what measures were missing from a patient safety point of view and anything else in terms of the overall facilities for the Trust in relation to that measurement.

PG reported that the upgrade had initially gone really well and the key thing was around the soft services and being able to report on the KPIs. She advised that should the trial go well, then this would be in place relatively quickly with the team so even whilst procuring a full system, there would still be the ability to report on those soft services KPIs. Concurrently running was the procurement exercise for the new system and in terms of a timescale, the start of the trail began at the end of August, there was now a team in Selby who were planning this and it has been agreed that the trial would continue until November to see if it worked. If the trial was a success, the service would continue to be used until a system had been procured. **LM requested that further to the trial completing in November, that an update report be provided to the Committee in December which would describe the cost/benefit analysis to provide assurance that there was no harm to patient safety by not having these measures.**

PG noted that in terms of KPI's there were 20 which were not reported on so the position was improving as earlier in the year this position was much higher. In June the Committee received the full dashboard and it was noted that it would be helpful to have this brought forward again and picked up through future updates to the Committee.

The Committee noted the report.

PG left the meeting

EPAM minutes

The Committee noted the minutes.

Resources Committee Annual Report

The Committee had nothing of note to add or amend to the presented annual report and therefore the Resources Assurance Committee Annual Report 2020/21 was approved.

Board Assurance Framework

MT reported that there was work ongoing with BA and the Executive Directors on the principle of risk in achieving the strategy. For the purpose of this Committee, it was PR2,4

and 7 on Workforce, Digital and Finance with a significant amount of work ongoing. Specifically one thing was the triangulation of data from a governance perspective. For example, some of the gaps that had come from the IT toolkit be added to the gaps of control on the BAF.

The committee noted the report and the on-going progress, working with the Executive Directors on developing the Board Assurance Framework.

Corporate Risk Register (CRR)/Risk Management Report

BA reported the he was working to dovetail his work on risk appetite with AB and was replicating this with PM and DR. He advised that there would be risk appetite statements, newly set scores in terms of gross net and target risk score and any actions where any risks were outside of appetite. He reported that the next round of meetings were in early October with a view to having a draft of all those risks to be presented by the end of October. On the CRR BA advised that he had begun a deep dive on cyber in July and this was included in the agenda. Because of the resource challenges as discussed earlier in the meeting, it was felt that there was a need for a deep dive on insufficient staff poising risk and was presented to the Risk Committee at its meeting on the 20th September and would be detailed in the next quarter's risk report for the Resources Assurance Committee. There were a number of actions that were due in the next quarter but there was more interest in tracking those through to completion over the course of the next few months.

The Committee noted the contents of the report.

Reflection on the Meeting and Any other business

- Need someone from IT support for the next meeting.
- The committee agreed to report any reflections outside of the meeting

Time and Date of next meeting

The next meeting will be held on 19 October 2021 at 9am face to face with Webex available for additional attendees.

Minutes
Resources Assurance Committee
19 October 2021

Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (ABert), Polly McMeekin (PM), Simon Hayes (SH) for Dylan Roberts, Penny Gillyard (PG), Michael Taylor (MT), Jim Dillon (JD), Cheryl Gaynor (for minutes), Rebecca Bradley (RB), Ruth Dunlop (RD).

Apologies for Absence:

Dylan Roberts (DR)

Welcome and Introductions

LM welcomed Mike Taylor to the meeting as the new Associate Director of Corporate Governance.

It was noted and agreed that the meeting was recorded for the purpose of the minutes and would be destroyed following the approval of the minutes. Any requests to listen to the recording much be made through the Chair of the Committee.

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 21 September 2021

The minutes of the last meeting held on 21 September 2021 were agreed as a correct record.

Matters arising from the minutes

Action log updates:

Action 94 (CPD System Developments): Hoped to get Yorkshire Ambulance present and a Clinician then this may happen at the November Board meeting but if not then certainly December.

Action 93 (Cyber): Ongoing. Planned completion and expected to be presented at the next meeting of the Committee. SH confirmed that an exercise was planned for the 8th November and an update would follow this.

Action 91 and 92 (People Plan and WRES/WDES): These actions were linked. PM advised that the action plan would primarily be based around the training roll out which was paused due to operational pressures in the organisation. The training was around staff value ambassadors and sponsor work and reviewing the policies and procedures on a care group/directorate level. LM agreed that the action was around understanding what was being carried out in terms of the training and communication following discussions at the Committee around culture. PM noted that she would include a summary update in the monthly IBR report to cover this. LM requested that as long as this was linked in to the discussion at Board around values and behaviour culture the committee accepted this. Action completed.

Action 88 (R&D Update): item on the agenda. Noted to ensure that Non-executive Director Matt Morgan was invited once a quarter when the R&D updates were due to be presented. Action completed.

Action 87 (Library Services): This was complete and any progress to be updated through the IBR report in future. Action completed.

Action 86 & 85 (Information Governance Quarterly Report) linked in terms of action and an update was on the agenda. Action completed.

Action 69 (Gender Pay Gap): This was on the agenda. Action completed.

LLP action – LM noted that it was preferred to present these actions be consolidated as part of the quarterly LLP update report of executive issues. The next update was due in January 2022 and the action list was updated to reflect this.

It was requested that the future Committee agenda's note the completed actions for the last month.

Research and Development Quarterly Update

PM presented the Research and Development (R&D) quarterly update to the Committee on the activities of the R&D department since April 2021. PM summarised as:

- A new R&D strategy had been written and agreed. A new Research Committee had been established which had oversight of the delivery of the strategy.
- Relationships had been strengthened with HYMS (Hull York Medical School) and they had offered the Trust 5 Clinical Academic posts of mutual benefit to both organisations research and Human Resources (HR) agenda.
- The Trust was behind on accruals (number of patients entered onto a clinical trial) however pace had since been picked up and Yorkshire and Humber were part of the Clinical Research network who produced reports which were national. Yorkshire and Humber was the second highest region for research activity currently and the Trust was a large contributing factor to the Yorkshire and Humber region and consequently the Trust was catching up on accruals. A large part of this was a

psychological study on the impact of covid-19 which managed to reach a vast proportion of the workforce.

- A key progress in terms of research activity was the submission of several grants for external funding as this ultimately raised the research profile for the Trust.
- Strengthened links with York St John University by employing four jointly supported Allied Health Professional PhDs. Also discussing other jointly supported posts, clinical services and future grant applications with them.
- Begun discussions with Coventry University and how the Trust could support research in the student nursing curriculum with a view that this may expand beyond just nursing.

The Trust continued to have various tensions and respond to patient safety need in the moment, there was deployment of a number of research nurses into front line work which meant that proportionally the research was stepped down. Research needed to be protected however, the Trust was struggling significantly with the shortage of the workforce and hence why consequently research is put on hold. It was worth being sighted on disciplines occurring.

LM highlighted that the research was for patients and suggested an improvement to the strategy structure, for example moving patients as the final strategic theme to the first theme to reflect the importance i.e. that patients are at the heart of everything we do in the Trust.

The Committee noted the report and the progress of the R&D Department.

Gender Pay Gap Update

PM presented the report which updated the Committee on the Trust progress against its Gender Pay Gap 2021 action plan.

The Committee noted that the pressure and wellbeing of the workforce was in a new territory for the Trust, the workload had significantly increased within the HR function. A number of work streams were taking a back seat because of immediate operational pressures. One area that was progressing in a proactive pace was the Agile working agenda and had engaged in NHS England & Improvement's Flex for the Future national programme (agile and flexible working was part of the People Plan in that the NHS needed to embrace this area much more). Some data analysis had been carried out as part of that through the staff survey - 53.5% of staff reported job satisfaction from flexible working and would agree that the Trust had responded to flexible working requests in a positive way. 40% of Trust vacancies were now advertised as flexible working with aspirations of this to be 100%. 44.8% staff were working part time and was a fairly balanced split in terms of senior or junior roles. 48.6% of staff were working flexibly according to either learning hub or the payroll system. 6.9% of leavers had sighted work life balance as a reason for leaving and the Trust aimed to reduce this figure. It was thought that all of the work around agile and flexible working would help with the gender pay gap along with a review of the starting salaries guidance as an important aspect of the gap.

JD highlighted the expectation that requests for flexible working would increase and enquired whether the Trust was in a position to keep up with the demand. PM advised that it was dependant on the role and also the ability for the Trust's IT infrastructure to be able

to respond to that - this was a risk as it was known that there was deficit in this particular area. There were real improvements made in clinical areas such as the job planning principles for consultants where a proportion of their time could now be completed remotely. There had also been some remote working around outpatient activity. The risks associated with this were primarily around the infrastructure rather than a cultural barrier. SH noted that he was a member of the Agile and Flexible Working Group as well as the Chair of Sub Group 1 which discussed the IT elements in supporting agile working. He described that there were a two aspects, the back end enabling staff to work which included the network, Wi-Fi, AOVPN's etc. and the font which included the end user capability such as the desktops, laptops etc. These elements and costs associated with this were being discussed within the group. It was important to consider what the support would look like for the staff. LM noted that as winter approached it was worth considering that there may be additional staff who would look to work more agile or flexibly. LM requested that it would be **beneficial for the Committee to receive an understanding at a future meeting of how this roll-out was progressing and could be included as part of the standing digital update.** In particular as winter was approaching the Trust was likely you see more staff wanting or needing to work from home. If technology allowed for agile and flexible working for staff, then the Trust was embracing this as an organisation.

LM highlighted that there was no dedicated project / programme support for the agile working agenda, which inevitably affected the pace of delivery as the members of each group were prioritising operational workload. Although the report was well received, it didn't provide assurance of what the actions or next steps were and when they were expected to be achieved with a clear understanding of what the link between IT and HR were doing. PM advised that a dedicated programme was The Building Better Care Programme which herself as the Director of Workforce and Organisational Development and Wendy Scott, Chief Operating Officer were joint leads for that programme. In terms of support for the delivery of the Agile and flexible working plan specifically, the Trust had agreed some additional human resources support, one of which was around the organisational values, behaviours and culture and was expected that this work stream would be picked up by this additional resource as there was a need to drive this forward.

The Committee noted the report and Trust progress.

Occupational Health Annual Report

PM presented the occupational health annual report. Occupational Health was a specialised function like most health specialities there was a workforce shortage and very few nurses and physicians were training to be in occupational health. The resource was finely balanced pre-covid in managing pre-employment checks and also management referrals in the main. Was light touch and reactive and serviced the entire workforce including the LLP and also had 38 other external contracts. The purpose of the external contracts and the targets associated with it generated an income of £350,000, the report detailed that the Trust was woefully falling short of that. Covid had been a significant contributing factor as to why. Managers were still expected to carry out a risk assessment and whilst they manage that, occupational health oversee a part of it. The Trust and LLP work was prioritised over the external contracts which wasn't a challenge as a number of the external contracts were furloughed or not working however, a consequence was that the income was reduced. PM was submitting a case to the Executive Committee to ask what the direction of travel was. There was no sign of the workload relenting and the Trust

had seen a significant increase of manager referrals going through occupational health. Some of this was managed by reviewing the sickness absence policy and questioning whether the policy referred to occupational health a little too soon and could this be changed to ease some pressure. There was approximately a 1 month wait to see occupational health currently and need the support, advice and guidance from the function. LM questioned whether this may increase over the next few months and was there a projection of the trend. PM assured that there was no expectation that there would be any reduction in absence any time soon. There was a concern for the occupational health staff. Page 67 of the report noted that there were 62 qualified mental health first aiders which was great however, the ideal would be 100 and the Trust was aspiring to that figure. Was there any help needed to get to that? There was a good programme for rolling out mental health, there were the fairness champions and now also values ambassadors as well as the mental health first aiders but there comes to a point where these rolls need to be consolidated.

The Trust made a significant investment in the Mental Health and Wellbeing of staff and developed the area. It was a balance of managing the pro-active work and be less reactive.

The Committee noted the report.

Workforce Integrated Business Report

PM presented the workforce element of the Trusts Integrated Business Report and highlighted a few key areas.

It was noted that workforce capacity had continued to be a challenge and reflected in temporary nurse staffing demands there had been an unfilled rate to 37% which was the highest since April 2020 and there were a number of things in place to work on mitigating this.

The Trust has started the staff vaccination programme for flu and covid-19 boosters. The Trust was informed that the priority was flu over the covid-19 booster. The campaign commenced on the 5th October through vaccination hubs and were positively seeing around 80% of staff opting for co-administration (covid-19 and flu together). The Trust was prioritising frontline and vulnerable staff and was fully booked well into November but hoped to open up in mid-November to all non-frontline staff. The Trust was looking to complete the entire campaign by the 2nd week of December. These dates might slip given the covid-19 vaccination with a bout of 2 or 3 week delay. Started on the 5th August and reported 17.7% of uptake for flu and 18.4% uptake for covid-19 booster.

A report had been written for the Executive Committee to be presented at the meeting on the 20th October on workforce resilience for winter which detailed 12 initiatives however there were some concerns about some of the contents. This required a debate as the national position is that elective activity was protected and within that, knowing through winter, there is a shortage of elderly and acute medicine nurses. There has been no recruitment in those specialties therefore the proposal was to deploy in a planned way some surgery into medicine and the debate was around what was the right approach to take.

PM highlighted page 23 of the IBR which sighted employment tribunals where around 80% were unrepresented. The charge to bring a claim to tribunal had dropped in 2017 and brought it to a low level but starting to see those increasing which was a considerable amount of work to manage those claims. JD expressed his interest in the overall legal fees to include capital work and tribunal etc. to get an understanding of what the Trust was spending on this. **AB agreed to pull this together as an action.**

In relation to staff absence LM noted that the top three reasons for absence was mental health, MSK and infections diseases, was there a continued trend here – PM advised that 26% was expected to continue, in relation to the mental health absence support, for the next 6-12 months RAFT was being rolled out and there were also other good initiatives in place. Not all of the absence was work related and was down to the environment or people not being able to get away for holiday etc. in some cases but overall it was difficult to predict any ongoing trend. In terms of infectious decease in particular it wasn't expected that this would reduce during winter.

The Committee noted the report

PM left the meeting.

DIS Security Posture (As-Is) and Roadmap

SH presented the main report which was a consolidation of two programme of work; information governance (IG) with data protection and also cyber security. A discovery exercise had been completed around the Trust posture or maturity when it came to cyber security and IG. There were a number of key findings such as; multi-year non-compliance against ESP toolkit, against Dionach Cyber Essentials + and also against Internal Security audits. There was also large scale technical debt and lack of investment in terms of architectural, design, build, operations and support perspective.

Looking at the Trust from a maturity posture perspective against standard methodologies, the Trust would be level 1 (level 5 being ideal) against its IG and cyber. Key findings were around lack of leadership and accountability Security Leadership in place with accountability to deliver any action plan.

Essential Services Programme – SH updated that work in this area had consisted of a roadmap of the next 18 months of the activities that need to be completed which was managed and governed by the Essential Services Programme and delivered by the Chief Digital Information Officer to the wider Executive and **Resources Committee with a monthly update**. The roadmap of activities was represented in the report and a number of anticipated outcomes for year 1 and 2. Recruitment activity of the operating model was key in bringing in the relevant resources around cyber security for its infrastructure and application within the Trust. The Chief Digital Information Officer was key to driving the posture and maturity into focussing on the right activities validating what was aimed to be achieved in particular around funding. A submission bid had been put forward for cyber security to NHSX, NHS Digital and NHS England and Improvement (Unified Tech Fund) for an amount of funding for this year to support with a view to return for further funding the following year.

In relation to the IG register, RB highlighted that the primary focus for this was around the audit actions, the timescales had been ambitious in the strategy. The audit actions push

towards compliance, particularly focussing on success measures against the toolkit and meeting those standards and also the accountability framework from the regulator. A recent development was that audit had offered 30 days support in relation to the completion of the information asset register.

JD queried what the single biggest threat was and what was being done to mitigate that. There were multiple priorities over the next 18 months in terms of cyber and IG but overall an understanding what best practice could look like for the Trust was important and a consolidated plan with a fundamental piece looking at vulnerabilities from within. For example, considering end users and what can be done with them to help alleviate and remediate some of the problems there were.

It was raised that there was some confusion around the way in which the dates were presented on the IG YTH 2201 Data Security and Protection Toolkit and was requested that future update reports detailed a clear understanding the actual date that had been agreed with audit versus the target date in order to demonstrate assurance that this was being actioned and managed.

The Committee requested that consideration be given when using acronyms in the report.

MT advised that the actions and recommendations from the IG and the IT toolkit this report would be included into the Board Assurance Framework.

The Committee reviewed and noted the report and gained assurance around its year 1 and 2 plans.

RB left the meeting

6m PIR - 2018/19-05 Involvement and Participation in York Community Stadium

AB presented the report which provided 6 Month Post Implementation Review (PIR) for Business Case 2018/19-05 - Involvement and Participation in York Community Stadium Project. He advised that this case had subsequently been signed off by Mark Quinn as the Care Group 6 Director who had presented the case to at the recent Executive Committee. The format used was one that had been used in the past and AB welcomed comments on the content and how this was approached. The approval of the business case was over 2 years ago but the delay in construction meant that the report was presented as 6 months from go live in terms of provision. The report will be brought back in 12 months with the intention of doing another review at the end of the first year. The Committee noted that this was the norm in terms of strategic investments that the Trust made and would become familiar with the documents in terms of benefits analysis. The Committee noted the good practice to ensure that the Trust was getting what it wanted out of its investments. The Committee were assured that there were no additional funds required following the use of alternative accommodation that were noted in the report as mitigating impacts or risks around construction delays.

LM highlighted that it would be beneficial for the committee to understand the lessons learnt against the case in the 12 month PIR report, demonstrated with a summary of ‘what went well, lessons learnt and even better if’.

AB reported that covid-19 and the restrictions around social distancing was preventing a number of staff going through the training system. Consequently the Trust was unable to move anything because of space issues.

Financial Integrated Business Report

AB reported that the request of the Trust was to balance position in Month 6 (end of H1) and this had been achieved. The Trust was taking a pessimistic view in terms of charges and costs and everything that was required to be included to meet the month 6 balanced position. In terms of H1 the Trust had done what had been asked and had managed that within the resource. In terms of H2 the Trust was still working through and a draft income and expenditure plan would be submitted to the Board of Directors for the 2nd half of the financial year as there are details available of the allocations. It was broadly in line with what was expected such as less money than H1. Covid spend was reducing and stabilising and were going to push for efficiency delivery in the second half of the year. AB raised concern in terms of where the draft position was showing a deficit of £4/5m. Some significant investments had been made and set an efficiency programme to deliver that. Pressures on the organisation have meant that the efficiency delivery has not yet been met however, there would be a push to catch-up on that. AB noted that the position was not yet finalised and was meeting with HCV ICS to agree on a number of contingency funds and allocations for winter etc. so there was hope for some improvement in that position. Surplus funds would not be something available to the Trust in the H2 so there was a need to constrict send in order for the Trust to deliver any expectation to balance its financial position.

Emergency capital funding was something that the Trust was pushing for as a medium term agenda. The Committee acknowledged that it was unlikely that the Trust would be supported with anything in the financial year in relation to emergency funding given the national position and the lack of CDEL cover.

The Committee noted the target 2% efficiency improvement requirement.

Nothing to add to the BAF.

The Committee noted the report.

LLP Quarterly Update – Q2

Penny Gillyard (PG) and Malcom Veigas (MV) joined the meeting.

AB presented the report which provide a monthly review of YTHFM's performance against the KPIs. It was pleasing to report a continued theme of improvement. The latest EPAM meeting had also been through the report.

The Committee noted that the figures were reflected in the experience staff were having which was good and it was picked up that the figures against the KPIs had improved. The Committee advised that they were keen to see a comparison of what this was like 2 years ago when KPI's were not being met. A visible trend over an annual basis would really

show the progress made and would be commendable to all the staff in terms of the work being done.

AB advised that it was preferred to refer back to a quarterly update with January being the next report. The Committee agreed that this would include a high level quarterly update lifting out key areas that were to be brought to the Committee and escalated to the Board, this could also include a comparative.

The Committee noted that sickness absence remained a significant challenge.

MV reported that he wanted to begin developing some qualitative datasets which meant beginning to meet and engage with Care Group leads on a quarterly basis to share information which would ultimately feed into better understanding of the work being carried out. A report would be brought back as part of the next quarterly LLP update.

PG advised that they were now reporting on all KPIs and building into the trend report would include the KPI reporting. There was now a focus on the soft services to report on through the trial of the new app.

VIU Scheme Interim Progress Report

PG reported that the from last month the capital team had been working with the contractor Kier and the clinical teams to complete a high options appraisal of alternative ways of delivering the project which didn't require a water mains to be diverted but did preserve the approved schedule of accommodation and minimise the impact on the project budget and programme. An options report was prepared for the Executive Committee to be discussed at its meeting on the 20th October 2021 which included a high level summary of the options; move the water main and continue with the project as intended (not preferred), make the extension building slimmer and by removing the existing VIU locate it in the original location so it didn't clash with the water main. Another option was to move the location to the service car park opposite the MRI unit or look at splitting the proposed across two buildings. None of the options were risk or problem free. Outcomes following the Executive Committee would be included in the next quarterly update.

The Committee were assured to see that there were options being presented and agreed to receive an update of the outcome from the Executive Committee as part of the LLP quarterly update in January 2022.

Grounds Maintenance Briefing Note

PG advised that the grounds maintenance work was working progress and that the team were reviewing the course of action in order to complete the work effectively. The Director of Property and Assets was preparing an options report to be presented as part of the LLP quarterly update in January.

Workforce Task and Finish Group - LLP sickness

MV updated the Committee on the Workforce Task and Finish Group in relation to LLP sickness absence and advised that it had now been meeting for up to 3 months. There were around 870 lower paid staff who tended to have a contextually different life which consequently results in sickness, notably the biggest areas were MSK and anxiety. 59 cases were currently going through the sickness process. Actions to date from the group were that the process was to be reviewed to include a retraining exercise with all relevant staff using HR colleagues and due by the end of November. This also included a revised approach to recruitment and a co-ordinating role of a business coordinator role. Also looking at reduction of the ratio of supervisors to domestics. In terms of recruitment there were some initiatives reported to work towards encouraging recruits such as refer a friend and receive vouchers and also free parking on interview. In addition to these incentives there were job fairs being held which was hoped would start to make a positive difference.

PG advised that the Task and Finish Group were looking into sickness from every avenue so the recruitment measures put in place was having a positive impact. Another area that was being considered was the relationship with occupational health services and there was understanding that this team had been stretched. LLP training with sickness absence was to also support with the types of referrals that were being sent through to occupational health and working closely with the team to ensure that the re right referrals were coming through. There had also been some investment in some new kit and equipment to help with MSK concerns such as replacing traditional wet mops with microfiber.

Vaccination Campaign Update
2:14

PG reported that the vaccination campaign had been promoted through the LLP staff newsletter. The clinics were fully booked up so there were not currently any further opportunity to get any more staff through for vaccination however 10.64% of LLP staff frontline had had their flu vaccine and 12% for the Covid-19 booster. PG continued to work closely with the Vaccinations manager around when the clinics were opened up again and were set to run the communications again to encourage staff to attend.

The Committee noted that it was good to see that this was progressing.

EPAM minutes and assurance escalation report

The Committee noted the EPAM minutes and assurance escalation report.

Board Assurance Framework (BAF)

PG advised that the LLP had also been developing a Board Assurance Framework and were working with the Risk Manager to use the same methodology as the Trust. There was also a CIP being developed for the LLP where a half day planning session was arranged to set out a 3 year programme for with the position for 2021/22 on target to achieve.

PG and MV left the meeting.

MT advised that the update of the Board Assurance Framework was nearly completion and aiming to complete by the end of November to be presented to the Board. In relation to this committee there was particular reference to PR 4, 5, 6 and 7 had been documented both in terms of risk appetite and in actions. PR 2 – minimum service standard variety in keeping safe in terms of the IG toolkit, there were gaps in control. Questions were currently being asked around whether the organisation has the right risks in the context of achieving its strategy. The Board would receive a development session on 4th November to discuss where the Trust would like to be with the BAF and the final sign off of what the BAF risks would be at the 24th November public board meeting.

Reflection on the Meeting and Any other business

- MT – picked up on the action around the LLP quarterly report and emphasis more on what was needed and where responsibilities sit for the Committee going forwards
- Good in terms of time that we have spent and chaired well
- SH – informative and collaborative, would take away presenting and how to provide a professional report including consideration around acronyms
- RD - Workforce and the finance risks that were carried at an executive level, good to see and understand how they were being discussed
- AB - Expecting resetting the Resources agenda and looking forward to developing the agenda. Would have been great to have discussed the I&E report but timings were difficult in terms of the detail and information available
- JD - We are focussing on the strategic things and having conversation about things that are important, the papers are read and we are focussed as a Committee
- JD - Feel well informed and have a great opportunity to discuss what we need to be discussing.

Time and Date of next meeting

The next meeting will be held on 16 November 2021 at 9.00am face to face with Webex available for additional attendees.

AOB – LM like to make sure that the agenda is lined up to what the Board is expecting and what we have planned on the agenda for Resources.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 2021 (October 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: November 2021

EXECUTIVE SUMMARIES

Quality & Safety

• 16 Serious Incidents declared in October.

• % Compliance with Stage 2 (Written) Duty of Candour is 92%

• Regrettably we have seen an increased incidence of both pressure ulcers and falls in the month of October. Workforce shortfalls continue to be a contributing factor as discussed at the Trust Improvement Groups. The impact is the inability to provide consistent care as per planned frequency, e.g. intentional rounds, position change and enhanced supervision. This has been escalated within Care Groups and through the Quality and Patient Safety Group.

• There were 129 medication incidents during October which is within the normal variation. Although this report states there were 4 medication incidents causing moderate or above harm one of these is a duplicate incident which will be rejected and one has been investigated and the harm downgraded. These are monitored at Medication Safety Group upon investigation completion.

• The sustained increase in new complaint cases (61 this month) has had an impact on performance and care groups have struggled to deal with the increase at this challenging time. Overall performance is at 51% for closed complaints within timescales.

• 14 hr post take compliance has improved slightly at York (80.2%), however Scarborough performance has dropped by 0.8& to 80.0%. NEWS compliance within 1 hour has decreased further at York (now 86.0%), however Scarborough has increased further (93.2%).

• Increased referrals to Outreach at both Scarborough and York in October reflective of winter workload pre covid, with slight increase in cardiac arrests at Scarborough but slightly below the mean in York.

• Deaths per 1,000 bed days have increased slightly from previous month to 8.78 deaths per 1,000 bed days. This is higher than the October 2020 figure. There were 12 SJCR's requested by the Medical Examiners in September. These are monitored at the Learning from Deaths Group.

• The Trust has had a total of 85 cases of C.Diff from April 2021; of which 43 were community-onset healthcare-associated (COHA) and 42 healthcare-onset healthcare-associated (HOHA) cases. There were 12 HOHA and COHA cases in October 2021. It appears unlikely that the target will be met (133 in total for financial year). An external review of our C.Diff position from NHSEI has took place, report expected in mid-November 2021.

• The emergency caesarean section rate at York has increased to 21.6% for October, the highest percentage in the data set provided.
• There were 10 occasions were the Maternity units had to close; 9 at York and 1 in Scarborough.

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

Workforce

The Winter Vaccination Programme commenced on 5th October with almost 29% of frontline staff having received their flu vaccine and almost 30% of frontline staff receiving their Covid booster by 1st November.

A number of initiatives which form the Workforce Resilience Programme were approved by the Executive Committee in October. These initiatives, which are intended to mitigate workforce challenges across the organisation, will be put into action throughout November and December.

Work continues with regards to embedding the new Trust values and awareness sessions have started with the aim of supporting all staff in becoming values ambassadors.

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 October 2021 (Month 7).

Emergency Financial Regime

During 2020/21, to support the NHS in its response to COVID-19 all normal financial arrangements were suspended and a new national, temporary, emergency financial framework was put in operation. This saw an arrangement where for the first half year of 2020/21 the focus was on providing whatever resources organisations needed, within reason, in responding to the pandemic; with the second half of the year seeing a change in focus through the reintroduction of financial control with the Trust being expected to live within a defined allocation agreed with system partners.

For 2021/22, the allocation based approach used in the second half year of 2020/21 was initially rolled forward and applied to the first half year (April 2021 - September 2021) only.

In late September 2021, NHSE&I announced the financial framework that will be in place for the second half year, 2021/22, which primarily signalled a continuation of the approach adopted in the first half year with some further adjustments for inflation including the meeting the cost of the 3% pay deal; together with an increased efficiency requirement over that required in the first half of the year.

The final financial plan for the second half of the year, 2021/22 (with an indicative full year plan for information only), was submitted to and agreed by the Board at its 4 November 2021 meeting. The agreed plan results in a balanced I&E position for both the second half of the year, and the full year in total.

Month 7 Position

For October, the Trust is reporting a pre adjusted I&E position of £155k surplus against a £59k deficit plan, placing it £214k ahead of the plan agreed by the Board, and to submitted

as part of the ICS plan to NHSE&I on 16 November. This is primarily driven by the net impact of ERF income in the first half of the year being behind plan with the associated cost of delivery also being behind plan; offset by other net underlying Trust performance being broadly equally ahead of plan.

The Trusts overall CIP target for 2021/22 totals £8.1m, of which the Trust has delivered £1.8m.

The Trust's compliance with the Better Payments Practice Code (BPPC) is currently averaging around 94% of suppliers being paid within 30 days.

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

Research & Development

Our key outcomes in the last month are as follows:

- We have had another strong month for our accruals and we are still on track to reach our CRN target of 4020 accruals by 31st March 2022. Our biggest recruiters this month have been Clinical Characterisation Protocol a global study recording data from Covid positive patients (168 accruals this month)
- No grants have been submitted in the last month
- Congratulations to Dr James Turvill who has had a success as a co applicant on a large national Health Technology Assessment Grant. The study aims to look at Faecal Immunochemical Test (FIT) based tools to triage patients in primary care
- We are working in partnership with Hull York Medical School, to arrange several clinical academic posts, and the first appointment in Ophthalmology will be interviewing soon, as the post has now closed for advert
- Commercial Research Manager interviews are being held mid-November and we are confident we should make an appointment this time
- We continue to support our Emergency Department by redeploying some Research Nurses each and every week, and anticipate this will continue until March 2022.
- We are creating several working groups at present to take on and deliver the different work packages of the new research strategy

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

2021. 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 10th of November there were 78 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 3,642 COVID-19 positive inpatients since 17th March 2020, with 2,852 patients discharged, sadly 711 patients have died. Since the beginning of July 2021 there have been 823 new COVID-19 positive inpatients and ninety six deaths.

As at the 10th of November, York Hospital has two COVID-19 positive wards with one COVID-19 positive ward at Scarborough Hospital, isolation rooms on Beech ward are also being utilised for COVID-19 positive patients on the Scarborough site. The three dedicated wards equate to fifty four beds that are COVID-19 only and are not available for general non-elective admissions. Not all of the COVID-19 patients are on the COVID-19 dedicated wards; a number are on a critical care ward or have been stepped down to an amber ward following clinical as they are over their fourteen day infectious period.

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

Trust Planning

The workforce risk that the Trust highlighted as part of the H1 2021-22 activity plan materialised to a greater extent than was anticipated through quarters one and two. This 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 over the last three months, limiting the availability of support from the system to reduce delays to patients or support urgent care demand. The Trust currently has a sickness absence rate of circa 8% of which approximately 14% are COVID-19 related. The first week of November 2021 saw 552 daily absences and reduced bank/agency pick up of shifts. This is however an improved position from mid-August 2021 (circa 800 daily absences).

The pressure on medical staffing has contributed to the cancellation of 287 outpatient clinics within fourteen days of the planned date and there were 138 elective patients cancelled by the Trust for either COVID-19 reasons (Staff isolating) or clinician/nursing unavailability during October 2021.

Elective inpatients are required to have a COVID-19 PCR test prior to admission, unfortunately in October 2021 forty six patients did not attend their test and subsequently had their surgery or endoscopy cancelled (July 2021; 72, August and September 2021; 49). This is ‘lost’ activity as the Trust is unable to reallocate the theatre to other patients due to the need for them to have a PCR test before they attend.

Compared to the activity outturn in October 2019 the Trust delivered the following levels of elective care activity:

Point of Delivery	October 2019 Outturn	October 2021 Actual	Variance	Proportion of October 2019 delivered in October 2021
First Outpatient Appts	15,975	12,617	-3,358	79%
Follow up Outpatient Appts	35,683	33,122	-2,561	93%
Ordinary Electives*	773	460	-313	60%
Day Cases	6,839	5,702	-1,137	83%

*Ordinary Elective figures are based on discharge date.

Planning guidance for the period October 2021 to March 2022 was released on the 30th of September. The Trust has engaged with partners in the HCV ICS and has submitted the Trust plan ahead of the final HCV ICS submission on the 16th of November.

An additional £1bn Elective Recovery Fund (ERF) has been made available to the NHS in the second half of 2021-22 to support activity above the level funded within system financial envelopes.

Systems that achieve completed referral to treatment (RTT) pathway activity above a 2019/20 threshold of 89% will be able to draw down from the ERF. In October 2021 the Trust completed 98% of the RTT pathways that were completed in October 2019.

October 2021 Performance Headlines:

• 69.1% of ED patients were admitted, transferred or discharged within four hours during October 2021.
• The Trust reported eighty one 12 hour Trolley Breaches.
• September 2021 saw challenging cancer performance with the Trust achieving three out of the seven core national standards.
• 1,688 fifty-two week wait pathways have been declared for the end of October 2021.
• 137 104+ week wait pathways have been declared for the end of October 2021, this is ahead of the Improvement Trajectory (157) that has been submitted to NHSI/E.
• 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 66.2% in September to 65.3% at the end of October 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 Sponsor	Wendy Scott, Chief Operating Officer

Digital and Information Service

Limited number of things to report this month as work on Essential services programme is progressing as planned and we are waiting with baited breath for the response to our Unified Tech Fund bid of just over £2m, that if successful will help us deliver the smart foundations we need.

Of frustration is the increased amount of rigour and work that will have to be put into our Electronic Patient Record case. A process equivalent to the Scarborough ED case has

been stipulated which means we need to consider where to get the specialists skills and expertise in to support that process and that recognise the elongated time and effort required for that process.

The Intelligence and Insight Team continue to receive an unprecedented number of data requests from NHSE/I (up 170%) and FOIs. Unfortunately this results in limiting the ability to support the Trust in developing internal operational reporting. This issue is being experienced by all acute providers, we are working closely with colleagues in the analytical teams within HCV and joint push back is taken where appropriate.

In addition, we have received early insight to a change in national SUS and ECS reporting which will create significant burden. A paper with further details on both the required reporting, operational and process changes will be taken to Executive Committee shortly.

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
24 November 2021
NHS Workforce Race Equality Standard

/ Trust Strategic Goals

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

/ Recommendation

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

/ Purpose of the Report

This report is for information and has been shared with the Resources Committee for discussion prior to submitting the Workforce Race Equality Standard (WRES) return for 2021 to NHS England by August. The WRES action plan will be drafted in partnership with the BAME Network and was submitted before the 30th September 2021 deadline.

/ Executive Summary – Key Points

The WRES data is to be submitted to the Strategic Data Collection Service (SDCS) by 31st August 2021 with an associated action plan to be published by 30th September 2021. The workforce profile highlights the lack of diversity among staff in pay bands 8a upwards and the significant need to address this balance from Board level positions down. Results from the 2020 staff survey, show that staff from a BAME background have reported worse experiences than White staff in relation to experiences of bullying, harassment, abuse and discrimination at work.

/ Recommendation

The Board of Directors is asked to note the content of the Workforce Race Equality Standard prior to its publication on the Trust website and submitted to NHS England.

Authors: Sian Longhorne, Deputy Head of Resources & Sarah Vignaux, HR Business Partner

Director Sponsor: Polly McMeekin, Director of Workforce and OD.

Date: November 2021

1. Introduction and Background

The Trust is required to complete the Workforce Race Equality Standard (WRES) each year and submit the data to NHS England by 31st August. The data and action plan must be published on the Trust website before 30th September.

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from Black, Asian and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The WRES requires us to demonstrate progress against a number of indicators on workforce equality, including a specific indicator to address the low levels of BAME Board representation.

2. WRES submission.

The Trust WRES return is included at Appendix A for review prior to submission. Whilst indicators one and nine work to snap-shot dates of 31st March 2020 and 31st March 2021; indicators two, three and four take data over a twelve-month period 1st April 2020 to 31st March 2021. Indicators five, six, seven and eight are taken from the 2020 annual staff survey.

Indicator 1: The data below summarises the representation of BAME staff members employed across the organisation

	Mar-19	Mar-20	Net change 19-20	Mar-21	Net change 20-21	Net change 19-21
Band 1*	1	0	-1	0	0	-1
Band 2	77	82	5	153	71	76
Band 3	17	18	1	26	8	9
Band 4	31	35	4	74	39	43
Band 5	175	240	65	294	54	119
Band 6	61	69	8	84	15	23
Band 7	22	27	5	34	7	12
Band 8a	8	7	-1	9	2	1
Band 8b	0	0	0	1	1	1
Band 8c	0	0	0	0	0	0
Band 8d	0	0	0	0	0	0
Band 9	0	0	0	0	0	0
VSM	2	0	-2	1	1	-1
Consultant	89	90	1	101	11	12
Non-consultant career grade	70	82	12	79	-3	9
Trainee grade	113	143	30	252	109	139

*The Trust now only employs two staff in band 1, both of whom are white

2.1 Data Analysis

The table above shows that BAME representation has improved over the past three years across roles in Agenda for Change bands 2 -7 and in the medical and dental staff group. BAME representation in senior, non-medical roles is still very low and it remains the case that there is no BAME representation on the Board.

Although BAME representation has improved amongst medical and dental staff, representation at all grades is lower than national benchmark data for all doctors in England (as presented in the WRES indicators for the medical workforce 2020). In particular, benchmark data for the Consultant workforce in England showed BAME representation of 37.6% (in 2020). The data for this Trust in the WRES 2021 submission shows BAME representation within the Consultant workforce of 23.8%.

Unfortunately, despite the improvements identified in BAME representation, indicator two shows that the relative likelihood of White staff being appointed from shortlisting compared to BAME staff has increased from 1.76% in 2020 to 2.61% in 2021. In part, this reflects a change in how we account for international recruitment in our data: this year, those appointments have been set aside as candidates follow an alternative appointment pathway[1], which does not involve open competition with UK candidates. The change puts greater focus on outcomes from the Trust's ordinary selection process.

WRES indicator three shows that the relative likelihood of BAME staff entering the formal disciplinary process compared to White staff has increased from 0.00 in the period 2018-2020 to 0.51 in the period 2019 – 2021 (this indicator is calculated over a two year rolling period) and the relative likelihood figure of 0.51 is based on an average of two staff each year from a BAME background entering the formal disciplinary process.

For the 2021 WRES return the relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff is calculated as 1.06. This is a deterioration in comparison to the figure of 0.86 which was returned in the 2019/20 submission. This indicator is likely to be, in part, impacted by changes to what courses are classed as mandatory and non-mandatory.

Indicators five, six, seven and eight within the WRES relate to the 2020 annual staff survey. They highlight the differing adverse perceptions of our BAME staff about their experience whilst at work when compared to their white colleagues. BAME staff responding to the survey reported worse experiences than white staff in relation to experiences of bullying, harassment or abuse at work. 25.5% of respondents reported experiences of bullying, harassment or abuse from patients, relatives or the public (22.5% for white staff), whilst 31% reported experiences of bullying, harassment or abuse from other staff (24.8% for white staff).

The percentage of BAME staff who believed that the organisation provides equal opportunities for career progression or promotion (75.8%) was much lower than the percentage of white staff believing the same (87.1%). The result in the 2020 survey for BAME staff on this question was a deterioration from 78.4% in the previous year's survey.

16% of our BAME staff reported they had experienced discrimination from their manager/team leader or other colleagues over the previous 12 months. This compares to 6.3% of our white workforce. The result for this question for BAME staff is not significantly changed from the previous year's survey.

[1] During 2020-21, 68 nurses and 14 doctors were appointed to the Trust via the international recruitment pathway

2.2 Progress Against Last Year's Action Plan

Since last July the Race Equality Network has fully established its identity as a staff network, with its own branding and email address which sets it apart from the Trust corporately as a network for staff by staff. The Network has over 25 members, with a monthly meeting schedule. There have been 4 guest speakers at their meetings this year, those being the Chief Executive, Director of Workforce, Recruitments Leads and ODIL.

The network are involved in a number of key pieces of work including ablution facilities at York, working with the LLP to create menus to support a diverse workforce and inputting in to the reverse mentoring program. They have also been raising awareness about the network through recruitment channels, international nursing and at junior doctors inductions and have established contacts at both Hull and Mid Yorkshire hospitals to look at best practice models.

The Trust has established a reverse mentoring programme with 18 mentoring partnerships between senior managers and BAME staff workshops are underway with the participants and individual conversations will commence from September.

2.3 2021 Equality Action Plan

A proposed action plan has been put together in Appendix B, as per last year this is a combined Equality Action Plan based on our WDES and Workforce Race Equality Standard (WRES) submissions and feedback from our Staff networks.

The action plan has been shared with all of the staff networks to ensure the action plan is reflective of the views of staff members and the networks can hold the Trust to account for delivery of the actions.

Appendix A

SubmissionTemplate
Workforce Race Equality Standards 2020/21 template

Answer Required
Auto Populated
N/A

	INDICATOR	DATA ITEM		MEASURE	2020 WHITE	2020 BME	2020 ETHNICITY UNKNOWN/NULL	2021 WHITE	2021 BME	2021 ETHNICITY UNKNOWN/NULL	Notes
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		1a) Non Clinical workforce		Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	
		1	Under Band 1	Headcount	0	0	0	0	0	0	
		2	Band 1	Headcount	296	6	14	271	3	16	
		3	Band 2	Headcount	449	13	27	567	27	37	
		4	Band 3	Headcount	91	0	1	88	0	3	
		5	Band 4	Headcount	39	0	1	34	0	1	
		6	Band 5	Headcount	39	2	0	39	1	0	
		7	Band 6	Headcount	23	0	0	22	0	0	
		8	Band 7	Headcount	17	1	0	18	1	0	
		9	Band 8A	Headcount	6	0	0	7	0	0	
		10	Band 8B	Headcount	2	0	0	1	0	0	
		11	Band 8C	Headcount	2	0	0	2	0	0	
		12	Band 8D	Headcount	0	0	0	2	1	0	
		13	Band 9	Headcount	0	0	0	0	0	0	
		14	VSM	Headcount	3	0	0	1	1	0	
			1b) Clinical workforce of which Non Medical								
		15	Under Band 1	Headcount	0	0	0	0	0	0	
		16	Band 1	Headcount	0	0	0	1	1	0	
		17	Band 2	Headcount	0	0	0	26	1	0	
		18	Band 3	Headcount	0	0	0	1	0	0	
		19	Band 4	Headcount	0	0	0	1	0	0	
		20	Band 5	Headcount	0	0	0	6	1	0	
		21	Band 6	Headcount	8	0	0	10	0	0	
		22	Band 7	Headcount	3	0	0	3	0	0	
		23	Band 8A	Headcount	1	0	0	1	0	0	
		24	Band 8B	Headcount	0	0	0	0	0	0	
		25	Band 8C	Headcount	0	0	0	0	0	0	
		26	Band 8D	Headcount	0	0	0	0	0	0	
		27	Band 9	Headcount	0	0	0	0	0	0	
		28	VSM	Headcount	0	0	0	0	0	0	
			Of which Medical & Dental								
		29	Consultants	Headcount	0	0	0	0	0	0	
		30	*of which Senior medical manager*	Headcount	0	0	0	0	0	0	
		31	Non-consultant career grade	Headcount	0	0	0	0	0	0	
		32	Trainee grades	Headcount	0	0	0	0	0	0	
		33	Other	Headcount	0	0	0	0	0	0	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount	491	55	7	417	47	73	
		35	Number appointed from shortlisting	Headcount	94	5	2	124	12	66	
		36	Relative likelihood of appointment from shortlisting	Auto calculated	19.14%	9.09%	28.57%	29.74%	25.53%	90.41%	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated	2.11			1.16			
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated	979	22	43	1101	37	57	
		39	Number of staff entering the formal disciplinary process	Headcount	2	1	1	5	0	2	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated	0.20%	4.55%	2.33%	0.45%	0.00%	3.51%	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated		22.25			0.00		

SubmissionTemplate
Workforce Race Equality Standards 2020/21 template

Answer Required
Auto Populated
N/A

INDICATOR	DATA ITEM		MEASURE	2020 WHITE	2020 BME	2020 ETHNICITY UNKNOWN/NULL	2021 WHITE	2021 BME	2021 ETHNICITY UNKNOWN/NULL	Notes
4 Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce	Auto calculated	979	22	43	1101	37	57	
	43	Number of staff accessing non-mandatory training and CPD:	Headcount	138	2	3	38	3	16	
	44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated	14.10%	9.09%	6.98%	3.45%	8.11%	28.07%	
	45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated	1.55			0.43			
9 Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator	46	Total Board members	Headcount	1	0	0	1	1	0	
	47	*of which: Voting Board members*	Headcount	1	0	0	1	1	0	
	48	*: Non Voting Board members*	Auto calculated	0	0	0	0	0	0	
	49	Total Board members	Auto calculated	1	0	0	1	1	0	
	50	*of which: Exec Board members*	Headcount	1	0	0	0	1	0	
	51	*: Non Executive Board members*	Auto calculated	0	0	0	1	0	0	
	52	Number of staff in overall workforce	Auto calculated	979	22	43	1101	37	57	
	53	Total Board members - % by Ethnicity	Auto calculated	100.0%	0.0%	0.0%	50.0%	50.0%	0.0%	
	54	Voting Board Member - % by Ethnicity	Auto calculated	100.0%	0.0%	0.0%	50.0%	50.0%	0.0%	
	55	Non Voting Board Member - % by Ethnicity	Auto calculated							
	56	Executive Board Member - % by Ethnicity	Auto calculated	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	
	57	Non Executive Board Member - % by Ethnicity	Auto calculated				100.0%	0.0%	0.0%	
	58	Overall workforce - % by Ethnicity	Auto calculated	93.8%	2.1%	4.1%	92.1%	3.1%	4.8%	
	59	Difference (Total Board -Overall workforce)	Auto calculated	6.2%	-2.1%	-4.1%	-42.1%	46.9%	-4.8%	

Appendix B – Proposed Equality Action Plan

Metric	Objective	Action/s	Timescales	Lead/s	Why
1	Increase the number of staff declaring their protected characteristic status via ESR	• Work with the staff networks to develop a trust wide communications campaign highlighting the benefits of declaring protected characteristic status, to include new starters and current employees • Work with the staff networks to explore any challenges that they may have encountered in using ESR • Continue work with the Recruitment Team to encourage new starters to declare protected characteristics • Promote ESR functionality (self-service)	To be completed by February	Director of Workforce and OD HR Workforce Lead Human Resources Business Partner Communications Staff network chairs	Necessary to improve the data quality
2	Reduce the inequality in the recruitment and selection process.	• Make information available to potential job applicants about the trust's commitment to inclusive recruitment and that we welcome applications from all applicants. • Review of scope of advertising and methods used to attract individuals • Explore using targeted adverts encouraging candidates from ethnic backgrounds to apply including for senior manager posts • Ongoing engagement between the staff networks and Trust recruitment team. • Review training offer provided to recruiting managers and panels to include unconscious bias training and the	To be delivered between November and February	Director of Workforce and OD Recruitment Lead HR Workforce Lead Human Resources Business Partner Communications Staff network chairs	To improve career progression prospects for BAME and disabled staff

		disability confident scheme. • Provide advice regarding the composition of panels through the recruitment and selection process, including supporting creation of interviewer pools to drive more diverse panels for example individuals from a BAME background or with a disability • Launch of new values-based interview questions, incorporating specific questions pertaining to equality, diversity and inclusion • Review the accessibility of the application process with Networks.			
3	Reduce the relative likelihood of BAME or disabled staff entering the capability and disciplinary process	• BAME representation on the panel at disciplinary hearings where a BAME member of staff is involved • Representatives from all staff networks to be invited to participate in the Trust's Employment Policy Group to provide feedback on all policy developments. • Ensure reasonable adjustments are referenced in all policies • Continuing the development of an Open and Just Culture within the Trust, encourage the use of the NHS Just Culture guide which is designed to reduce unconscious bias in decision making around an individual's involvement in an incident. • New investigation training to be rolled out within the Trust. • Considering impact of specific EDI	To be completed by March	Director of Workforce and OD HR Workforce Lead Human Resources Business Partner	To increase the confidence of staff entering into the capability process that they will be treated fairly

		related issues and contribution to allegations and whether specific Network Peer support is needed			
4	Reduce the incidence of BAME or disabled staff experiencing harassment, bullying and abuse from patients and colleagues.	• Raise awareness of existing reporting processes and support available • Hold sessions with staff networks to gather further feedback and utilise feedback gathered from staff by staff for actions linked to this metric • Seek feedback from staff networks in the development of the new Challenging Bullying and Harassment Policy. • Representatives from all staff networks to be invited to the Trust's Employment Policy Group to provide feedback on all policy developments.	To be completed by December	Director of Workforce and OD HR Workforce Lead Human Resources Business Partner	Part of the overall organisational goal to create an inclusive culture
5	Reduce inequality in career progress opportunities for BAME and disabled staff	• Work with professional leads to interrogate data around movement of staff between the lower, middle and upper sections of our pay structure to identify any factors which restrict opportunities for BAME and disabled staff & formulate action plan to address issues • Review appraisal paperwork of a selection of BAME and disabled staff who have been in same post or pay band level for three years to evaluate whether they have had opportunities for career development • Develop talent and leadership management programmes that will	To be completed by May	Director of Workforce and OD ODIL Lead Recruitment Lead	To improve career progression prospects for BAME and disabled staff

		support BAME and disabled groups of staff to progress – helping the Trust to ensure that the workforce is more representative at middle to senior levels. Promote National NHS programmes e.g. Stepping Up • Support the development of the reverse mentoring programme • Work with professional leads to interrogate recruitment data and identify barriers			
6	Reduce level of presenteeism experienced by BAME and disabled groups of staff	• Promote the Agile and Flexible Working policy that is fully supportive of those colleagues who wish to work from home • Through the Trust networks (Enable & Carers) establish the steps the Trust needs to take. • Adopt a 'Health passport' for staff to use within the organisation from point of recruitment which keeps an up to date record of reasonable adjustments required for the individual.	To be completed between November and April.	Director of Workforce and OD Operational HR Team Enable & Carers staff network chairs	Create a healthier workplace for staff and improve wellbeing for all
7	Increase the percentage of BAME and disabled staff satisfaction rate	• Work with staff networks and other key partners, to explore issues and identify interventions to improve the satisfaction rate • Ensure all management development sessions explore their responsibility in relation to workplace equality: what they should be doing about it and how they	To be completed by June	Director of Workforce and OD ODIL Lead Staff network chairs Communications HR Workforce Lead Human Resources Business Partner	Part of the overall organisational goal to create an inclusive culture

		can set expectations for leadership • Equality and Diversity Training to be reviewed and considered as part of the Statutory and Mandatory programme of training for the Trust • Showcase/Celebrate role models from BAME and disabled staff groups through greater visibility in Trust Communications.			
8	Increase percentage of BAME and disabled groups of staff that feel that their request/s for reasonable adjustments have been adequately managed.	• Promote the Agile and Flexible Working policy and the recently improved guidance for line managers on how to facilitate reasonable adjustments for their staff • Adopt a 'Health passport' for staff to use within the organisation from point of recruitment which keeps an up to date record of reasonable adjustments required for the individual. • Continue to promote Health & Wellbeing conversations within the workplace.	To be developed between November and March	Director of Workforce and OD Operational HR Team Staff network chairs	Create a healthier workplace for staff and improve wellbeing for all
9	Reduce gap in staff engagement scores	• Hold workshop session with staff networks to explore the data and develop actions to reduce the gap in staff engagement scores. • Staff networks to play a role in the roll out of the Trust values and behaviours. • Staff network representatives to be in attendance at the Fairness Forum to provide updates and feedback. • Ensure actions taken by the Fairness Forum reflect the voice of the staff	To be developed between November and March	ODIL lead Staff network chairs	Create a culture and environment where Disabled and BAME staff feel able to speak up and have a voice

		networks.			
10	Reduce the gap between Board representation and overall representation of BAME and disabled staff in the workforce	• Ensure the process for appointment of non-executive directors encourages diverse applicants, including those who identify as Disabled, from a BAME background, or have a protected characteristic • In partnership with the Race Equality and Disabled staff networks organise a board development about the WDES, WRES and the inequalities experienced by Disabled staff, BAME staff and those with other protected characteristics • Share recruitment information through recognised diverse organisations and recruitment agencies. • As a demonstration of trust commitment to inclusion, support and develop the reverse mentoring programme, providing opportunity for Disabled staff network members, Race Equality staff network members and LGBTQ+ network members to have mentoring relationship with Board members. From hearing insights and lived experiences, Board members will be better informed in making decisions that benefit all staff and patients. • Non-Executive Director development programme to improve representation on the board • Continue with the extended catchment area of Yorkshire & Humber for Non-	To be completed by May	Director of Workforce and OD ODIL Lead Staff network chairs	To demonstrate visible leadership in this area at senior levels

		Executive Director recruitment			

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Resources Assurance Committee
21 September 2021
NHS Workforce Disability Equality Standard

/ 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

For submission to Resources Committee for discussion prior to submitting the Workforce Disability Equality Standard (WDES) return for 2021 to NHS England by August. The WDES action plan will be drafted alongside the Workforce Race Equality Standard action plan and will be submitted before 30th September 2021 deadline.

/ Executive Summary – Key Points

The WDES data is to be submitted to the Strategic Data Collection Service (SDCS) by 31st August 2021 with an associated action plan to be published by 30th September 2021. The workforce profile highlights that there continues to be improvements in the numbers of staff declaring their disability status. However, staff who have declared a long term condition or illness, reported through the 2020 staff survey lower levels of staff engagement and worse experiences with regards to bullying, harassment and violence (than staff who did not declare a long term condition or illness).

/ Recommendation

Resources Committee is asked to note the content of this report prior to its publication on the Trust website and submission to NHS England.

Authors: Sian Longhorne, Deputy Head of Resources & Sarah Vignaux, HR Business Partner

Director Sponsor: Polly McMeekin, Director of Workforce and OD.

Date: September 2021

1. Introduction and Background

The Trust is required to complete the Workforce Disability Equality Standard (WDES) each year and submit the data to NHS England by 31st August. The data and action plan must be published on the Trust website before 30th September.

The WDES is a set of ten specific measures which enable NHS organisations to compare the workforce and career experiences of disabled and non-disabled staff members. Completing the return year on year allows for the Trust to show progress of disability equality.

2. WDES submission.

The Trust WDES return is included at Appendix A for review prior to submission.

The Trust continues to see improvements in the number of staff who have declared their disability status (see table 1 below) although in the past year there has been a reduction in the proportion of staff within senior roles and in the medical and dental groups who have declared a disability.

According to the Employer's Forum on Disability, 18% of the working age population in Britain are disabled, as defined by the Equality Act 2010. The table below therefore indicates significant underrepresentation of the disabled population within our workforce.

Results of the Office for National Statistics Annual Population Survey, showed that in the year to June 2020, employment rates amongst those with a self-reported disability within the working age population in the Yorkshire and the Humber region were 53.6%, compared to 80.2% amongst the non-disabled working age population.

Table 1 - Staff members with a declared disability

	2020	2021
Non-clinical		
Cluster 1 (Bands 1 - 4)	3.1%	3.5%
Cluster 2 (Band 5 - 7)	2.3%	2.9%
Cluster 3 (Bands 8a - 8b)	2.4%	3.4%
Cluster 4 (Bands 8c - 9 & VSM)	3.1%	2.6%
Clinical		
Cluster 1 (Bands 1 - 4)	3.1%	3.3%
Cluster 2 (Band 5 - 7)	2.8%	3.2%
Cluster 3 (Bands 8a - 8b)	1.1%	1.5%
Cluster 4 (Bands 8c - 9 & VSM)	0.0%	0.0%
Cluster 5 (Medical & Dental Staff, Consultants)	0.8%	0.7%
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	2.6%	1.7%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	2.6%	2.3%

It should be acknowledged the declaration rates which are taken from ESR are not representative of our workforce with a disability / long term health condition. Intelligence gathered during the COVID pandemic in relation to risk and vulnerability of employees due to underlying health conditions provides a picture of nearer 20% of our workforce that may have a disability as described by the Equality Act 2010. There is no legal requirement

under the Equality Act for individuals to disclose a disability to their employer and we have to accept that there may be a number of reasons why individual may choose not to disclose this information. This might include for example, fear of discrimination, not considering themselves to be disabled and / or not understanding how we use the data that we collect. To address some of these possible considerations we have added targeted actions within the Equality action plan.

Since the 2019/20 WDES submission, the metric measuring the relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting has improved from 1.61 to 1.08.

The Trust has retained its Disability Confident status. Through participating in the Guaranteed Interview scheme we have assurance that all disabled applicants who meet the minimum criteria for the job role are offered an interview. This is an area that we will provide some continued focus within the Trust action plan; availability of interviews virtually may assist disabled applicants in the future.

The Trust has seen, for the second year in a row, a reduction in the likelihood of a disabled staff member entering a capability process; this has reduced from 9.27 (2019 return) to 8.79 (2020 return) to 6.27 (2021 return). It should be noted though that this figure reflects that one staff member, who declared themselves disabled, entered a formal performance management process in a rolling two year period (April 2019 – March 2021).

Reasonable adjustments are considered for all employees where the need arises, advice is available for all staff members through the Trust intranet site to help facilitate reasonable adjustments. In the 2020 staff survey, 77.1% of staff responding to the survey who declared that they had a long term health condition or illness, said that the Trust had made adequate adjustments to enable them to carry out their work. This compared to a national average of 75.5%.

Results from the 2020 staff survey showed an overall staff engagement score of 6.4, amongst those staff who responded to the survey and declared a long term condition or illness. This compared to an overall staff engagement score of 7 amongst those who declared that they did not have a long term condition or illness.

The results of the survey also showed that staff who declared a long term condition or illness reported worse experiences (than staff who did not declare a long term condition or illness) in terms of experiencing bullying, harassment or abuse. Of the three questions within the staff survey relating to experiences of bullying, harassment or abuse, the scores amongst staff with a long term condition or illness for two questions deteriorated from the previous year.

It remains the case that there are no members of the Board who have declared a disability.

2.1 Progress Against Last Year's Action Plan

The Trust formally launched the Enable network in June 2021. This network is to support staff with disabilities, serious or long term health conditions. The network aims to create a supportive environment where members can share their own experiences and work with the Trust to improve inclusivity.

Enable have routes of escalation through both the Deputy Director of Workforce during their established recurring monthly meetings and through the Fairness Forum, where feedback from network meetings on themes and trends is discussed. The Fairness Forum provides the governance structure for the group and ensures that pieces of work that the

network wishes to progress are in line with the corporate focus and where this is not the case, the network has a voice to provide appropriate challenge to the organisation.

The Trust during July reaccredited for its Disability Confident status. Disability Confident is a government run scheme. To achieve the accreditation, as a Trust we have to evidence that we take steps to actively recruit and retain individuals with disabilities (as defined by the Equality Act 2010).

During a recent review process, we have also provided a wealth of evidence to ensure our continued Mindful Employer status, a charter run by Devon Partnership Trusts, demonstrating a commitment to better mental health at work.

The 2021 appraisal window is currently open and this process helps to ensure that an individual health and wellbeing conversation takes place with every employee and everyone has the chance to review their opportunity for flexible working.

The information available on the intranet for all staff members in relation to reasonable adjustments has been refreshed and improved over the last year, making the resources easier to access and guidance readily available.

Whilst there has been some improvements in the data this year the Trust needs to continue to improve on the Equality agenda, as set out in the NHS People Plan and our local action plan will help to facilitate this.

2.2 2021 Equality Action Plan

A proposed action plan has been put together in Appendix B, as per last year this is a combined Equality Action Plan based on our WDES and Workforce Race Equality Standard (WRES) submissions and feedback from our Staff networks.

The action plan has been shared with all of the staff networks to ensure the action plan is reflective of the views of staff members and the networks can hold the Trust to account for delivery of the actions.

Appendix A

Workforce Disability Equality Standard (WDES) Data Collection

WDES

For: **York and Scarborough Teaching Hospitals NHS Foundation Trust**; Wed 1 April 2020 to Wed 31 March 2021

Submitted: **Thu 26 Aug. 2021, 2:14 p.m.** by **Amara Ashraf (amara.ashraf@york.nhs.uk, York and Scarborough Teaching Hospitals NHS Foundation Trust)**

Status: **Complete**

Home

Home

Workforce Disability Equality Standard – Data Collection Framework

Introduction

This data is being collected as part of the 2021 data collection for the Workforce Disability Equality Standard (WDES). The aim of WDES is to improve the working and career experiences of Disabled staff in the NHS. The WDES is mandated through the NHS Standard Contract and has been approved as a data collection by the NHSX Data Alliance Partnership . It has also been subject to a data protection impact assessment.

The Data Collection Framework (DCF) should be used to submit data for the WDES metrics (note the information on the tab for metrics 4 to 9a for NHS trusts). The survey tab contains a series of qualitative questions and should also be completed.

Guidance on how to complete the DCF has been produced and is available via this link .

Navigation and Completion

Each section of the DCF can be accessed using the links near the top of the page. Please note:

- White boxes will collect the data. The grey boxes will be automatically filled when all the required information has been entered.
- Items marked with a red asterisk * are compulsory.
- Entries and changes are not saved automatically. At the foot of each section is a button labelled “Save as draft”: this should be used as often as possible.
- Once a section is complete, check the “This page is complete” box at the bottom.
- Once all sections are complete, the “Submit” button can be pressed at the foot of any section.
- Each page may be saved as a PDF or printed using the standard process for your browser. (For example, in Chrome, pressing the three dots at the top-right of the screen brings up several options including Print.)
- Once the data has been submitted, an option will be given allowing a PDF version of the submission to be produced. You are strongly advised to do this and retain it for your records, and to aid in the completion of your 2021 Action Plan.
- Do not use the Back button on your browser: this will return you to the Open Collections screen, and any unsaved data will be lost.

Bank and Agency staff

Trusts should only include Band and Agency staff in the 2021 return if they were also included in the 2020 return. Please use the Notes sections to indicate whether Bank/Agency staff have been included or not.

Deadlines

NHS trusts should submit their data between **1 July 2021** and by **close of business on 31 August 2021**.

National healthcare organisations should submit their data between **1 August 2021** and by **close of business on 30 September 2021**.

Queries

For advice on submitting the data, please email england.wdes-datahelpdesk@nhs.net

Our information governance notice can be viewed here: data collection notice

Our Guidance can be viewed here: Guidance

Web form technical support queries should be sent to: ips.servicedesk@nhseandi.nhs.uk

Technical support queries about your account and password, locked accounts and password resets should be sent to: itservicedesk@nhseandi.nhs.uk

Metric 1 - non-clinical

Metric 1 - non-clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2021.

If including Bank and Agency staff, please enter them in the "Other" category

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	0 *	0 %	2 *	1 %	0 *	0 %	2
Band 2	17 *	4 %	314 *	7 %	79 *	1 %	410

Band 3	19	*	4	%	353	*	7	%	77	*	1	%	449
Band 4	10	*	2	%	261	*	6	%	164	*	3	%	435
Band 5	2	*	1	%	102	*	6	%	42	*	2	%	146
Band 6	3	*	2	%	76	*	7	%	28	*	2	%	107
Band 7	6	*	4	%	82	*	6	%	37	*	2	%	125
Band 8a	2	*	3	%	33	*	5	%	30	*	4	%	65
Band 8b	1	*	4	%	10	*	4	%	13	*	5	%	24
Band 8c	0	*	0	%	6	*	4	%	7	*	5	%	13
Band 8d	1	*	5	%	12	*	6	%	5	*	2	%	18
Band 9	0	*	0	%	1	*	1	%	0	*	0	%	1
VSM	0	*	0	%	5	*	8	%	1	*	1	%	6
Other e.g. Bank/Agency, please specify	0	*	0	%	0	*	0	%	1	*	1	%	1

Notes

Total non-clinical	61	3.4 %	1257	69.8 %	484	26.9 %	1802

Non-clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	46	3.5 %	930	71.8 %	320	24.7 %	1296
AfC Bands 5, 6 and 7	11	2.9 %	260	68.8 %	107	28.3 %	378
AfC Bands 8a and 8b	3	3.4 %	43	48.3 %	43	48.3 %	89
AfC Bands 8c, 8d, 9 and VSM	1	2.6 %	24	63.2 %	13	34.2 %	38

Metric 1 - clinical

The percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2021.

If including Bank and Agency staff, please enter them in the "Other" category

Metric 1 - clinical

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
Under Band 1	0 *	%	0 *	%	0 *	%	0
Band 1	0 *	0 %	0 *	0 %	2 *	1 %	2
Band 2	58 *	3 %	1533 *	8 %	297 *	15 %	1888
Band 3	17 *	3 %	399 *	7 %	127 *	23 %	543

Band 4	18 *	5 %	276 *	7 %	54 *	1 %	348
Band 5	59 *	3 %	1287 *	7 %	297 *	1 %	1643
Band 6	41 *	3 %	994 *	7 %	308 *	2 %	1343
Band 7	14 *	2 %	402 *	6 %	195 *	3 %	611
Band 8a	2 *	1 %	97 *	6 %	61 *	3 %	160
Band 8b	1 *	2 %	18 *	5 %	15 *	4 %	34
Band 8c	0 *	0 %	17 *	8 %	4 *	1 %	21
Band 8d	0 *	0 %	6 *	8 %	1 *	1 %	7
Band 9	0 *	%	0 *	%	0 *	%	0
VSM	0 *	0 %	12 *	1 %	0 *	0 %	12
Other e.g. Bank/Agency, please specify	0 *	%	0 *	%	0 *	%	0

Notes

Medical & Dental Staff, Consultants	3 *	0.7 %	291 *	68.5 %	131 *	30.8 %	425
Medical & Dental Staff, Non-Consultants career grade	3 *	1.7 %	146 *	80.1 %	32 *	17.8 %	181
Medical & Dental Staff, trainee grades	14 *	2.3 %	563 *	92.4 %	32 *	5.3 %	609
Total clinical	210	3.2 %	5041	76.2 %	1361	20.6 %	6612
Total medical & dental	20	1.6 %	1000	82.3 %	195	16 %	1215
Total clinical & non-clinical	291	3 %	7298	75.8 %	2040	21.2 %	9629

Clinical summary by pay band grouping

	Disabled Headcount	Disabled Percent	Non-disabled Headcount	Non-disabled Percent	Disability Unknown Headcount	Disability Unknown Percent	Total Headcount
AfC Bands 1 (and under), 1, 2, 3 and 4	93	3.3 %	2208	79.4 %	480	17.3 %	2781
AfC Bands 5, 6 and 7	114	3.2 %	2683	74.6 %	800	22.2 %	3597
AfC Bands 8a and 8b	3	1.5 %	115	59.3 %	76	39.2 %	194
AfC Bands 8c, 8d, 9 and VSM	0	0 %	35	87.5 %	5	12.5 %	40

Metric 2

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Note:
i) This refers to both external and internal posts.

ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the Survey section to ensure comparability between organisations.

	Disabled	Non-disabled	Disability Unknown
Number of shortlisted applicants	318 *	4161 *	298 *
Number appointed from shortlisting	37 *	680 *	142 *
Likelihood of shortlisting/appointed	0.12	0.16	0.48

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts 1.40

Notes

Metric 3

Metric 3 - Capability

Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Note:
i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.

ii. This metric applies to capability on the **grounds of performance and not ill health**.

Clarification for people completing the data collection: enter the number of staff entering the capability process from 1 April 2019 to 31 March 2021, divided by 2.

	Disabled	Non-disabled	Disability Unknown
Number of staff in workforce	291	7298	2040
Number of staff entering the formal capability process	0.5 *	2 *	0.5 *
Likelihood of staff entering the formal capability process	0.00	0.00	0.00

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff 6.27

Notes

Metric 4 to 9a

Please note that you are not required to submit data for WDES Metrics 4 to 9a. These metrics relate to the NHS Staff Survey and the WDES Implementation Team will access this data directly.

However, you should include data for these metrics when discussing, producing and publishing your organisation's WDES annual report. The annual report, which should be developed in partnership with the organisation's Disabled staff network and ratified by the Board, must contain data for all 10 metrics along with an action plan that sets out the actions the organisation will deliver over the coming 12 months.

Metric 9b

Metric 9 - Staff Engagement

b) Has your organisation taken action to facilitate the voices of Disabled staff to be heard?

(•) Yes * ( ) No

Please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.

Enable is a new staff network which has been launched this year, the group provides support and signposting for employees with a disability or long term health condition. Enable is actively involved in the development of Equality Action Plans, development of ED&I training programs and are consulted on work being undertaken by the organisation to support our workforce with a disability or long term health condition. An example of this is the introduction of a health passport. Enable has voice to escalate key concerns and any barriers raised by members of the network (as appropriate) via the Deputy Director Of Workforce and via the Fairness forum which is the Trust Equality and Diversity Governance Group. Enable are actively encouraged to bring forward ideas on what actions the Trust should take to support employees and may either take forward the work themselves or be consulted by those who do. *

Notes

Metric 10

Metric 10 - Board voting membership

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The data for this metric should be a snapshot as of 31st March 2021.

	Disabled	Non-disabled	Disability Unknown	Total
Total Board members	0 *	13 *	2 *	15
How many are voting members?	0 *	12 *	2 *	14
Number of non-voting members	0	1	0	1
How many are Exec Board members?	0 *	7 *	0 *	7
Number of non-exec members	0	6	2	8
Number of staff in overall workforce (from Metric 1)	291	7298	2040	9629
Total Board members - % by Disability	0 %	86.67 %	13.33 %	
Voting Board members - % by Disability	0 %	85.71 %	14.29 %	
Non-Voting Board Member - % by Disability	0 %	100 %	0 %	
Executive Board Member - % by Disability	0 %	100 %	0 %	
Non-Executive Board Member - % by Disability	0 %	75 %	25 %	
Overall workforce - % by Disability	3.02 %	75.79 %	21.19 %	
Difference % (Total Board - Overall workforce)	-3.02 %	10.88 %	-7.86 %	
Difference % (Voting membership - Overall Workforce)	-3.02 %	9.92 %	-6.9 %	
Difference % (Executive membership - Overall Workforce)	-3.02 %	24.21 %	-21.19 %	

Notes

Survey

Survey

Question 1

Name and contact details of the lead(s) compiling this report.

Name *
Amara Ashraf

Email Address *
amara.ashraf@york.nhs.uk

Name
Sian Longhorne

Email Address
sian.longhorne@york.nhs.uk

Question 2

Name and contact details of the Board lead for the Workforce Disability Equality Standard.

Name *
Polly McMeekin

Job Title *
Director of Workforce & Organisa

Email *
polly.mcmeekin@york.nhs.uk

Question 3

Name of commissioner, name of commissioning body and email address that the WDES Annual report (containing the WDES metrics report and action plan) will be sent to.

Name of Commissioner
Polly McMeekin

Name of Commissioning Body *
York & Scarborough Teaching H

Email *
polly.mcmeekin@york.nhs.uk

Question 4

Unique URL link or existing web page on which the WDES Annual report will be published.

https://www.yorkhospitals.nhs.uk/about-us/equality-and-diversity/workforce-disability-and-race-equality-standards *

Question 5

Date of Board meeting at which organisation's WDES Annual report will be ratified. If the date is not known, please provide an approximate date or explain why a date cannot be provided.

August - September 2021 *

Question 6

Does your organisation participate in any programmes or initiatives that are focused on disability equality and inclusion?

- (●) Yes *
- ( ) No

Please select one or more:

- [ ] Project SEARCH *
- [x] Disability Confident Scheme
- [ ] NHS Learning Disability Employment Programme (LDEP) pledge
- [ ] NHS Employers Equality and Inclusion Partners Programme
- [x] Disability Equality Staff Network Group
- [x] Equality and Diversity Conferences
- [ ] Other – please specify

Question 7

Do your staff have access to the ESR self-service portal?

- (●) Yes *
- ( ) No

Question 8

Since you published your WDES 2020/21 Action Plan, have any steps been taken within your organisation to improve the declaration rate for disability status?

- ( ) Yes *
- (●) No

Question 9

What level of Disability Confident accreditation does your organisation currently hold?

- ( ) None *
- ( ) Level 1 - Committed
- (●) Level 2 - Employer
- ( ) Level 3 - Leader

Question 10

Does your organisation use the Guaranteed Interview Scheme?

- (●) Yes *
- ( ) No

Please add any examples of interventions that have impacted positively on the recruitment of Disabled staff.

- [ ] Review of the implementation of the Guaranteed Interview Scheme *
- [ ] Disabled people on interview panels
- [x] Disabled people advising review of recruitment processes
- [ ] Review of recruitment policy and procedures
- [x] External communications
- [ ] Other - Please specify

Question 11

Has your organisation compared any of the following other datasets you hold to the WDES Metric 4 (Harassment, Bullying or Abuse)?

- [ ] Grievance *
- [ ] Disciplinary
- [ ] Exit
- [ ] Data held by Staffside representatives
- [ ] Data held by Freedom to speak up guardians
- [ ] Data held by Health and Wellbeing leads
- [x] Other

Currently, this is not something we routinely cover. *

Question 12

Please add any actions taken since your 2020/21 WDES Action Plan was published to reduce harassment, bullying or abuse in relation to Disabled staff.

- [ ] Dignity at Work Campaign *
- [ ] Disability Awareness campaigns
- [x] Harassment and Bullying policy revision
- [ ] Consultation event
- [x] Champions/ ambassadors/advisors
- [x] Peer support scheme
- [ ] Training events
- [ ] None applicable
- [ ] Not at present but planned in the next 12 months
- [ ] Other

Question 13

Does your organisation provide any targeted career development opportunities for Disabled staff?

- ( ) Yes *
- (●) No
- ( ) Not at present but planned in the next 12 months

Question 14

Does your 2020/21 WDES Action Plan set out any targeted actions to reduce presenteeism i.e. feeling pressured to come to work when not feeling well?

- (•) Yes *
- ( ) No
- ( ) Not at present but planned in the next 12 months

We are adopting a health passport and we continue to develop and promote a culture of agile and flexible working. *

Question 15

Does your 2020/21 WDES Action Plan set out any targeted actions to increase the workplace satisfaction of Disabled staff?

- (•) Yes *
- ( ) No
- ( ) Not at present but planned in the next 12 months

- [ ] Disability networks/groups *
- [x] Consultation events
- [x] Health and wellbeing days
- [x] Line manager disability awareness training
- [x] All staff disability awareness training
- [ ] Other – please specify

Question 16

Does your organisation have a reasonable adjustments policy?

- ( ) Yes *
- (•) No
- ( ) Not at present but planned in the next 12 months

Question 17

Are costs for reasonable adjustments met through centralised or local budgets?

- ( ) Centralised budgets *
- (•) Local budgets
- ( ) Both

Question 18

Have you undertaken any actions in the last 12 months to improve the reasonable adjustments process?

- (•) Yes *
- ( ) No
- ( ) Not at present but planned in the next 12 months

If yes, or planned, please select relevant examples. Please feel free to expand in the free text box.

- [x] Training for managers *
- [x] Consultation events involving Disabled staff
- [x] Guidance and support provision
- [x] Internal communications
- [ ] Reasonable adjustment policy revision
- [ ] Sharing best practice examples through induction/intranet/training
- [x] Disability/Workplace adjustments passport
- [ ] Other - please specify

Question 19

Please list any actions contained in your 2020/21 WDES Action Plan that have not been completed.

We recognise that we have further work to do to increase reporting of Protected characteristics through ESR, work has commenced and continues to be a feature on our action plan going forward. Work has begun in reducing the inequality in recruitment shortlisting and career progression, there were some delays as we were anticipating further central guidance to inform our specific actions. We have not specifically listed each outstanding action as it appears on our action plan, we acknowledged as work began, that there were overlaps both between the actions listed and with other pieces of work within the Trust. Additionally some actions have been approached differently than set out on the original action plan as these have developed as the networks have been established. *

Question 20

Are there plans for your Trust to merge with another trust in the next 12 months?

- ( ) Yes *
- (•) No

Question 21

Has the Board reviewed the 2020/21 WDES Action Plan in the last 6 months?

- (•) Yes *
- ( ) No

Question 22

Do you have any further comments?

No further comments.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes
Group Audit Committee
16 September 2021

Attendance:

Mrs J McAleese (JM), Non-executive Director (Chair); Mr S Holmberg (SH), Non-executive Director; Mrs L Mellor (LM), Non-executive Director; Mr A Bertram (AB), Finance Director; Mrs H Kemp-Taylor (HKT), Head of Internal Audit; Mr J Hodgson (JH), Internal Audit Manager; Ms M Hall (MH), Counter Fraud Specialist; Mrs C Johnson (CJ), Deputy Director of Governance and Patient Safety; Mrs P Gilyard (PG), LLP Director of Resources; Mr M Dalton (MD), Engagement Lead, Mazars; Mr M Taylor (MT), Associate Director of Corporate Governance, Ms J Hall (JHa), Governance Consultant; Mrs T Astley (TA), Assistant to FT Secretary, minute taker

Apologies for Absence:

Mr S Kitching (SK), Deputy Finance Director; Mr S Moss (SM), Counter Fraud Manager; Mr M Outterside (MO), Senior Manager, Mazars;

21/77 Chair's Introduction and Welcome

JM welcomed everyone and declared the meeting quorate. JM noted that the meeting was being recorded for the sole purpose of taking the minutes. The recording would be destroyed once the minutes had been completed. All participants gave their agreement to this.

21/78 Declaration of Interests

There were no further declarations of interest.

21/79 Minutes of the last meetings

The minutes of the meetings held on the 11 May 2021 and 10 June 2021 were agreed as a correct record.

21/80 Matters arising

Feedback from the Board on escalated items

JM stated that there was no feedback from the board on escalated items as the last two meetings focussed specifically on items associated with year-end.

HPV Incident Report

JM gave an overview of the incident that happened in 2019. She explained that the Committee wanted assurance that all learning had been captured from the incident and the Board had commissioned Internal Audit to investigate.

HKT confirmed that the investigation had been completed and that the report was presently in draft. There had been some challenges around the contents of the report and the recommendations. She explained that it had been two years since the incident and some staff had left the Trust. She had spoken with the Chief Nurse and asked her to supply evidence in response to her statements. The report had also been seen by the Director of Workforce and the Medical Director.

HKT suggested that the report came to the Audit Committee before it went elsewhere. JM replied that because it was 3 months until the next committee meeting, she would like the Committee to authorise her and AB to sign off the final report on the Committee's behalf so as not to delay the process. At the next meeting, the Committee will receive an update on the recommendations and the actions taken.

CJ stated that she would like on record that she had read the draft report and there were a few discrepancies in there that needed correcting. She drew attention to the improvements that had taken place around SIs since she started at the Trust in June 2020, regarding systems, processes and action plans. JM acknowledged all the improvements made since the incident and the work CJ was doing.

JH commented that there was a separate review around SIs where they were looking at incidents prior to the new process being actioned in April/May 2021. The report was currently in draft and would be discussed with CJ shortly. He stated that there were still some concerns over the SI process and the outcome of the report would be limited assurance.

AB confirmed that the HPV report will go to Board in October. Prior to that, the Chief Executive will take it to the Executive Committee on the 6 October subject to the report being finalised. He would want the Executive Committee to provide the oversight and management to the delivery of the recommendations. In the New Year an update will be provided at Board on the progress made.

SH commented that as the report concentrated on the HPV incident, the recommendations would be a useful check to see how closely CJ's work matched those to give some assistance and to provide a benchmark as to the progress being made.

The Committee:

- **Agreed that JM/AB sign off the HPV final report on the Committee's behalf.**

21/81 External Audit Progress Report

MD gave an overview of his report and highlighted the following: -

- Financial Statements - EA confirmed that they issued a modified opinion on the Trust's financial statements on the 14 June 2021, in relation to stock balances.

- Whole of Government Accounts (WGA) work – positive outcome which was reported to the NAO on 14 June 2021.

- Value For Money (VFM) – reminder that EA reported in their Audit Completion Report at the June committee meeting they would report a significant weakness in VFM arrangements and the associated VFM recommendation in relation to the two outstanding CQC conditions of registration. It recommended that the Trust maintain its progress to date and also the enhanced arrangements put in place to address the recommendations made by the CQC.

The Committee:

- **Received the report and noted its contents.**

21/82 External Audit's Annual Report

MD confirmed that the Board was satisfied with the report. No further comments were made.

The Committee:

- **Received the report and noted its contents.**

Action: TA to publish the report on the Trust's website.

21/83 YTHFM Internal Audit Progress Report

JH gave an overview of the report and highlighted the following: -

- Responsibility for sustainability has moved over to the LLP. In future IA will be reporting on this topic under the LLP section.

- IA had not yet completed any of its audits so performance currently stood at zero and will be updated as the audits were completed.

- As at beginning of August, IA had completed 10 days against an initial programme of work of 80 days. This had been extended to 95 days with the addition of the sustainability audit.

- Procurement of Goods & Services audit will begin imminently and will include the management of contractors.

JH commented that there was really positive engagement with the LLP management team and thanked PG for facilitating this. He also informed the Committee that IA were looking to strengthen their offering in terms of audits going forward and will be able to deliver some of the sustainability agenda audits.

LM was really pleased that sustainability had been transferred to the LLP. Hopefully, through the LLP, management will receive regular updates on sustainability.

The Committee:

- **Received the report and noted its contents.**

21/84 Internal Audit Outstanding Actions

JH gave a summary of the report and highlighted the following: -

- 19 recommendations had been implemented
- 2 were overdue without a revised target date
- 4 were overdue due with a revised target date
- 4 were not yet due

JH confirmed that the Committee would need to be focussed on the red and amber coloured actions and to ensure that the target dates were not continually revised and pushed back.

LM referred to the yellow-coloured actions and queried the colour of actions that were not yet due but potentially could be in jeopardy because the action could not be implemented by that date. JH replied that it would still be yellow as IA would only know if management provided an update in terms of delivery of that recommendation. Going forward, he suggested highlighting the action if an action was in jeopardy.

The Committee discussed how the Executives should be taking ownership for implementing the actions and updating IA where possible if an action was in jeopardy of not meeting its target date. There was a concern that if the implementation of actions were prolonged then ownership would dissipate as people move on. JH suggested attending a Corporate Directors' meeting to impress on them the importance of updating the recommendations status. JM suggested escalating it to Board. AB suggested combining this with the outstanding action from the last minutes around visibility of the Audit Committee and invite Executives to a meeting to give an update on what was happening in their area in relation to recommendations. The Committee thought it was a really good idea.

JH was asked to colour code the tables to make the recommendations easier to understand.

The Committee:

- **Received the report and noted its contents.**

Action: JH to colour code the Recommendations tables.

Action: Invite Executives to Audit Committee meetings to give update on recommendations in their area.

21/85 Counter Fraud Progress Report

MH gave an overview of her report and highlighted the following: -

- Masterclasses – these have been well received. Extra dates were being arranged.
- Crime Awareness Week – this has been postponed and will be rearranged next spring.
- Referrals – working while sick. Dishonest job application. Misuse of study time.

- Post event assurance exercise submitted to CFA – in two parts, first part was submitted yesterday, second part will not be submitted due to data format.

MT referred to the section on generic risk of fraud and asked if there was anything he should be concerned about. MH replied that there were no current major concerns.

MT also referred to the controls and assurance feeding into the risk assessment and asked if the Trust had its own preventative controls, segregation of duties, etc., because it read like all the controls were coming from Counter Fraud. MH replied that this was not the case and she will take his comment on board.

LM referred to the use of planned days and queried why out of 190 days only 52 had been used. MH replied that the planned days were for a financial year, so run from March to April. The 52 days used was up to 20 August 2021 when the report was produced.

The Committee:

- **Received the report and noted its contents.**

21/86 Counter Fraud Annual Report

MH spoke about the new standards to complete which were not published until Q4, although compliance was expected for the full year. As a consequence, the Trust has an amber rating.

She spoke about the standards and the ratings for those, and commented that out of 13 standards 3 were red ratings as the Trust could not comply with requirements. There were also some amber ratings. She explained how these will be improved in order to comply and hopefully improve ratings for next year.

SH asked how the Trust's rating compared to other Trusts. MH replied that the CFA will probably release benchmarking information for comparison in due course.

LM referred to the phishing training for finance and asked if any digital training could be triangulated with IT department training. MH replied that they do liaise with IT and will take her comment on board.

AB suggested having a Fraud Awareness session at Board. A short masterclass would be very useful.

The Committee:

- **Received the report and noted its contents.**

Action: MT to arrange a Fraud Awareness session for Board.
Action: LM to speak to CDIO around linking IT training sessions with the training being carried out by the Counter Fraud team.

21/87 Quality Committee update

SH referred to his escalation log and highlighted the following: -

- HPV and Caroline's work - governance in relation to quality had improved enormously over the last 18 months.
- Issues that were discussed at the Quality Committee were escalated in more appropriate fashion to the Board. The Board was fully sighted on areas of concern.
- Because some issues had been an area of concern for some time it was hard to gain traction on some of them. It came down to staffing levels, use of existing resources, and condition of the estate.
- Saving babies lives agenda – not fully complaint yet in some areas which primarily related to staffing issues.

The Committee:

- **Noted SH's update.**

21/88 Resources Committee update

LM referred to her escalation log and highlighted the following: -

- From LLP/Digital perspective clear statement of the business case and benefits was lacking in each of the cases. Hopefully, with PIR activity this will improve.
- Digital – cybersecurity a big risk. The committee requested a clear plan with actions to provide assurance on the process around prevention and recovery. An update will be given at the next meeting.
- Information Governance – there were gaps that have been evidenced in a report. Hopefully, this will be improved now extra resources were in place.
- Risk – there was an interconnection of all risks from each committee. She felt more work was needed around risk appetite and tolerance, strategic context, and the balance of priorities, short and long term, at Board level.

JM asked to what extent did risk drive the agendas when putting them together. The BAF should really be driving the Board and sub-board Committees' agendas. MT agreed and confirmed that going forward the agendas will be reconciled with the BAF and the CRR. There were gaps in the system which needed to be addressed and he will be meeting with the Chairs of the various committees to discuss this. It was work in progress.

The Committee:

- **Noted LM's update.**

21/89 Data Quality Group Update

AB gave an overview of the Group. At the last meeting the Group was given a presentation on data sources that supported the Quality Account. It was agreed that it would be useful for Internal Audit to review the sources of data assurance for the indicators included in the Quality Account for 2021/22.

JH gave an overview of his report titled "Quality Account – Data Assurance" in the pack which showed the lines of assurance and where there were gaps. Five areas did not have a form of assurance at all. He asked the Audit Committee if it wanted to commission an audit on some of these areas to see if there were robust controls around the collection, validation and reporting of data. JM replied that on most of the areas they did have assurance and the role of the Committee was to be assured that it was accurate. On the

basis of what had been reported she was happy to leave it as an operational issue and move on to other issues that the Committee had concerns about.

AB commented that the vast majority of data that supported the Quality Account was subject to one or more levels of assurances but there were gaps and at the moment there was no mainstream assurance piece that validated the senior decision-making review and the few metrics around that, and that was heralded as quite a significant patient flow issue, patient safety issue and patient management issue. He believed there was a place for Internal Audit to find some way of building that into the programme. There was an assurance gap that needed to be closed.

HKT suggested CJ and Nicky look at this and then the Audit Committee would be assured that this was being dealt with by management. LM added that she would like this to be triangulated with Becky as there was a lot of work asked for at the Resources Committee on the whole issue around governance of data, and she has identified gaps so, operationally, it must link in with the work she was doing.

AB stated that the next DQG meeting will be held in the autumn. A topic for the next meeting was put forward by Nicky Slater who suggested that the Group look at data quality issues around a sample of the national clinical audits that the Trust submitted data on. She suggested two orthopaedic audits to review. SH suggested choosing audits where the Trust was an outlier or where the Trust excelled. AB said he would take SH suggestion on board when planning the next meeting.

The Committee:

- **Received the report and noted its contents.**

Action: CJ/Nicky Slater/Becky/JH/HKT to link with each other on the work being undertaken around governance of data, quality of data, and actions taken to correct the identified gaps.

21/90 Internal Audit Progress Report

JH gave an overview of his report and highlighted the following: -

- Reports - 3 reports have been issued in final, 5 reports were in draft.
- KPI's – one report failed the KPI with regard to receiving management responses within 15 working days of issuing the draft. This will be picked up with the executives.
- Performance – IA has currently delivered 25% of its overarching program starting from June 2021.
- Limited Assurance meetings – 3 have been completed.

LM referred to the IT issues and commended JH's report. However, she was concerned that there were a number of examples where actions were targeted to be completed over a year ago in some instances and asked why they were so late from a process point of view and what lessons could be learned. How much of this was now correlated with risk and was the Trust's risk heightened as a result of this. JM replied that the CDIO will be attending the next Audit Committee meeting and the Committee can ask those questions then.

MT referred to an issue with Windows 7 devices which were still in operation and advised that this was really high on NHSE's risk register because of the cyber vulnerabilities. He would want that addressed sooner rather than later in the Trust. JM asked for this to be noted as a priority action.

MT asked if the Trust had an Information Governance group. AB replied that there was a committee called IGEC, Information Governance Executive Committee, which he set up a number of years ago. The CDIO chairs this committee.

The Committee:

- **Received the report and noted its contents.**
- **Approved the changes to the 2021/22 audit plan as requested in the report.**
- **Noted the cyber vulnerabilities of Windows 7 devices which should be updated as a priority action.**

Action: Invite Jim Taylor, Medical Director, to March 2022 meeting.
Action: Internal Audit Progress Report – Sept 21 – to be added to Dec meeting.

21/91 Internal Audit Outstanding Recommendations

JH gave a summary of the report and referred to the table showing the analysis of outstanding recommendations by each executive. One concern was the number of outstanding actions for the CDIO which will be picked up at the December meeting.

JM commented that she had already raised her concern with JH around the number of actions for which there was no update. This tied in with the suggestion of inviting Executives to meetings to give an update on their area.

CJ commented that there were updates she had given that did not appear in the report. JH replied that the report was produced on 24 August so it did not show the current position.

The Committee:

- **Received the report and noted its contents.**

21/92 Annual Losses and Special Payments Report

AB gave an overview of his report. In terms of assurance around process, he commented that they have either been made as a result of a legal process or they have been in line with the Audit Committee's approved Scheme of Delegation around making such payments. He highlighted that there was an increase in employer's liability claims from £56k to £121k.

The Committee:

- **Received the report and noted its contents, particularly the increase in employer's liability claims, and the assurance from AB that there was no cause for concern.**

21/93 Annual STA Report

AB apologised for the content of the report as the narrative did not match the table. He will supply an updated report with the minutes of the meeting. He gave an overview of the report and highlighted the following: -

- The vast majority of the Trust's STAs were appropriate with 45 compliant and 7 rejected. They were predominantly in the field of the Digital & Information Services team. The CDIO was sighted on this and was seeking to work with the Procurement team to ensure compliance.

- There were 15 STAs that had not been returned but the procurement had proceeded because of the urgent nature of it. He proposed to write on behalf of the Audit Committee to explain that the Audit Committee was concerned that their STA had not been returned, and ask that it should be returned within the next 7 days, and if that was not possible, then ask them to report back to the Audit Committee as to why that was the case.

- In relation to the LLP, 19 STAs were compliant and 25 were rejected. Out of those 25, 15 were rejected because the LLP's name did not appear on the framework that the LLP used. The remaining 10 were rejected because of an issue. 4 STAs had not been returned and AB proposed the same action as above. The Procurement Team was working with the LLP to overcome the issues.

LM asked for assurance that the right process was in place within the areas where the STAs were being rejected. AB replied that progress was being made.

The Committee:

- **Received the report and noted its contents.**

Action: AB to give update at the next meeting on LLP STA compliance progress.

21/94 Treasury Management Policy

AB stated that there was a change as requested by Internal Audit / Audit Committee that reference was made to the use of standing operating procedures around cash flow management. This has been inserted into the policy.

The Committee:

- **Approved the Treasury Management Policy.**

21/95 Board Assurance Framework (BAF)

MT gave an overview of the BAF and explained that a new set of risks and a new process has been devised by the Risk Manager. He explained the process around scoring. He informed that the Board was making progress with risk appetite. In terms of progression, he would like to work with the Directors to have an understanding of the areas of concern for NHSE/I board and challenge that back across the Trust's current risks. This can then be mapped across the governance structure to link the corporate and the quality agendas together to make it a more robust process.

LM asked what the timeline was to finally complete the template. MT replied he was working with the Risk Manager on this. JM added that the BAF had been a work in

progress for over a year now and asked what assurance can be given to the Audit Committee that, in the absence of a fully completed BAF, the organisation was still focused on the biggest risks and was managing them accordingly. In reply, AB referred to the Head of Internal Audit Opinion and the work undertaken at year end to allow HKT to agree that process. The organisation did have a BAF and although there were developmental issues around that, it was in existence. The BAF should not be called a "work in progress BAF". The Committee agreed.

LM commented that she was still not assured on the risk around the BAF process until there was an action plan for each risk. There were significant gaps in the template, it was not comprehensive, no plans and no targets. She wanted assurance of an end date for the template.

AB stated that the Risk Manager had a mandate from the Board who had agreed this approach. The Risk Manager regularly met with the Executives. He recently met with AB and agreed a risk appetite statement for finance, agreed a set of scores and agreed a set of actions. The Risk Manager was expecting to return to the Board in October/November with a full suite of documents.

JH commented that the BAF belonged to the Board, not just the Executives, and it was the responsibility of the whole Board to fill in the document.

HKT commented that IA would be undertaking a review of the BAF and working with MT on this. They should be able to report back to the Committee meeting in either December 2021 or March 2022. JM added that the Committee was encouraged by the progress being made by the Risk Manager to complete this.

The Committee:

- **Received the BAF and noted its contents, but were not assured of the BAF process as there were no actions or targets to mitigate the risk.**

Action: MT/Risk Manager to complete template and submit to November Board.
Action: MT to speak to NEDs re becoming involved in filling in the BAF.

21/96 Audit Committee Terms of Reference & Work Programme

JH gave an overview of the Terms of Reference and highlighted the amendments at the front of the report. She asked the Committee to approve these.

JH gave an overview of the Work Programme and asked the Committee to approve it.

The Committee:

- **Approved the Audit Committee Terms of Reference**
- **Approved the Work Programme subject to IA, Counter Fraud and AB feedback.**

Action: HKT/JH/AB/MH/SM to check that the work programme was in line with their reporting requirements.

21/97 Audit Committee Annual Report 2020/21

JM advised that this will go to the Board in September and then go the CoG in December.

The Committee:

- **Approved the report.**

21/98 Proposed Meeting Dates for 2022-23

JM asked for the Committee's views on whether the Audit meetings, going forward, will be virtual/F2F or be a combination. Her view was that there could be two F2F meetings, in the summer and December. The others would be virtual.

The Committee:

- **Accepted the proposed meeting dates for 2022-23.**
- **Agreed the combination of virtual/F2F meetings going forward, noting that meetings should be either virtual or F2F and not a hybrid.**

21/99 Any Other Business

No other business.

21/100 Items to be Escalated to Board

- Internal Audit Outstanding Actions
- Encouraging the Executives to update the BAF
- Ask the Executives to attend an Audit meeting annually to give an update in their area of responsibility.
- Inform of upcoming Masterclass on Counter Fraud
- DSPT Toolkit/CDIO will attend December Audit meeting
- Encourage/support being undertaken by the Risk Manager in order to populate fully the BAF
- External Auditor's Annual Report

Action: MT to add External Auditor's Annual Report to Board agenda for September.

21/101 Review of Meeting

- Good meeting, really useful discussions, massive agenda.
- Excellent suggestion to invite other executives to the meeting, to hold people to account for the delivery of the actions, and it also ties in with the aim to improve the visibility of the Committee.
- Really good challenge.
- Pleased to note that the Trust was demonstrating more of a grip in terms of the challenges from the NEDs.
- Would like shortened papers.
- Link Audit agenda to the BAF going forward.
- Request that when discussing a particular issue the executive be invited to attend.
- Any reports should show a clear triangulation with what was happening with the other committees.
- Would like the meetings to be reduced to around 2 hours.

- Request to link issues with the three lines of defence model.

21/102 Date and Time of Next Meeting

The next meeting of the Group Audit Committee will be held on 9 December 2021, 09.00 – 13.00, venue TBC.

Group Audit Committee - 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	Ongoing
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	Ongoing
21/82	16.09.21	Publish External Auditors Annual report on the Trust's website.	TA	Sept 2021	Completed
21/84	16.09.21	Action: JH to colour code the Recommendations tables.	JH	Dec 2021	
21/84	16.09.21	Invite executives to Audit meetings to give update on recommendations in their area.	MT/TA	Dec 2021	Ongoing
21/86	16.09.21	Arrange a Fraud Awareness session for Board.	MT	TBA	
21/86	16.09.21	Speak to CDIO around linking IT training sessions with the training being carried out by the Counter Fraud team.	LM	Dec 2021	
21/89	16.09.21	Link with each other on the work being undertaken around governance of data, quality of data, and actions taken to correct the identified gaps.	CJ/Nicky Slater/ Becky Bradley/ JH/HKT	Dec 2021	
21/90	16.09.21	Invite Jim Taylor, Medical Director, to March 2022 meeting.	MT/TA	Mar 2022	

21/90	16.09.21	Add Internal Audit Progress Report – Sept 21 – to Dec meeting.	TA	Dec 2021	
21/93	16.09.21	Give update at the next meeting on LLP STA compliance progress.	AB	Dec 2021	
21/95	16.09.21	Complete template and submit to November Board.	MT/Risk Manager	Nov 2021 Board	
21/95	16.09.21	Speak to NEDs re becoming involved in filling in the BAF.	MT	Dec 2021	
21/96	16.09.21	Check that the Audit Committee work programme was in line with their reporting requirements.	HKT/JH/ AB/MH/ SM	Dec 2021	
21/100	16.09.21	Add External Auditor's Annual Report to Board agenda for September.	MT	Sep 2021	

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
24 November 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 on this to the December Risk Committee.

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: 12th November 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 was 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 in December. 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	Develop Winter Workforce Plan – Nov21 Implement Values and Behaviours (includes Just Culture) - Dec21 E-Job planning - Mar22 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% (September). 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.
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.

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 held on 15th September and agreed to to be monthly thereafter. 3. A new Oversight & Assurance meeting commenced in September. CG3 and CG6 will hold quarterly meetings and. CG1 and CG2 monthly as 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 November 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. November 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 at the end of the year 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

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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

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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