York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 25th May 2022
Time: 9:00am – 11:00am

Boardroom, Trust HQ, 2nd Floor, York Hospital

NHS
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 25th May 2022

TIME	MEETING	ATTENDEES
9:00 – 11:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
11:15 – 1:15	Board of Directors – Private	Board of Directors
2:00 – 4:00	Board of Directors – 'People' Time-Out session	Board of Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
Public Agenda

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

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
1.	**Welcome and Introductions**	Chair	Verbal	-	9.00
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 March 2022** To be agreed as an accurate record.	Chair	A	9	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Verbal	-	
6.	**Patient Story** To receive a patient story.	Chief Nurse	Verbal	-	9.05
7.	**Chief Executive's Update** To receive an update from the Chief Executive including current pressures and Trust Priorties	Chief Executive	B (to follow)	-	9.25

York and Scarborough Teaching Hospitals
NHS Foundation Trust

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
8.	**Board Assurance Framework 2021/22** To receive and note the year-end report.	Chief Executive	C	21	9.45
Strategic Goal: To deliver safe and high quality patient care					
9. 9.1	**Nurse Staffing Report** To receive the report. Appendix 1-2	Chief Nurse	D	37	9.50
10.	**Nurse Recruitment and Retention Report** To receive the report.	Chief Nurse	E	49	9.55
11.	**Final Ockenden Report and Trust Update** To receive the report to include: • Perinatal Clinical QualitySurveillance Report (incl.Ockenden, PMRT andContinuity of Carer) • Response to final Ockenden report	Chief Nurse	 F1 F2	 53 71	10.00
12.	**CQC Update** To receive the report. Appendix A	Chief Nurse	G	91	10.15
13.	**Quality Assurance Committee Minutes** To receive and note the minutes of the meetings held on 22 March and 19 April 2022.	Committee Chair	H1 H2	103 113	10.25
Strategic Goal: To ensure financial sustainability					

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
14.	**Group Audit Committee Minutes** To receive and note the minutes of the meeting held on 17 March 2022.	Committee Chair	I	123	10.30
Strategic Goal: To support an engaged, healthy and resilient workforce					
15.	**Resources Assurance Committee Minutes** To receive and note the minutes of the meetings held on 22 March and 19 April 2022.	Committee Chair	J1 J2	137 149	10.35
16.	**Integrated Business Report** To receive and discuss the IBR, highlighting any areas of concern not already discussed.	All	*Separate Report*	-	10.40
Governance					
17.	**Annual Provider Licence - Self certification** To approve the self-certications.	Associate Director of Corporate Governance	K	157	10.45
18.	**Fit and Proper Persons Review** To note the Fit and Proper Persons Review.	Associate Director of Corporate Governance	L	183	10.50
19.	**Any other business including questions from the public**	Chair	Verbal	-	10.55
19.1	• May Executive Committee minutes				
19.2	• Star Award nominations - June				

ITEM	SUBJECT	LEAD	PAPER	PAGE	TIME
20.	**Time and Date of next meeting** The next meeting held in public will be on 29 June 2022.				
21.	**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.				
22.	**Close**				11.00

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes
Board of Directors Meeting (Public)
30 March 2022

Minutes of the Public Board of Directors meeting held on Wednesday 30 March 2022 in Classroom 1&2, Medical Education Centre, 5th Floor Admin Block, York Hospital, commenced at 9:30am and concluded at 11:15am.

Members present:

Non-executive Directors
- Alan Downey (Chair)
- Jenny McAleese (JM)
- Steve Holmberg (SH) – Virtual presence
- Lynne Mellor (LM)
- Jim Dillon (JD)
- Matt Morgan (MM) – Virtual presence
- Lorraine Boyd (LB)
- Denise McConnell (DM)

Associate Non-executive Directors
- Ash Clay (AC)

Executive Directors
- Simon Morritt, Chief Executive (SM)
- Andrew Bertram, Deputy Chief Executive/Finance Director (AB)
- Heather McNair, Chief Nurse (HM)
- Wendy Scott, Chief Operating Officer (WS)
- Polly McMeekin, Director of Workforce & OD (PM)
- Dylan Roberts, Chief Digital Information Officer (DR)

Corporate Directors
- Lucy Brown, Director of Communications (LBr)

In Attendance:
- Mike Taylor, Associate Director of Corporate Governance (MT)
- Cheryl Gaynor, Executive Support Manager (for minutes)
- Ed Smith, Deputy Medical Director (ES) (attended for Jim Taylor)
- Andy Williams, Interim Chief Digital Information Officer (as of 1 April 2022)

Observers:
Ashani Rathnakeerthi, Honorary Clinical Fellow commenced in the Trust on 14 March for 12 months

The Chair welcomed everyone to the meeting.

21/144 Apologies for absence

Apologies were received from:

- Jim Taylor, Medical Director

21/145 Declaration of Interests

There were no declarations of interest to note.

21/146 Minutes of the meeting held on 26 January 2022

The Board approved the minutes of the meeting held on 26 January 2022 as an accurate record of the meeting.

The Board:
Approved the minutes of the meeting held on 26 January 2022.

21/147 Matters arising from the minutes

21/139 **Integrated Business Report**	The Board discussed the size and layout of the report and agreed that this needed to be managed and realigned in future reports. The Board also agreed the need in distilling a difference in conversations at the Board meeting and at the Board Sub-Committees where the data was discussed in more detail. It was important to understand not only how the report looked but also how the Board used the report going forwards.	Mike Taylor	March 2022	Completed
21/142 **Any Other Business – BAF**	LM highlighted the Board Assurance Framework and the Trust consideration around its contribution overall to net zero and suggested this to be included as part of the Framework. Net zero covered a series of areas and cuts across various services of the Trust. SM agreed to take this forward and discuss offline with MT with a view to bring back to the Board.	Simon Morritt and Mike Taylor	March 2022	Completed

21/148 Patient Story

A patient relative Karen Spilsbury attended the Board meeting supported by Assistant Chief Nurse (Workforce, Education and Infection Prevention and Control) Emma George. Karen presented to the Board following her mother's inpatient stay at York Hospital in early April 2021 and her expression of concerns for her care at the time. Karen shared her story and feedback on her experiences and Emma detailed the learning outcomes and process implementations as a result of the investigation into her mother's care.

The Board:

- **Noted the contents of the presentation.**
- **Thanked Karen and Emma for their attendance.**

Actions:

- **No actions.**

21/149 Chief Executive's Update

<u>Operational Pressures</u>
SM and WS reported on the current operational pressures, notably:

- 292 covid-positive patients reported that morning
- Most significant pressure ever experienced
- 150 York Beds and 50 Scarborough beds closed
- Need to ensure that every action necessary is carried out to discharge patients appropriately
- Sickness rates have increase, now around 8 to 9% sickness with around a third of that being covid related.
- Conversations taking place around the IPC arrangements in relation to managing covid. Extensive conversations internally and now holding those regionally. Any changes that can be made to elevate that pressure will be primarily considered.

<u>Helipad</u>
On the 28th March SM attended an opening of the new Helipad at the Scarborough Hospital site. SM reported that thanks to a £500,000 donation by HELP Appeal, a new larger helipad meant that as well as landing the air ambulance, the much larger search and rescue helicopter would also be able to land near the hospital making a huge difference for incidents out to sea.

<u>Scarborough Urgent and Emergency Care Unit</u>
SM reminded the Board the in December 2018 the Trust was part of a successful Humber, Coast and Vale ICS bid for capital to support the transformation of urgent and emergency care at Scarborough Hospital. He advised that since then the Trust had been working through various stages of developing the full business case and was now delighted to advise that the full case had been formally approved by the Department of Health and Social Care and NHS England and Improvement Joint Investment Sub Committee.

SM reconfirmed that the £47m project would deliver a two-storey new build combining and expanding the current emergency department, same day emergency care, frailty and the acute medical unit. The second floor will house our level 1, 2 and 3 critical care services

bringing together all critical care patients and staff in one location and enabling expedited anaesthetic and outreach services into the new acute and emergency department. The scheme also included work to address essential site-wide engineering infrastructure in support of the capital build.

2022/23 planning submission

SM reported that it was clear from the draft plans that the financial figures and outlook were challenging in terms of moving into 2022/23 as the Trust was expected to deliver its recovery programme whilst seeing an end to additional funding for managing the pandemic alongside a return to delivering efficiency targets. Plans were to be submitted by the end of April 2022 following the submission of draft plans earlier in the month.

Working Towards a Healthy Bridlington: feedback report
SM reported that East Riding of Yorkshire Council had been leading a piece of work with the Trust and other partnering organisations around improving the health and wellbeing of people living in and around Bridlington, following and engagement process, a report was published (www.healthybridlington.co.uk) . SM advised that there was an engagement session planned for the 5th April for key stakeholders and members of the local community which was to consider in more detail how the work will be progressed. However, this was postponed due to the pandemic with a view to a new date being arranged in due course.

New Integrated Care Board
SM advised that he had now received formal approval of his appointment as a designate partner member of the new HCV Integrated Care Board which starts formally from the 1st July. As a consequence of this SM advised that he would be stepping down as a member of the HCV Transitional Executive Team from the end of March.

Chief Digital Information Officer
The recruitment process for the replacement of the departed Chief Digital Information officer Dylan Roberts replacement was underway, however in the meantime Andy Williams had taken up the role on an interim basis. Andy had a wealth of experience in this field, and most recently had been the Interim CDIO for Humber, Coast and Vale Health and Care Partnership. The Board thanked Dylan for his work and wished him well in his future.

The Board:
- **Noted the contents of the report.**
- **Congratulated Simon on his appointment to the Integrated Care Board**

Actions:
- **No actions.**

21/150 Demonstration of a Clinical Digital Care Record

Nik Coventry, Janet Farr and Kevin Beatson joined the meeting to deliver a demonstration of a Clinical Digital Care Record for digitalisation of nursing documentation.

Clinical Digital Documentation and M

The Board:

- **Noted the contents of the presentation.**
- **Thanked Nik, Janet, and Kevin for an excellent demonstration of the Digital Nursing Documentation project.**

Actions:
- **No actions.**

21/151 Nurse Staffing Report

HM presented the report which delivered information and assurance to the Board on how the Trust had responded to provide the safest and effective nurse staffing levels during January 2022. The report also provided some detail on the undertaking of the Safer Nursing Care Tool in June 2022. The Safer Nursing Care Tool is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels.

The Board:
- **Received and noted the report.**

Actions:
- **No actions.**

21/152 Ockenden Report Update

LB reported that there was no further update to the presented report on Perinatal Clinical Quality Surveillance and Ockenden Update.

The Board were assured that the action planning was in place following feedback from the National Team in November 2021 in relation to the 7 Immediate Essential Actions identified in the Ockenden Report what was published in December 2021.

HM highlighted that the Care Group continued to work towards offering all women a Continuity of Carer (CoC) by 2023 with the level of received CoC having increased in January 2022. It was anticipated that there would be a variation in these figures as CoC teams were currently working differently to manage the deficit in midwifery staffing across the Trust. The Board were assured that the Associate Chief Nurse & Deputy Head of Midwifery had met with the national team to describe the challenges and were supported to continue to work in the current model with a view to planning the reintroduction of birth availability CoC teams from July 2022.

The Board:
- **Noted and received the reports**
- **Considered the Maternity Services action planning against the 7 Immediate Essential Actions of the Ockenden Report was sufficient to ensure safety in the maternity service.**

Actions:
- **No actions.**

21/153 Care Quality Commission (CQC) Update

HM presented the report and provided the Board with an updated position of communication between the Trust and the CQC along with action plan progress and outlined next steps in achieving excellence. HM advised that there were two action that

were behind delivery and were ongoing. On in particular presented a high risk to the trust which related to the recruitment of a Paediatric Emergency Medicine (PEM) consultant for the Scarborough Emergency Department. HM advised that non-compliance with this recommendation could result in a Section 31 condition notice. The Medical Director was progressing conversations to promote the identification of an appropriate solution.

The Board noted that the Effective Deep Dive into the CQC key lines of enquiry had been undertaken with an MDT approach to ensure a holistic view of specialties. Each specialty assessment had fed into Care Group governance meetings and the subsequent care group summary reports were developed and had been presented to the Quality and Regulations Group. Most of the escalations were covered with an improvement plan with each of the Care Groups but despite having approximate ratings, the Board acknowledged that a singular significant finding during a live inspection could lead to an overall rating of inadequate/requires improvement. Examples of this could have included staffing and skill mix or long waits in the emergency departments.

The Board:

- **Accept the report as an updated position for the Trust in relation to CQC action plans (Section 29A, Section 31, & Must-Do actions).**
- **Acknowledge the increase in whistleblowing concerns received, and the associated risk of unannounced inspection. (Appendix C)**
- **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.**

Actions:

- **No actions.**

21/154 Quality Assurance Committee Minutes

Minutes of Quality Assurance Committee 18 January 2022

The Board noted the minutes of the Quality Assurance Committee held on 18 January 2022 meeting.

Minutes of Quality Assurance Committee 15 February 2022

The Board noted the minutes of the Quality Assurance Committee held on 15 February 2022 meeting.

21/155 Gender Pay Gap

PM presented the report which provided a snapshot of the Trusts gender pay gap as at the 31 March 2021. The Gender Pay Gap legislation required all employers of 250 or more employees to publish their gender pay gap as at the 31 March each year. The report detailed the Trust's snapshot position was 30.89% mean and 21.6% median (median being likely more accurate and more reflecting of the actual workforce). Areas of particular focus was in the medical and dental workforce where there is a median pay gap of 0%. Across the entire workforce the Trust was 80% female. Within the medical and dental staff group there is a gender split of 61% male and goes to 70% male in a consultant body and is where the particular focus was.

A number of actions around reducing the gender pay gap were highlighted assuring continuous improvement in line with the NHS People Promise to reduce the gap. A direction set by the 'Flex for the Future' programme (jointly delivered by NHSE&I and Timewise) was the agile and flexible working agenda. A review had also been undertaken into Job Planning Principles allowing SPA time in Medical and Dental roles to be worked from home which was not something that had previously been considered.

The Board:

- **Noted and approved the report for submission.**

Actions:

- **No actions.**

21/156 Resources Assurance Committee Minutes

Minutes of Resources Assurance Committee 18 January 2022

The Board noted the minutes of the Resources Assurance Committee held on 18 January 2022 meeting.

Minutes of Resources Assurance Committee 15 February 2022

The Board noted the minutes of the Resources Assurance Committee held on 15 February 2022 meeting.

21/157 Integrated Business Report

The Board noted the detailed summaries in the report for the following areas with nothing additional raised to note:

- Quality and Safety
- Finance
- Workforce
- Research and Development
- Operational performance
- Digital and information service

The Board:

- **Received and noted the report.**

Actions:

- **No actions.**

21/158 Health and Safety Policy – York Teaching Hospital Facilities Management (YTHFM)

MT presented the report which delivered a revised YTHFM Health and Safety Policy to the Board. The Board noted that the YTHFM follows Trust Policies and Procedures however it was required to have its own Health & Safety Policy. Notable areas of changes to the policy included:

- Scope
- Accountability's and Responsibilities
- Contractors, Consultants and Visitors Responsibilities

The Board:

- **Approved the YTHFM Health and Safety Policy.**

Actions:

- **No actions.**

21/159 Modern Slavery Declaration

MT presented the report which sought approval for the Modern Slavery declaration. MT highlighted that the Modern Slavery Act 2015 was designed to consolidate various offences relating to human trafficking and slavery. In line with all businesses with ah turnover greater than £36 million per annum, the Trust (the NHS) was obliged to comply with the Act. A written slavery and human trafficking statement was to be prepared annually and should include the steps the Trust has taken during the financial year to ensure that slavery and human trafficking had not taken place in any part of the supply chain or its business and required approval of the Board of Directors and the LLP Management Group.

The Board:

- **Approved the Modern Slavery declaration**
- **Agreed the slavery and human trafficking statement be signed by the Chair and Chief Executive**
- **Agreed the statement would continue to be presented on the Trust website.**

Actions:

- **Chair and Chief Executive to sign the slavery and human trafficking statement.**

21/160 Standing Financial Instructions

AB presented the report as a request for update to tendering limits as part of the Standing Financial Instructions. The current requirement was to tender where the value was greater than £25,000 and this had not changed for some time and was out of line with other ICS acute partners. The Board were asked to approve the request of a new value of £50,000 (inc VAT).

The Board:

- **Approved the £50,000 (inc VAT) tendering limit**

Actions:

- **No actions.**

21/161 Any Other Business

MT requested the Board's approval for the signing and sealing of legal documentation following the sale of a small piece of land at the Scarborough Hospital site.

The Board:

- **Approved delegated authority to sign and seal.**

Actions:

- **MT to arrange formal signing and sealing of the agreed legal documentation.**

21/162 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 25 May 2022.

Action log

Minute Number and Title	Action	Lead	Date Due	Date Completed
21/132 **Carbon Reduction Grant Funding Business Case Update and Preferred Bidder Status Request**	As a matter of good practice, AC suggested that the Head of Sustainability as the lead for this case, liaise with other Trusts that has worked with Vital Energi to gain some learning from their experiences. SM agreed to take this forward.	Simon Morritt	March 2022	
21/138 **Q3 Guardian of Safe Working Hours**	SM highlighted that the report focussed on informing the Board of the situation rather than more solution orientated. Problems in the report appeared to relate predominately to one or two areas and there needed to be understanding if there were any pressures from Health Education England regarding needing to demonstrate improvement and what the Trust plans were around those improvements. JT agreed to investigate this and report back as the report presented did not go into this depth of information.	James Taylor	March 2022	
21/139 **Integrated Business Report**	The Board discussed the size and layout of the report and agreed that this needed to be managed and realigned in future reports. The Board also agreed the need in distilling a difference in conversations at the Board meeting and at the Board Sub-Committees where the data was discussed in more detail. It was important to understand not only how the report looked but also how the Board used the report going forwards.	Mike Taylor	March 2022	

21/142 **Any Other Business – BAF**	LM highlighted the Board Assurance Framework and the Trust consideration around its contribution overall to net zero and suggested this to be included as part of the Framework. Net zero covered a series of areas and cuts across various services of the Trust. SM agreed to take this forward and discuss offline with MT with a view to bring back to the Board.	Simon Morritt and Mike Taylor	March 2022	

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
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 year end status of the Trust's Board Assurance Framework.

Executive Summary – Key Points

- The final Trust 2021/22 Board Assurance Framework is reported to the Board of Directors
- The process to identify the 2022/23 Board Assurance Framework is in progress following the 16 May Risk Committee in the context of the Trust's 2022/23 Priorities
- The 2022/23 Board Assurance Framework will subsequently be reported to the following assurance committees in 2022/23:
    - Finance and Performance Assurance Committee;
    - Quality and Safety Assurance Committee; and,
    - People and Culture Assurance Committee

Recommendation

The Board of Directors is asked to note the final status of the Trust's Board Assurance Framework.

Author: Mike Taylor, Associate Director of Corporate Governance

Director Sponsor: Simon Morritt, Chief Executive

Date: 16 May 2022

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. 2021/22 Board Assurance Framework

The Trust's 2021/22 Board Assurance Framework has had its risks reviewed and challenged over the year both at the Risk Committee on a monthly basis, the Board of Directors on a quarterly basis and for assurance at the Resources and Quality Assurance Committees on a monthly basis.

The BAF has reflected the operational pressures of the Trust including recovery from the pandemic, pressures on the Trust workforce, recovery of elective care, meeting the demands of urgent care and financial pressures.

This has involved reviewing specifically the following:

- Risk ratings; gross, net and target;
- Risk mitigating actions and their status in achieving target risk ratings; and,
- Risk appetite under significant and prolonged current operating pressures and the subsequent effect on the gross and net scores

3. 2022/23 Board Assurance Framework reporting

The 2022/23 Board Assurance Framework is currently being finalised and risks will specifically be reported for assurance over the following Sub-Committees of the Board of Directors as from Q2 of 2022/23:

- Finance and Performance Committee;
- Quality and Safety Committee; and,
- People and Culture Committee

With the interdependent nature of the BAF risks and their assurances, the escalations between Committees will be an important process to ensure that the Trust has identified and is efficiently managing its risks and is assured in their management.

4. Recommendation

The Board of Directors is asked to note the final status of the Trust's Board Assurance Framework.

Risk No.	Risk Description	Net Risk Rating			Risk Owner	Target Risk Rating			Date to Achieve / Review Target	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	4	16	Heather McNair	2	3	6	Apr-22	
PR2	Access to patient diagnostic and treatment is delayed leading to patients suffering unintended or avoidable harm	5	4	20	Jim Taylor	4	3	12	Apr-22	
PR3	Failure to deliver constitutional/regulatory performance and waiting time targets	4	4	16	Wendy Scott	3	4	12	Apr-22	
PR4	Inability to manage vacancy rates and develop existing staff	4	4	16	Polly McMeekin	3	4	12	Mar-23	
PR5	Risk of inadequate funding to deliver the Trust and System Strategies	3	2	6	Andy Bertram	3	2	6	Achieved	
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	Apr-22	

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

Risk description	PR1 - 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	4	3	**Date to achieve target score: To be reviewed in Mar 2022**	**Risk Owner:**	**Heather McNair**
Overall risk rating	16	16	6		**Links to CRR:**	**CN1, COO1-2, WFOD1-3, DIS1-5, MD1**

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
Redeployment of speclialist nurses	None identified	Risk assessed each service; low, medium, high	Quality Impact Assessments for each service	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	Complete	Polly McMeekin	**Nov-21**
Continuation of International Nurse Recruitment (NMC temporary register)	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	PR 2- 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. The current pandemic has impacted on our ability to deliver safe effective quality care and increased the risk 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	5	5	4	**Risk Appetite: Exceeding**		
Likelihood	5	4	3	**Date to achieve target score: To be reviewed April 2022**	**Risk Owner:**	**Jim Taylor**
Overall risk rating	25	20	12		**Links to CRR:**	**COO1-2, WFOD1-3, DIS1-5, MD1**

Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Clinical standards	None identified	-Board of Directors -Quality Assurance Committee	- IBR - Minutes and actions of papers (Board, Executive, Quality Committee)	System pressures including ambulance and across local authorities with surges in activity leads to difficulties in applying cocnsistent high clinical standards
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	PR 3 - 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	5	4	3	Risk Appetite: Exceeding		
Likelihood	4	4	4	Date to review target score: April 2022	Risk Owner:	Wendy Scott
Overall risk rating	20	16	12		Links to CRR:	COO1-2, FIN1, DIS1-2

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 Dec 2021/Jan 2022	None identified	- Scenario testing of surge plans - Silver and Gold Command standard operating procedures	- Results of scenario testing - OPEL 4 daily calls assurance to YAS and NHSEI on Ambulance turnaround	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 Trust strategy	None identified	-Trust intranet	- Refeshed Trust 2 Year Strategy	- Strategy awaiting publication
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	- Elective recovery planning and monitoring of waiting lists	- Reporting on progress of meeting waiting lists	- None identified
Deployment of health inequality assessment to inform waiting list management	None identified	- Board	- Health inequality considerations at Board	- Specific system 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	PR 4 - 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 (inc Covid impact on staff absence/redeployment/release) 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	5	4	3	**Risk Appetite: Exceeding**		
Likelihood	5	4	4	**Date to review target score: March 2023**	**Risk Owner:**	**Polly McMeekin**
Overall risk rating	25	16	12		**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 June 2019 approval - 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
Leadership 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 on a case by case basis	National contract limitations National training programmes	-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
Thank You Campaign	None identified	Communications and hospitality provision in Spring/Summer 2021	- Well received by staff in feedback	None identified
Workforce resilience model	None identified	Executive Committee	Executive Committee approval October 2021	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	**Apr-22**
Implement Values and Behaviours	Commenced roll out during Summer 2021	Polly McMeekin	**Apr-22**
Continuation of International Nurse Recruitment	Pipeline of circa 18 per month. BC approved to Mar 2022	Polly McMeekin	**Apr-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	**May-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	PR 5 - 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	3	3	Risk Appetite: Inside Tolerance		
Likelihood	5	2	2	Date to achieve target score: Achieved	Risk Owner:	Andrew Bertram
Overall risk rating	25	6	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.	Complete	A Bertram	**Nov-21**
H2 distribution of ICS central allocations (e.g. covid funding) to be agreed.	Complete	A Bertram	**Nov-21**
Confirm efficiency requirement and match to identified plans with a view to identifying any residual requirement.	Complete	A Bertram	**Nov-21**
Model H2 Elective Recovery Fund costs and income earning potential to maximise funded elective recovery activity.	Complete	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.	Complete	A Bertram	**Nov-21**

Strategic Objective: Contribute to the system's sustainability

Risk description	PR 6 - 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 to give us assurance on what we need to do to be safe and compliant	- 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 - Next submission to NHS Digital in February and on target	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	Due to pressures and inability to get full attendance to the IFG Group meetings
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	Resources and capacity to complete the necessary review and rewrite of these

The identification, investigation, recording and reporting of IG incidents	None identified	- Information Governance Team - Datix	- IG breach reports	Gap in terms of full awareness TRUST WIDE of the incident report process
Review and sign-off of IG documentation	None identified	-Information Governance Team	- IG team sign-off	Resources and capacity to complete the necessary review and rewrite of these and engagement at IGEG
Essential Services Programme	Capacity to deliver ESP potentially	Plan of delivery of ESP	- Essential Services Programme Strategy	None Identified
IT Service management standards / processes	Low maturity due to lack of training			No robust security and IG major incident management process

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

Action description	Progress to date / Status	Lead action owner	Due Date
Continue to review funding for ESP	COMPLETED - Funding secured from Trust and UTF	Dylan Roberts	**Feb-22**
Implement the proposed DIS structure	Minimum funding secured and formal consultation process starting	Dylan Roberts	**Apr-22**
Deliver the DSP Toolkit plan	In progress and on target	Dylan Roberts	**Nov-22**

Strategic Objective: Contribute to the system's sustainability

Risk description	PR 7 - 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**
Impact	3	2	2	**Risk Appetite: Inside Tolerance**
Likelihood	3	3	3	**Date to achieve target score: April 2022**
Overall risk rating	9	6	6	

Lead Committee: Executive Committee	
Risk Owner:	**Simon Morritt**
Links to CRR:	**N/A**

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

Board of Directors
25 May 2022
Nurse Workforce Report

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

To provide information and assurance to the Trust Board on how the Trust has responded to provide the safest and effective nurse staffing levels during March 2022. This will include the requirement to submit the safer staffing metrics using Care Hours per Patient Day (CHPPD).

Executive Summary

- The Board of Directors is asked to accept this report as assurance of the continued work to maintain the nursing workforce and sustain safe staffing levels and consideration of the recent retention figures.
- Proposed support for the International Nurse programme in 2022/23
- Undertaking of the Safer Nursing Care Tool in June 2022 to assist and strengthen the establishment reviews.
- Response to the CQC inspection in regard to nurse staffing levels

Detailed Recommendation

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

Author: Emma George, Assistant Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: May 2022

1. Introduction and Background

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

2. Detail of Report and Assurance

2.1 Nurse Staffing levels, Associated Risk and Establishment Reviews

The Trust has complied with the submission of CHPPD data and the March 2022 submission is attached in Appendix 1. The table below details the overview of each care group for March 2022.

Care Group	Day				Night			
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
CG1	74%	68%	10%	-	89%	90%	0%	-
CG2	78%	87%	10%	-	87%	95%	6%	-
CG3	75%	76%	-	-	87%	95%	-	-
CG4	66%	71%	-	-	98%	85%	-	-
CG5	71%	58%	-	-	81%	56%	-	-
CG6	-	-	-	-	-	-	-	-
Total	74%	74%	16%	-	87%	90%	2%	-

The average day fill rate in March for Registered Nurses/Midwives was 74%, this is an 8% deterioration from January 2022 and for Non – Registered Nurses, 74%, which indicates a 4% reduction since last month, more concerning this is a 9% reduction over the past 2 months. The average night fill rate for Registered Nurses/Midwives was 87% showing a 2% deterioration and for Non – Registered Nurses/Midwives, 90%, indicating a 13% reduction from January 2022.

There are 26 Wards below the 80% average RN day fill rate, 8 more than January 2022, 2 of these are in Bridlington Hospital and work below their occupancy. This indicates an ongoing deterioration from December 2021. Of the 26 wards, 6 are on the Scarborough site, 17 on the York site.

There are 10 wards below 80% RN fill rate for nights which shows deterioration of 2 wards since February. CCU in York the RN is regularly deployed to support the cardiology ward and the Cardiac Outreach Nurse supports CCU, the acute floor is below 80% in York. Wards that have more than 2 Registered Nurses can be redeployed to support other wards.

This is monitored and is a regular pattern and through the establishment reviews using a triangulation of quality indicators and professional judgement there is consideration of news roles and ways of working, such as the Patient Services Operative role and flexible shifts such as shorter shifts or a twilight shift.

Temporary Staffing

The Temporary Staffing team continue to grow with over 3,300 nursing staff registered. With rolling adverts for RNs/RMs and monthly campaigns for HCSWs we are currently processing a high volume of candidates through the recruitment process; this includes 60

HCSWs, 18 RNs and 1 RM. We continue to work closely with Hull, Coventry and York Universities with 64 student nurses progressing through the fast track application route.

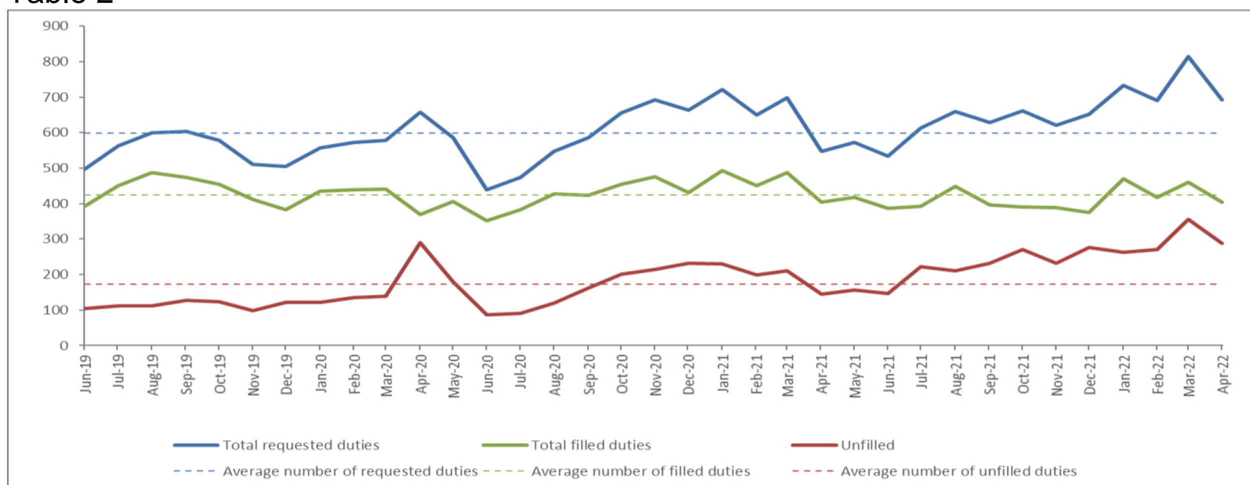
One of the biggest achievements for Temporary Staffing is that the compliance rate for Statutory and Mandatory training currently stands at 88% which is the highest record for compliance to date for the Trust. We are also working closely with the Work Based learning team to offer a patient observations training programme to those HCSWs that wish to develop within their bank role.

Agency supply continues to struggle to get back to pre-pandemic levels due to a distinct a lack of available workers in the market and with those who are available commanding the rates that they are prepared to work for. This has seen the organisation facing increased rates for limited agency supply; something that is being felt by other Trusts across the region. As a result of the lack of supply, the Trust continues to engage a high volume of nursing shifts from off framework providers. The team are currently in the process of reviewing existing agency suppliers, targeting those agencies that comply with the price cap to find out what they are doing as an agency to encourage new nurses to work in the organisation.

Demand remains high, leading to record numbers of nursing shifts being requested, with some weeks recording in excess of 3,000 shift requests.

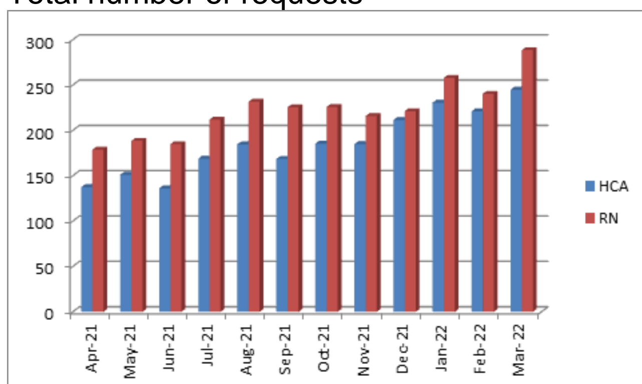
The Trust is reporting a significant unmet need in relation to temporary staffing requests for registered and unregistered nurses (table 2). In March 2022, 40% of all shift requests were unfilled, 4% more than January but less temporary shifts were requested.

Table 2



York Monthly Trend – FTE

Total number of requests



Demand for agency nurses remains high for Registered Nurses, showing an increase month of month.

Table 3: Agency filled

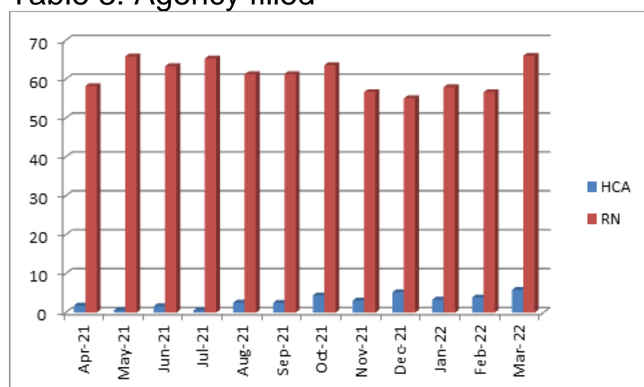
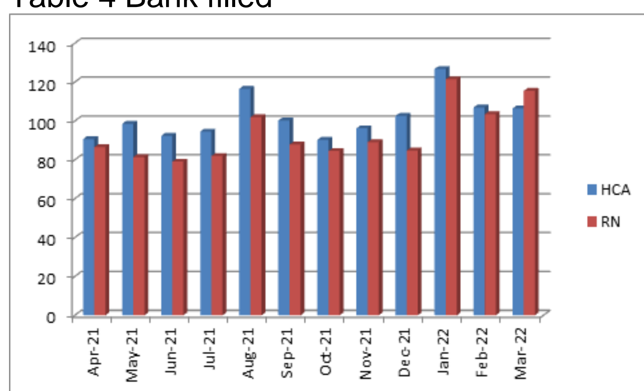


Table 4 Bank filled



Impact of sickness absence

Sickness absence rates in February 2022 for nursing and midwifery was 6.79% a decrease on the previous month of 0.76%. The ccumulative 12 month absence rates to Feb 22 are currently 7.59%. Additional Clinical Services is 7.76%, indicating a 1.78% decrease from 9.54% in January 2022. The absence rates for March 22 equate to 110 FTE HCAs and 163 FTE Registered Nurses and Midwives lost due to sickness which needs to be taken into the context of the current work pressures.

The impact of staff sickness has continued to be a challenge in March. The top reasons for sickness are COVID and health and well-being. The Matron of the Day for both acute sites oversees delivery with escalation to Associate Chief Nurses and Chief Nurse Team as required. The delivery of safe nurse staffing remains dynamic and challenging.

In April 2022 working collaboratively with senior nursing colleagues the process for deploying the nursing workforce and how it is escalated and mitigated has been through a transformation. This process describes the actions to take when the planned staffing levels fall below the agreed nurse establishment or is sub optimal when:

- The available staffing does not meet the patient's acuity and dependency needs.
- Short term absence
- The agreed nursing establishment does not meet the acuity and dependency of the patients due to skill mix, an increase in patient flow or inability to meet the needs of the patients.

An SOP has been developed entitled '**Daily Nursing and AHP Workforce and Escalation** '**Adult Inpatients Wards,** detailing the process (appendix 2). This is still being trialled and changes made but feedback has been positive and there is an ability to articulate where wards require additional support and the impact of this on patient care.

The Chief Nurse team had a £2.6M investment as a result of the establishment review paper with ½ year effect (£1.3M) in 2021/22. A review of this has commenced with the Assistant Chief Nurse and Care Group teams to review the previous establishments and provide an updated proposal for 2022/23 requirements. This will be presented to the executive committee in June 2022.
The associated risks, specifically temporarily increasing the registered nurse and HCA vacancy rates will be reflected in revised risk registers.
In terms of strategic planning the next step is well underway to review and develop a proposal to support investment aligned to the establishment review to ensure the entire identified requirement is met.

There is a plan to undertake a trust wide daily data collection of the Safer Nursing Care Tool (SNCT) in June 2022 and a dedicated part time Matron has commenced in post to lead this project to ensure it is embedded and sustained.

The Safer Nursing Care Tool is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels. The SNCT is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency terms. Training took place in November 2021 and there will be further refresher training in May 2022 with senior ward nurses by NHSE/I and the seconded Matron. The evidence will be used to support the annual establishment review process to ensure staffing levels are adequate for the needs of the patients on the ward and to inform the budget setting process for the next financial year.

Table 5 Nurse Vacancy Levels Trust wide and per site February 2022

Nurse Midwifery and Care Staff – Staffing Data - February 2022

Trust wide

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Trust wide	2,312.08	128.82	1,141.93	2,084.05	145.24	1,000.95	6.43	1.00	3.19	10.01	0.00	12.34	224.45	-15.42	131.83	9.71%	-11.97%	11.54%

York

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
York	1,640.44	91.32	744.12	1,490.35	88.24	638.49	5.43	1	1.59	7.01	0	4.6	148.51	4.08	102.62	9.05%	4.47%	13.79%

Scarborough and Bridlington

	Budgeted Establishment			Staff in post			Confirmed Leavers			Starters in next 3 month			Net Vacancy					
													WTE			%		
	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3	B5-8	B4	B2-3
Scarborough & Bridlington	671.64	37.50	397.81	593.70	57.00	362.46	1	0	1.6	3	0	7.74	75.94	-19.50	29.21	11.31%	-52.00%	7.34%

Table 5 details the February 2022, vacancy position for the Trust and for York, Scarborough and Bridlington sites March data is not available due to an issue with data extraction, there continues to be an increase in the net RN vacancy (Band 5- 8) presenting a further deterioration by 0.70% and for Band 2-3 an increase vacancy of 0.47%.

An additional paper will be presented to Quality Committee this month detailing an update on our nurse workforce and retention position with plans for retention and the development of a retention strategy.

2.2 Management of Nurse Staffing Levels in March 2022

As noted in the previous reports, the associated impact of Covid-19 has been highly significant and the Chief Nurse Team has continued to meet with and support teams who have been affected by the ongoing pressures associated with redeployment, and working in challenging circumstances. The impact of staff well-being and a feeling of exhaustion, morale are evident, where there may have been a willingness to work additional hours, there is a sense that staff feel they are unable to do this. There have been number of initiatives and incentives implemented to help maintain safe staffing levels through this period.

Incentives

There has been feedback from staff that they have found it difficult when they are asked to move to a different ward or site to help address issues with workforce availability. In response to this we have introduced flexibility payments on a short-term basis. This is a £30 flexibility payment for healthcare support workers and £50 for registered nurses and nurse associates. Where staff are requested to work in a ward area that is not their specialty a payment will be given and this has received positive feedback. This is being monitored but feedback is that this has been well received. This has now been extended until June 2022 due to the positive impact this has had.

Bank incentives

Incentive for staff on all bank shifts continues to be requested where there is a requirement but the impact of this is not yielding additional shifts due to staff exhaustion and the demand for temporary staffing increasing. This is monitored and reviewed by the temporary staffing team.

These incentives are flexible and are being reviewed on a regular basis to target areas where additional support may be required. An agreement has been made for incentives to be more targeted and planned so staff can consider if they would like to work rather than it being responsive and in the moment at times for example over bank holiday periods.

2.3 Quality indicators

There is a clear correlation between the increases in falls and pressure ulcer prevalence and the delivery of basic fundamental cares being delivered in ward areas, this is aligned to RN and HCA availability that is below current established levels. Root Cause Analysis indicates that nurse staffing levels is having an impact increase due to the unavailability to re assess patients at risk of falls which is an RN role. CHPPD indicates a further deterioration in care hours and this impacts quality of care.

The prevalence of pressure ulcers has also increased across some of the older adults' wards indicating that due to staffing pressures intentional rounding of patients has not been undertaken accordingly and the assessment and implementation of care that is provided by the Registered Nurse.

We continue to monitor the incidents and correlation between the quality of care and where this is a direct impact on nurse staffing levels and ensure targeted support will be given to these areas identified. There is a requirement for a change to the current nursing qaulity indicator dashboard and whilst there is a dashboard available, additional information is required. Due to demand and reduced resource in the DIS team there is a delay in this information being available at Care Group and organisational level.

Care Quality Commission (CQC)

On 29 March 2022, the CQC inspected 7 wards and reported that on the wards reviewed, six did not have their planned staffing levels in terms of nursing or healthcare. Of particular concern were the COVID wards. The CQC required a response and this was submitted with assurances concerning nurse staffing levels, how these are escalated and mitigation put in place. Several meetings have been held between the Matrons and Chief Nurse Team to discuss staffing requirements and escalations moving forward. The decision has been made to hold a daily staffing check-in meeting, which includes a Matron from each Care Group and will be chaired by one of the Associate Chief Nurses or Head of Nursing twice daily. A new template has been developed to capture the information and decision making with a focus on reviewing the impact on individual patients when staffing does not match demand or acuity with the use of red flags. It is recognised that there are not further Nurses or Healthcare Assistants to deploy so this is reliant on looking at what other resource we have within the Trust such as volunteers, corporate nursing team members, patient safety team members etc. There has been an organisational 'call to arms' which is coordinated centrally and staff are deployed daily as the check in meeting to where the need is.

The escalations and subsequent requests are taken to the dedicated Senior Nursing representative for Silver Command for these issues to be considered, with escalation to Gold command if the issues are not resolved. The emphasis is very much looking at how fundamental standards of care can be delivered.

2.4 Development work

NHSE / I North East and Yorkshire Regional continue with the work to deliver the expansion program for nurses, midwives and allied health professions. This is in response to the Governments pledge to increase the number of nurses by 50,000 by 2024.

The Trust is undertaking a review of recruitment and retention work programs such as attending the universities and recruitment events, also engaging with the regional work to ensure the Trust is best placed to benefit from any regional program of support.

Progress continues on the Trusts' 6 developments for nursing, listed below. The program of work the Trust is undertaking fully aligns to the new workforce expansion program which is overseen by regional NHSE / I teams.

- Trainee Nursing Associate Apprenticeship (tNA)
- International Registered Nurse Recruitment
- Registered Nurse Degree Apprenticeships
- HCSW recruitment to achieve 0% vacancy and a sustainability and retention plan
- Changes to the preceptorship programme to commence Nov 2022 to offer further support to the Newly Qualified Registered Nurses.
- Return to practice course commencing May 2022

It was agreed that the priority for the team was retention of workforce. Three work streams will be developed as a result of this. The main focus will be on retention of our workforce.

- Retaining our International Nurses and with a robust induction and career development programme.
- A pipeline/pathway for bands of nursing teams to ensure they are clear about opportunities to develop when they chose to work for our organisation.

- Flexible working programme that is effective

An ambitious target has been set within the workforce team

- By April 2023, to have no more than a 1% vacancy rate for Healthcare Assistants
- By April 2023, to have no more than a 7.5% vacancy rate for Registered Nurses

International Recruitment

The Trust continues to deliver the international nurse recruitment program. The Trust has welcomed a total of 324 international nurses (IN) with a further 75 expected to arrive by December 2022.

National issues with NMC Test of Competency (ToC) have continued to be challenging with 6 international nurses in Cohort 23 (arrived December 22) still waiting for test dates with an additional 13 of the current training cohort. New ToC centres are opening including at Leeds and Northumbria and it is expected that these will increase test capacity once the national backlog is tackled.

IN who have completed their ToC training and are waiting for test dates are working in their clinical areas as Pre Registered Nurses (Band 4) in the interim.

A review of the international nursing clinical education team has led to the development of new roles currently being recruited. The team will broaden its remit to include ward support for IN who continue to find acculturation and transition to the NHS challenging. The team will also support induction and preceptorship for IN over their first year in the organisation.

The Trust will host the first cohort of NHSE&I International Midwives (IM) through supporting their ToC training at the Science Park during April and May 2022. It is expected that 4 cohorts of IM will use the Trust training venue over the year.

Health Care Support Worker (HCSW) Recruitment

Funding has been secured to facilitate recruitment and provide additional support to enhance the recruitment of HCSWs new to healthcare and the NHS. The aim of the funding is to rapidly reduce vacancies by March 2022.

We received trajectories to achieve a zero vacancy position by March but it is evident that this has not been achieved. Work is ongoing with the regional team to provide support to organisations and currently there are weekly meetings with NHSEI to understand HCSW recruitment and WTE vacancy across the region.

The recruitment and nursing teams continue to strive to recruit HCSWs but currently sit with a 131 WTE vacancy. There is some caution with this due to the ongoing establishment reviews and increase in HCSW posts as a result and the accuracy of the current establishments and opening of additional capacity consequently increasing vacancies.

It is projected that we require 200 HCSWs in the next year and need to consider new ways to attract HCSWs who have an increased choice in work availability as the leisure and retail industry has opened and this work has commenced. It is now vitally important that the Trust embraces the output of this work as the attrition rate has increased recently.

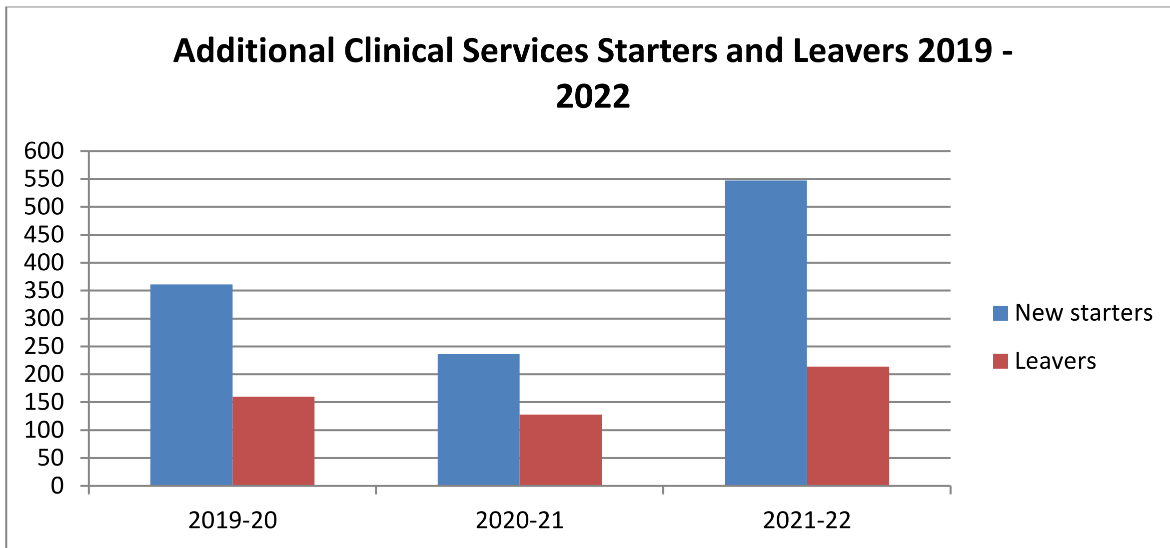


Table 4: Starters and Leavers of HCSW

All new recruits are enrolled on a comprehensive induction package which incorporates the Care Certificate. The induction has been reviewed following feedback to ensure it matches the needs of the HCSW in a more practical manner. In addition, the Work Based Learning team is working to facilitate individual's access to further education and highlighting apprenticeship routes to develop careers in healthcare and how we advertise this when recruiting to attract HCSWs into a career in healthcare. The Trust has also appointed two Band 4 Pastoral Roles for HCSWs who started in post this month. A HCA Recruitment and Retention Group has been established, chaired by the Assistant Chief Nurse, with membership from recruitment, education, ward staff, including HCAs. An improvement plan has been developed with an expectation that we will see an improvement in our recruitment and retention rates for HCAs.

Clinical Apprenticeships

The Trust continues to have a robust apprenticeship process; there are 55 Nursing Associate (NA) Apprentices. The next Nursing Associates cohorts will start in 2022 and will be split to enable the Trust to facilitate the placement requirements. The University of York cohort commenced in September 2022 with the recruitment process commencing April 2022.There are 9 Assistant Practitioner apprentices currently in training and 3 Senior Healthcare Support Worker apprentices due to complete March 2022. The process of recruitment is under review and how we ensure a pipeline of NAs and those that want to commence the RNDA programme but also the impact this is having on wards due to the transient workforce.
HEEYH has confirmed funding of £8,300 per apprentice, per year for RNDA 36/48 month programmes and NA/AP top-up to RNDA programmes at £8,300 per apprentice per year (maximum 2 year programme) for registrations between Sept 2020 and December 2021. Recent notification from HEE states this funding has been extended, with the caveat that apprentices must complete by 31st March 2024

There are 38 Registered Nurse Degree (RNDA) apprentices currently in training and Health Education England (HEE) has confirmed funding of £8,300 per apprentice per year (pro rata). We are ensuring that in the work to undertake establishment reviews across the organisation we align this with the amount of NA roles we require and how many commence the RNDA course promptly after qualifying.

The tender for the apprenticeship programmes is due for renewal and therefore we will be undertaking this process and alongside this, ensuring we have clear processes for all staff to follow that they are aware of the pathways available to develop in their career within our

organisation. We are also exploring the re-introduction of a HCA Apprenticeship course through local colleges to attract HCAs and to offer a clear career pipeline.

Return to Practice Course

A recruitment event planned for the 28th March, our recruitment event runs alongside a national campaign called 'once a nurse, always a nurse' aimed at attracting people back into the nursing profession. The course commences in May for 12 weeks with a guaranteed post at the end of the programme and we have appointed 3 to the programme who have been offered placements of their choice.

Professional Nurse Advocate (PNA)

There have ten individuals who have either undertaken or are undertaking PNA training. We have linked with the communication team and sent out an invitation to the PNA forum for anyone else who is undertaking or has undertaken PNA training.

The first forum meeting has been held and are planning the first restorative supervision sessions in May, focusing initially on newly qualified nurses and international nurses.

Preceptorship programme

The national preceptorship project is focused on the design, development and delivery of a national preceptorship framework and associated quality standard for all organisations in health and social care. The organisation is part of this national team and we have ambitions to commence this programme this year for the autumn cohort.

1. Using the National Preceptorship Framework, develop a Multi-Professional Preceptorship Framework and Programme to be used across the organisation for Nursing, Midwifery and AHP newly qualified staff members.
2. Meet the Gold core standard of preceptorship, as defined by the National team.
3. To improve the retention and recruitment rates for all professions involved.
4. To create a programme that incorporates the core areas of preceptorship, as defined by the National Framework.

Establish a clear process with recruitment and managers to identify newly qualified staff members and ensure they are allocated a preceptor and a place on the next preceptorship programme that follows their start

Undergraduate Education and work with schools and colleges

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

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

health and social care, this is a current challenge due to the availability of placements and has attended recent events at schools and colleges.

3. Conclusions

The Board of Directors should be assured that whilst the wards / units undertook delivery of elective work, the pressures of an unprecedented increase in staff absence and responded to an increase in acute care with demand across the Emergency Departments exceeding demand every month compared to 2019 – 20 the impact on nurse staffing levels cannot be underestimated. Nurse staffing levels have been flexed and reviewed daily and there has been oversight from the senior nursing team to support the decision making but it is evident through audit and nurse care indicators that the fundamental basics in care are being impacted as a result of constant challenges within the nurse staffing levels and has been indicated in the initial CQC response. An establishment review is in progress and will be presented to the Exec Committee in June 2022 detailing the additional requirements with an ongoing process for review every year.

4. Detailed Recommendation

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

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
Nursing Recruitment and Retention Report

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

To inform and update the Board of Directors in relation to the recruitment and retention figures for the Registered and Non – Registered Nursing workforce within the organisation. To report on the current vacancy position and forecast up until April 2023.

This report will also identify the plans for retention under a number of initiatives and the key ambitions of the NHS People Plan (2020/21) and Improving Staff Retention (NHS Employers 2022) with a proposal for an organisational retention strategy.

Executive Summary – Key Points

The UK government has pledged to have 50,000 more nurses in the NHS by 2024/25 and rapidly increasing the pace of recruitment across all roles and professions is a key focus of the We are the NHS: People Plan. Whilst this is an important element, we are also experiencing acceleration in our attrition rate within the nursing workforce.

Recommendation

- Recognition of the current position in regard to recruitment and retention figures and the impact this has patient care and staff morale/ well being
- Support for the implementation of a nursing and midwifery retention strategy and programme of work

Author: Emma George, Assistant Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: 17 May 2022

1. Introduction and background

Within York and Scarborough NHS Trust we have seen a stark increase in the turnover rate for both Registered and Non Registered Nurses. In May 2021, the turnover rate for Registered Nurses was 7.81%, in contrast, for April 2022 the rate has increased to 10.27%. This equates to an average of 16.51 leavers per month. This figure is across the whole of the organisation but when we drill this down to the acute wards the figure is as high as 33% in some ward areas (Appendix 1). For Non Registered this was 15.19% in May 2021 and 13.82% in April 2022. This has decreased due to the denominator increase due to recent HCA recruitment.

Table 1: Registered Nurse

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Establishment	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54	2292.54
In post	2049.68	2041.77	2033.86	2025.95	2018.04	2068.13	2094.22	2086.31	2078.4	2070.49	2092.58	2084.67
Projected leavers		16.51	16.51	16.51	16.51	16.51	16.51	16.51	16.51	16.51	16.51	16.51
Projected International Recruits							34				30	
Projected UK qualified starters		8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6
Projected NQs						58						
Vacancies	-242.86	-250.77	-258.68	-266.59	-274.5	-224.41	-198.32	-206.23	-214.14	-222.05	-199.96	-207.87

This table indicates the current leavers and starters across the organisation for Registered Nurses and therefore the residual gap of vacancies overlaid onto this are the projected newly qualified nurses, average UK starters and International Nurses.

The table indicates 207.87 FTE RN vacancies across the whole organisation, when this is interrogated further into ward inpatient areas, the vacancy is 138 FTE, this equates to a 14.82% vacancy. As a caution the vacancies will increase following the establishment reviews that will be undertaken and presented to the exec committee in June 2022 to request further investment in the nursing workforce.

Table 2: Non Registered

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Establishment	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87	1265.87
In post	1172.43	1185.18	1197.93	1210.68	1223.43	1236.18	1248.93	1261.68	1274.43	1287.18	1299.93	1312.68
Projected leavers		12.25	12.25	12.25	12.25	12.25	12.25	12.25	12.25	12.25	12.25	12.25
Projected New Starters		25	25	25	25	25	25	25	25	25	25	25
Vacancies	-93.44	-80.69	-67.94	-55.19	-42.44	-29.69	-16.94	-4.19	8.56	21.31	34.06	46.81

The Non Registered workforce has also experienced a similar picture; the table above demonstrates the current position with a vacancy of 93.44 FTE which equates to a 19.74% vacancy.

Table 2 above indicates the Non Registered establishments includes projected leavers and starters for the organisation; specific inpatient ward detail is explained in appendix 2. This is indicating a positive positon on the projected starters which is necessitated by permission to over recruit due to the projected increase in the non-registered workforce through the establishment reviews. A Health Care Assistant Recruitment and Retention Group has been established and will form part of the overarching retention strategy. An improvement plan has been developed with collaboration from a multi-disciplinary team.

2. Context and Next Steps

The covid-19 pandemic had increased workforce pressures exponentially. 92% of trusts told NHS Providers they had concerns about staff wellbeing, stress and burnout following

the pandemic. Workforce burnout has been described by many as the highest in the history of the NHS.

The Trust is undertaking a review of recruitment work programs such as attending universities and recruitment events, also engaging with the regional work to ensure the Trust is best placed to benefit from any regional program of support. Progress continues on the Trusts' 6 developments for nursing and as detailed in the monthly workforce paper.

In November 2019, a workforce timeout took place with a multi-disciplinary team, led by the Assistant Chief Nurse, supported by the Quality Improvement team and the outcomes were clear that whilst we can recruit, even limited numbers, it was unanimous that there needs to be a renewed focus on how we retain our nursing workforce. Retention of nurses is imperative at this time, using the guidance from NHS Employers.

An implementation strategy will be required to maximise retention opportunities across the themes listed below:

- Culture – Innovation, clear vision, focus on high quality care
- How we use data, collecting and analysing and meaningful
- Communication – how do we ensure staff feel listened to and involved
- New starters and support – on boarding and streamlining processes
- International nurses – how do they stay and thrive
- Development and career pathways – from volunteers to Registered Nurse
- Supporting staff in late career – How do they coach and offer pastoral support
- Flexible working – Understanding what flexibility is required
- Health and Well Being – Taking breaks, changing facilities and rest spaces
- Recognition and Reward – How do we reinvigorate with different ways of recognition

The Plan

Moving into 2022/23 there will be further forecast planning to calculate accurately alongside our retention figures the amount of Registered and Non Registered we require and to also target specific areas that can be shared with Care Groups monthly.

The plan is to build on the work already undertaken and to develop a collaborative retention strategy for Nursing and Midwifery ,with dialogue from front line staff to ensure engagement with a planned service improvement day to work together to improve workforce retention across the organisation.

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022 (March 2022 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

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. An introduction to Ockenden, Clinical Negligence Scheme, and Continuity of Carer is provided for context and information. Overall the report intends to provide assurance surrounding any identified issues, themes, and trends to demonstrate an embedded culture of continuous improvement.

Executive Summary – Key Points

- There have been no confirmed moderate harms in March 2022, one case going to Q&S in May form March that has had ongoing debate.
- There was 1 case for referral to MBRRACE as per national required standards
- There were 11 unit diverts in March 2022, all related to staffing. A divert means that care was provided on the alternate obstetric site within the Trust.
- CNST remains paused; progress demonstrated in safety action 2 and training compliance will be extended until December 2022.
- Initial review of the final Ockenden report published 30th March 2022 to be undertaken and presented at the Board in May.
- Significant concerns in relation to the Scarborough site being able to evidence multi disciplinary handovers and ward rounds.

- Plan to pause continuity underway. The LMS and regional team are aware and team leaders are working to make the practical changes necessary.

Recommendation

Receive & discuss the report and appendices.

Author: Sara Collier-Hield, Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: 29 April 2022

1. Detail of Report and Assurance

1.1 Introduction & Overview (Appendix A)

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. An introduction to Ockenden, Clinical Negligence Scheme, and Continuity of Carer is provided for context and information. Overall the report intends to provide assurance surrounding any identified issues, themes, and trends to demonstrate an embedded culture of continuous improvement.

The NHS Resolution Clinical Negligence Scheme (CNST) invites Trusts to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward Trusts who have implemented all elements of the 10 Maternity Safety Actions. Year 4 of the scheme was launched August 2021 and is currently paused. The Trust is awaiting the recommencement, with new timescales, from NHS Resolution. Despite this, the Trust continues to work towards overall achievement.

Emerging findings and recommendations from the Ockenden Report, an Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was published in December 2020. The Maternity Services Assessment and Assurance Tool, developed by NHSEI and published in December 2020, supported providers in the initial assessment of their current position against the 7 Immediate and Essential Actions (IEA) in the Ockenden Report. Since that time and as previously reported to the Board of Directors, the requirements in terms of the minimum evidence required to support compliance have evolved considerably, resulting in a total of 49 standards to be addressed by providers of maternity services.

Better Births: Improving Outcomes of Maternity Services in England (2016) outlined the Five Year Forward View for NHS Maternity Services in England. At the heart of this vision and in response to the evidence around increasing health outcomes and safety and decreasing health inequalities, is the provision of 'Continuity of Carer'. This is a model of care provided to women by the same midwife or small team of Midwives for the whole of pregnancy, birth and the postnatal period. Consideration needs to be given to the care planning and offer of a continuity model to women from BAME communities and those living in areas of deprivation.

1.2 Moderate Harm & Serious Incidents

Over the course of the reporting period there have been no incidents logged as 'Moderate' harm. One case from March, relating to infusion fluid given to a diabetic woman remains unconfirmed and will be discussed at Q&S in May 2022.

1.3 Healthcare Safety Investigation Branch Reports

No incidents have been reported to HSIB in March 2022. No completed reports have been received in the Trust during March 2022.

1.4 Perinatal Mortality Review Tool (Appendix B)

The thematic issues identified from PMRT and/or HSIB cases are:

- Mothers who live with family members who smoke but they were not offered referral to smoking cessation services
- Mothers progress in labour was not monitored on a partogram
- Mothers' labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out

All themes are added to mandatory training for staff.

The actions planned within the action plan have been enacted. Audits have either been completed, or are underway to establish the effectiveness of actions. Regarding the offering of referral to smoking cessation services; the audit following actions has indicated a marked improvement.

1.5 Unit diverts and closures

There were 11 diversions put in place between the two maternity units within March. Of these, 9 were diversions from Scarborough to York, and 2 were York to Scarborough.

Of the Scarborough diversions, all diversions were required as a consequence of understaffing (namely due to sickness), cumulating in high acuity, as opposed to a capacity issue. As a consequence of these issues, there were 2 NICE Safer Staffing Red Flags reported under the category of 'Delay between admission for induction and beginning of process'.

Of the York diversions, these were also as a consequence of staffing levels, and the consequential effects upon acuity. There were no subsequent NICE Safer Staffing Red Flags reported.

1.6 Training Compliance

Training compliance has been discussed at Labour Ward Forum on 27th April 2022 and in a separate meeting about compliance on the same day. Email correspondence with NHS Resolution following the meetings has confirmed that the end of June training compliance deadline will be extended until Dec 2022. This gives the MDT time to address the challenges in getting everyone through training in a period which was initially ten months (August 2021 – June 2022). As CNST is clear that the training counted must be from August 2021 the plan from next month will be to show the figures in Appendix A as a cumulative total since August rather than as a rolling year. It is thought this will be clearer for all audiences.

1.7 Safe Staffing

Maternity Staffing
The vacancy rates for midwives, is 5% at Scarborough site (2.45 wte: all maternity leaves) and 18% on the York site (11.4 wte permanent, 5.8 wte maternity leaves). Despite all efforts to recruit midwives, via continuous advertising, significant vacancies continue. Bank and agency are utilized. Agency use is minimal. The recruitment and retention midwife posts for each site have been appointed. The Scarborough post will commence 20th June 2022. 9 wte posts have been offered to newly qualified staff to commence in the Autumn. 3 international midwives have

successfully applied to join us once their training is complete. We hope to recruit a total of 6 international midwives this year.

Please see **Appendix C** for an overview of medical staffing during the reporting period. The Head of Midwifery will ask the clinical director to provide more narrative to support this report in subsequent months.

1.8 Service User Feedback

A meeting was held on the 29th April 2022 with the York commissioner and the LMS MVP Chair to identify next steps to support the function of both the Coast and Country MVP and the York MVP. A further planning meeting will take place mid May. York MVP needs a Chair and Coast and Country need a co-Chair or further support. Some feedback on ward G2 has been shared with the LMS MVP Chair and a further meeting is planned to include the ward sister to see how patient experience can be improved.

A patient experience action plan is now in place and the bereavement midwife, perinatal mental health midwife and infant feeding midwives have been asked to contribute feedback and actions from other patient experience tools they use to develop the plan.

At the time of writing this March Friends and Family Test reports are not available.

1.9 Staff Survey

The workforce lead and senior triumvirate will shortly be meeting to discuss the staff survey results. Action plans will follow and Appendix A will report on the 2021 figures to the two key questions required as part of this report. Ward leaders have been asked to prioritise booking on Values & Behaviours training in quarter 1 and appraisal training for all appraisers is to be scheduled to support staff to get the best out of the appraisal process.

1.10 The Maternity Incentive Scheme - CNST (Appendix D)

CNST (MIS) Year 4 was published in August 2021 and has subsequently had two revisions to timeframes as a result of Covid pressures; specifically around face to face training, the importance of responding to feedback during safety champion walk-arounds and MSDS submissions. The scheme has been paused Since November 2021 in light of the current staffing pressures on maternity services. Maternity services consider enacting the elements of CNST ‘business as usual’ and will continue to progress the current action plans until further information is provided by NHS Resolution. Whilst not formally published yet, email correspondence with NHS Resolution on 28 th April 2022 suggests revised deadlines will be January 2023.

1.11 Ockenden (Appendix E)

The Ockenden final report was published on 30th March 2022. There are 15 new actions (with 92 sub points) for maternity services in addition to the seven Immediate and Essential Actions (IEA’s) published in December 2020.

The request for all Trusts is to table the Ockenden final report at Trust Board in May 2022.

NHSEI have stated that they will await the publication of the East Kent report, expected end June 2022, before instructing Trusts further. Prior to Trust Board in May an initial review of the 92 points will be undertaken within the Care Group. Trusts are asked to continue focusing on the seven initial IEA's prior to the regional assurance visit on 23rd June 2022.

Progress with the IEA's is challenging. Lots of actions remain amber. The audits required for Ockenden are all underway and most show increasing compliance but 100% not achieved in key areas such as the multidisciplinary ward rounds twice daily on both sites. The Scarborough evening ward round and handover planned for 21:00 hours is very rarely getting Anaesthetist attendance (9.7% - March 2022) and Obstetrician attendance is irregular (64.5%). The Obstetric lead and Clinical Director are liaising with anaesthetic colleagues to look at solutions to address this. Job planning changes have been made to support obstetric attendance and recruitment to permanent consultant posts on the Scarborough site will also support an improvement.

A snapshot of the audits is included below this month. It can be included in Appendix A month by month if this is helpful for understanding.

March - York

Date	Time	Consultant Presence	Registrar presence	Anaesthetics	Midwifery Management inc coordinator	Board Round	Physical Ward Round	Time	Consultant Presence	Registrar presence	Anaesthetics	Midwifery Management inc coordinator	Board Round	Physical Ward Round	Analysis	Plan	Escalation
1st	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
2nd	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes			
3rd	8.3	yes	yes	yes	yes	yes	yes	2000	no	yes	yes	yes	yes	yes			
4th	8.3	yes	yes	no	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes	a message on white board to remind		
5th	8.3	yes	yes	no	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
6th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
7th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes			
8th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
9th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
10th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
11th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
12th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
13th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
14th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
15th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
16th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes	a message on white board to remind		
17th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	no	ward round not evidenced	LW coordinator to remind to	
18th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
19th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
20th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
21st	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
22nd	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes			
23rd	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
24th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
25th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes			
26th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	no	yes	yes	yes	email to anethetist and		
27th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
28th	08,30	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
29th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
30th	8.3	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
31st	800	yes	yes	yes	yes	yes	yes	2000	yes	yes	yes	yes	yes	yes			
Total		31	31	29	31	31	31		30	31	24	31	31	30			
		0	0	2	0	0	0		1	0	7	0	0	1			
		100%	100%	93.50%	100%	100%	100%		96.70%	100%	77.40%	100%	100%	96.70%			

March -Scarborough

Date	Time	Consultant Presence	Registrar presence	Anaesthetics	Midwifery Management inc coordinator	Board Round	Physical Ward Round	Time	Consultant Presence	Registrar presence	Anaesthetics	Midwifery Management inc coordinator	Board Round	Physical Ward Round	Analysis	Plan	Escalation
1st	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y		17:00 HANDOVER ALSO		
2nd	08:30	Y	Y	N	Y	Y		####	N	Y	N	Y	Y		CONSULTANT ATTENDED @ 17:00		
3rd	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
4th	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
5th	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y				
6th	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y				
7th	08:30	N	Y	Y	Y	Y		####	N	Y	N	Y	Y				
8th	08:30	Y	Y	Y	Y	Y		####	N	Y	N	Y	Y				
9th	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
10th	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
11th	08:30	Y	Y	Y	Y	Y		####	N	Y	N	Y	Y		CONSULTANT ATTENDANCE AT 17:00		
12th	08:30	Y	Y	N	Y	Y		####	N	Y	N	Y	Y				
13th	08:30	N	Y	Y	Y	Y		####	N	Y	N	Y	Y		CONSULTANT PRESENT AT 11AM		
14th	08:30	Y	Y	N	Y	Y		####	Y	N	N	Y	Y		RESIDENT CONSULTANT PRESENT		
15th	08:30	Y	Y	Y	Y	Y		####	Y	N	N	Y	Y		RESIDENT CONSULTANT PRESENT		
16th	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
17th	08:30	Y	Y	Y	Y	Y		####	N	N	N	Y	N		ONLY COORDINATOR SIGNED SHEET		
18th	08:30	Y	Y	Y	Y	Y		####	Y	N	N	Y	Y		17:00 HANDOVER		
19th	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y		ANAES - PHONED AT 20.45		
20th	08:30	Y	Y	N	Y	Y		####	N	Y	N	Y	Y		CONS PHONED AT 20.58		
21st	08:30	Y	Y	N	Y	Y		####	Y	Y	Y	Y	Y				
22nd	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
23rd	08:30	Y	Y	Y	Y	Y		####	Y	Y	Y	Y	Y				
24th	08:30	Y	Y	Y	Y	Y		####	N	Y	N	Y	Y				
25th	08:30	Y	Y	Y	Y	Y		####	Y	Y	N	Y	Y				
26th	08:30	N	Y	N	Y	Y		####	Y	Y	N	Y	Y		CONSULTANT IN UNIT UNTIL 4AM, ATTENDED AT 11.00 FOR HANDOVER		
27th	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y				
28th	08:30	Y	Y	N	Y	Y		####	Y	Y	N	Y	Y				
29th	08:30	N	Y	N	Y	Y		####	N	N	N	Y	Y				
30th	08:30	N	Y	Y	Y	Y		####	N	Y	N	Y	Y		ATTENDANCE AT 17:00		
31st	08:30	Y	Y	Y	Y	Y		####	Y	N	Y	Y	Y		IN THEATRE AT HANDOVER		
Total		26	31	18	31	31			20	25	3	31	30				
		5	0	13	0	0			11	6	28	0	1				
		83.90%	100%	58%	100%	100%			64.50%	80.60%	9.70%	100%	#####		New signing sheets being approved to encorporate physical ward round evidence		

1.12 Continuity of Carer (CoC)

Following a letter from NHSEI on 1st April 2022 the Trust was asked to immediately consider their midwifery staffing position and make a decision about whether or not they meet the safe minimum staffing requirements to continue with the provision of continuity of carer. For the York site, it is recognised that the safe minimum staffing level, according to the birthrate plus report in June 2021, is not met and therefore continuity will be paused on the York site. The plan to achieve continuity of carer in York was shared with Board in January 2022.

For the Scarborough site, who moved into continuity teams in January 2020, pausing continuity is a bigger change. The model on the East Coast has been adapted since January 2020 and changed, with the support of the regional team, in the Autumn of 2021. However, increased vacancy on the Scarborough site has led to teams feeling overstretched and trying to provide support to the hospital more frequently than would be expected in a continuity model. Via the maternity safety champions, PMA's, and in an open forum on 8th April 2022 enough concerns were raised that the decision has been taken to pause all continuity for the East Coast teams too. This has been discussed with the regional continuity of carer lead midwife and with the LMS Lead Midwife who acknowledge the decision made and the reasons why.

The national team are explicit that we can instigate a pause to continuity plans but we will be expected to progress once safe staffing levels are achieved. It is noted that in this current month the vacancy on Scarborough site is reasonably low. The decision to pause continuity is taken in the context of; a need to deploy staff in a cross site way to support two delivery suites, concerns raised by staff about not feeling fully trained in all areas of practice, the instability of the home birth service, on-going concerns that the model doesn't meet NHSE standards and staff frustrations around payment for working in a continuity model. Next steps locally include using LMS monies to re-instigate a continuity of carer lead midwife post locally with some admin support to take forward plans with a focus on training needs. There has been lots of learning for the service on the continuity journey which will inform our future.

1.13 Safety Champions Feedback

The Board level safety champion walkaround in April raised staff concerns in relation to;

- Staffing ongoing concern re. midwifery
- 4th scanning room is not up and running and the frustration re building works – *Caroline Alexander has escalated this*
- Retire & return and succession planning - *new Recruitment and Retention midwives will support with this.*
- The fact we are still offering home birth service when resource is so limited – *has been discussed with regional team who would prefer that we still try a service where possible rather than standing down completely*
- Theatres refusing to help with a section when staffing was very challenged that morning (because coordinator couldn't guarantee they'd be finished for 7.45) – *on-going work and business case required to have a dedicated non-midwife scrub role on each site 24/7.*

2. Next Steps

Overall this will provide the Trust with a clearer picture of risk and updates on improvement work as it progresses. Further relevant data fields will be added to the data sheet and the appendices will be continuously reviewed to ensure sufficient detail is provided whilst utilising the main body of the report to provide assurance about themes and trends.

3. Detailed Recommendations

To receive & discuss the report and appendices.

Monthly Oversight of Perinatal Clinical Quality - Appendix A

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

CQC Maternity Ratings - Scarborough Hospital Last Inspection: 16th October 2019	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Good	Good	Good	Good	Good

CQC Maternity Ratings - York Hospital Last Inspection: October 2015	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Good	Requires Improvement	Good	Good	Good

	2021				2022					
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of reviews completed using the Perinatal Mortality Review Tool	2	5	0	0	1	1	1			
Number of cases notified to MBRRACE	1	2	2	4	1	0	1			
Number of cases referred to HSIB as per eligibility criteria	1	1	1	0	1	0	0			
Number of received HSIB final reports	1	0	0	1	0	0	0			
Number of incidents with a harm rating of Moderate or above	1	2	1	1	3	0	1			
Number of Maternity Unit Diverts							11			
Number of Maternity Unit closures	4	10	4	2	3	5	0			
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	1	0	0	2 (CQC)	1 (CQC)			
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0			
Continuity of Carer										
Percentage of Continuity of Carer bookings	38%	40%	31%	37%	37%	40%	40%			
Of those booked for Continuity of Carer - Black, Asian and mixed ethnicity backgrounds	44%	38%	22%	29%	17%	60%	14%			
Of those booked for Continuity of Carer - Postcode for top decile for deprivation	84%	91%	94%	73%	96%	94%	83%			
Intrapartum Continutiy of Carer received - Overall	17%	15%	16%	8%	14%	25%	19%			
Intrapartum Continutiy of Carer received - Scarborough	43%	43%	42%	28%	38%	25%	19%			
Intrapartum Continutiy of Carer received - York	4%	6%	5%	0.42%	2.00%	0%	3%			
Intrapartum Continutiy of Carer received - Black, Asian and mixed ethnicity backgrounds	9%	7%	14%	14%	30%	25%	0%			
Intrapartum Continutiy of Carer received - Postcode for top decile for deprivation	42%	37%	23%	20%	48%	19%	9%			
Safe Staffing										
1 to 1 care in Labour - Scarborough	94%	99%	95%	94%	94%	98%	96%			
1 to 1 care in Labour - York	95%	93%	97%	96%	93%	96%	97%			
L/W Co-ordinator supernumary % - Scarborough	98%	99%	100%	100%	85%	97%	92%			
L/W Co-ordinator supernumary % - York	95%	93%	87%	99%	96%		100%			
Vacancy Rate - Scarborough (including maternity leaves)					1.72%		5%			
Vacancy Rate - York (including maternity leaves)					15.10%		18%			

	Scarborough Hospital	York Hospital
2020 Staff Survey: Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work (Reported annually)	58.97%	47.42%
2020 Staff Survey: Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to receive treatment (Reported annually)	69%	63%
2020 Staff Survey: Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	Awaiting Data	Awaiting Data

Training figures (rolling year)

March-22

York %	PROMPT	NLS	Fetal Monitoring	SBLv.2	Perinatal Mental Health	Bereavement	COVID19	Learning from incidents claims & complaints
Midwives	82	74	90	64	89	49	68	34
HCA/MSW	64	N/A	N/A	N/A	Not currently doing this training	64	64	N/A
Medical staff	61	N/A	64	58	36	N/A	70	42

PMRT – Appendix B

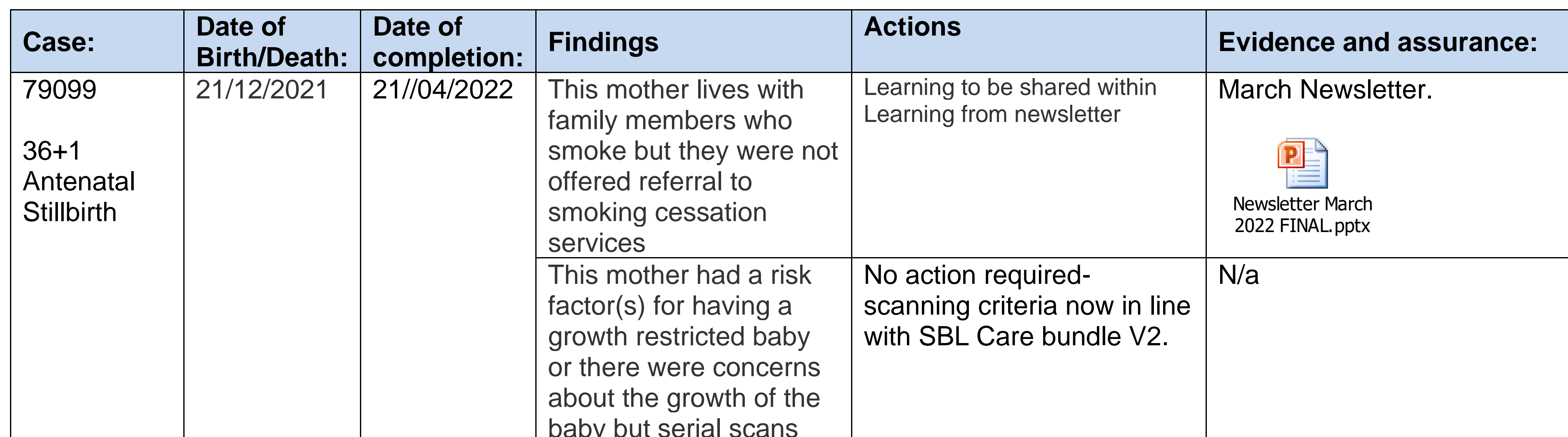
PMRT Notified cases

There was one case notified within this period.

Case:	Date of Death:	Delivered:	Summary:	Review Due Date:
80839/1	28/03/2022	30/03/2022	33+2 Antenatal Stillbirth	30/05/2022

PMRT Reports completed

There was one PMRT report completed within this period.



Case:	Date of Birth/Death:	Date of completion:	Findings	Actions	Evidence and assurance:
79099 36+1 Antenatal Stillbirth	21/12/2021	21//04/2022	This mother lives with family members who smoke but they were not offered referral to smoking cessation services	Learning to be shared within Learning from newsletter	March Newsletter. Newsletter March 2022 FINAL.pptx
			This mother had a risk factor(s) for having a growth restricted baby or there were concerns about the growth of the baby but serial scans	No action required- scanning criteria now in line with SBL Care bundle V2.	N/a

			were not planned		
			This mother's progress in labour was not monitored on a partogram	Face to face training is now being recommenced (January '22). The training will highlight the importance of documenting the mother's progress in labour on a partogram.	Training presentation.
			During this mothers' labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	Face to face training is now being recommenced (January '22). The training will highlight the importance of carrying out maternal observations in labour and documenting them on the partogram.	Training presentation.
			The baby had to be transferred elsewhere for the post-mortem	No action required- there is no facility to undertake baby post-mortems within the Trust.	N/A.

PMRT Ongoing cases

Site	Date of death	Reason PMRT required
Scarborough	13.10.21	41+1 Intrapartum Stillbirth (HSIB)
York	04.11.21	39 Intrapartum Stillbirth (HSIB)
York	21.11.21	23+1 Late Miscarriage
York	04.01.22	28+5 Antenatal Stillbirth

PCQS Appendix C: Medical Staffing (March 2022)

Obstetrics – Scarborough

A summary of the staffing challenges through March 2022 for Scarborough are highlighted below;

Issue	Mitigation	Assurance
2 x consultants not undertaking on call duties due to OH recommendations.	2 x long term locum consultants have been secured to support in covering on call duties including labour ward acute cover and non-resident on calls.	In July 2021 we recruited to 2 x consultant posts for Scarborough and 6 x consultant posts for York. 3 of these posts will support the non-resident on call in Scarborough with new local pay arrangements (this will be the first cross-site oncall cover embedded in a Consultant job plan). This will cover the OH gaps as well as providing an extra on call post to provide resilience in the service and work towards moving to a 1:8 rota by July 2022 (last summer the rota was 1:5 and has moved to a 1:7 in December 2021).
1 x consultant post vacancy	Long term Locum consultants being utilised to cover this shortfall in clinical activity at this time. This post has a specialty in diabetic maternal medicine, currently working through plan for cover until new SGH Consultant recruited. Incoming York Consultant for July 2022 has diabetic maternal medicine interest and there is an ambition to develop a fully integrated diabetic pathway as these new Consultants are recruited/ come into post.	Post is currently out to advert with a specific interest in maternal medicine listed in the advert. Interviews are planned for April 2022 – there has been interest in this post and the Clinical Director has spoken with prospective candidates. We have also added an additional post to the recruitment drive to support in the move to the 1:8 rota. They will be interviewed alongside the above post. We have 4 applicants for these two posts
1 x consultant on long term sick	Long term Locum consultants being utilised to cover their clinical activity at this time.	The long term sickness policy has been implemented and is being worked through. Supportive conversations are being held with the consultant and ways of supporting return to work are being explored.

1 x specialty doctor on phased return	Long term locum registrar was secured to support with cover of shifts.	Clinical Supervisor has been linking in regularly with the member of staff. A plan for phased return has been developed and is being implemented with the support of the service.
Impact of Covid-19	Throughout January we had a number of staff off due to Covid-19. This was across the consultant and lower tier rota. These gaps were filled with long term locum colleagues as well as reviewing and moving staff on the rota. Some non-urgent clinical activity was moved around.	Service Manager and Clinical Director/Clinical Lead support with the review and prioritisation of services across the site.

Obstetrics – York

A summary of the staffing challenges through March 2022 for York are highlighted below;

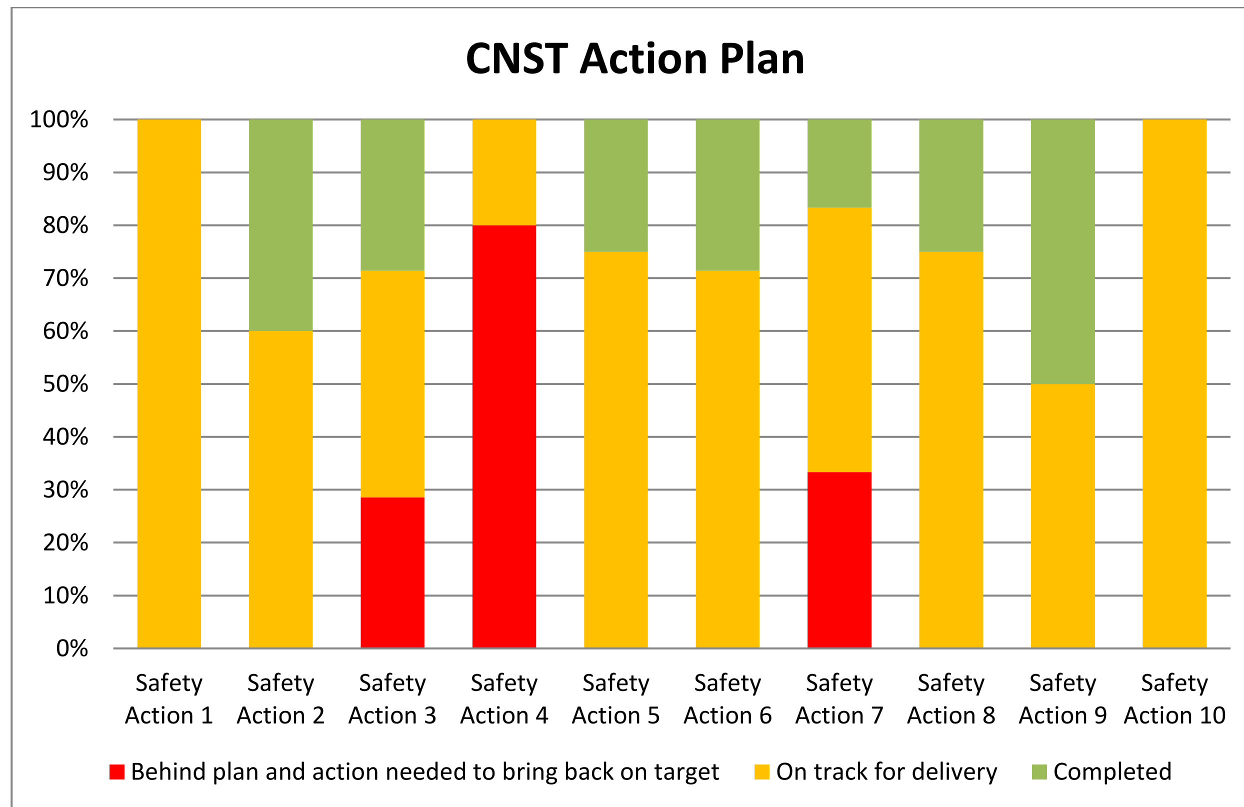
Issue	Mitigation	Assurance
3 x registrars either on maternity leave - **1.0 non entrustable reg** - **1.4 entrustable reg (2 x LTFT)**	Locum registrar cover has been sourced to cover the short term gaps.	We recruited into the 1.0 non entrustable and they started in Feb 2022. Interviews were held for the other entrustable post and an offer of appointment was been made for 1 x 1.0 WTE however the candidate gave back word. We have gone out again to recruit to this post. Interviews will be held w/c 16th May
Impact of Covid-19	Throughout January we had a number of staff off due to covid-19. This was across the consultant and lower tier rota. These gaps were filled with long term locum colleagues as well as reviewing and moving staff on the rota. Some non-urgent clinical activity was moved around.	Service Manager and Clinical Director/Clinical Lead support with the review and prioritisation of services across the site.

York and Scarborough Teaching Hospitals NHS Foundation Trust

CNST Highlight Report May 2022 – Appendix D

Project aim: NHS Resolution is operating year 4 of the CNST MIS which incentivises 10 key maternity safety actions.	**Project Lead:** Michala Little	**Trust Board declaration of completion :** currently paused, awaiting updated timeframe	Blue – action completed Red – significant risk Amber – in progress Green – on track

Safety Action 1	Safety Action 2	Safety Action 3	Safety Action 4	Safety Action 5	Safety Action 6	Safety Action 7	Safety Action 8	Safety Action 9	Safety Action 10
↔	↑	↔	↔	↔	↑	↔	↔	↔	↔



<table>
<tr><td colspan="2">Summary of Safety Actions: CNST CURRENTLY PAUSED

SA1 PMRT: The Care Group continue to report to MBRRACE and complete PMRT as per standards. Evidence that this safety action is fully compliant will be at the end of the reporting period.
SA2 MSDS Dataset: Contracts signed for rollout of digital maternity notes. 9 month implementation period predicted. Project manager to be appointed to in-house IT team to support (LMS funded)
SA3 Transitional Care services in place and ATAIN recommendations:
SA4 Clinical Workforce Planning: Paper produced by CD regarding RCOG requirements, in ratification process and to be presented to Board, via this paper once completed.
SA5 Midwifery Workforce planning: Workforce plans to Board and Executive Committee in January. Business case planning required. No further update to this safety action.
SA6 Saving Babies Lives: Implemented November 2021. Midwife sonographers training on track for completion in May
SA7 Working collaboratively with MVP: Meeting with LMS Chair and CCG planned to progress MVP work
SA8 Training (incorporating Ockenden Core Competency Framework): New trajectories and compliance figures to be formatted. 90% compliance will be extended to achieve by Nov/Dec 2022
SA9 Safety Champions: Safety Champions continue to meet bi-monthly. TOR agreed March 2022
SA10 HSIB: The Care Group continue to report to HSIB, as per national standards</td></tr>
<tr><td>Key risks:
Training compliance
MVP engagement
Labour Ward Coordinator Supernumerary Status
1 to 1 care in labour</td><td>Escalations/support required with:

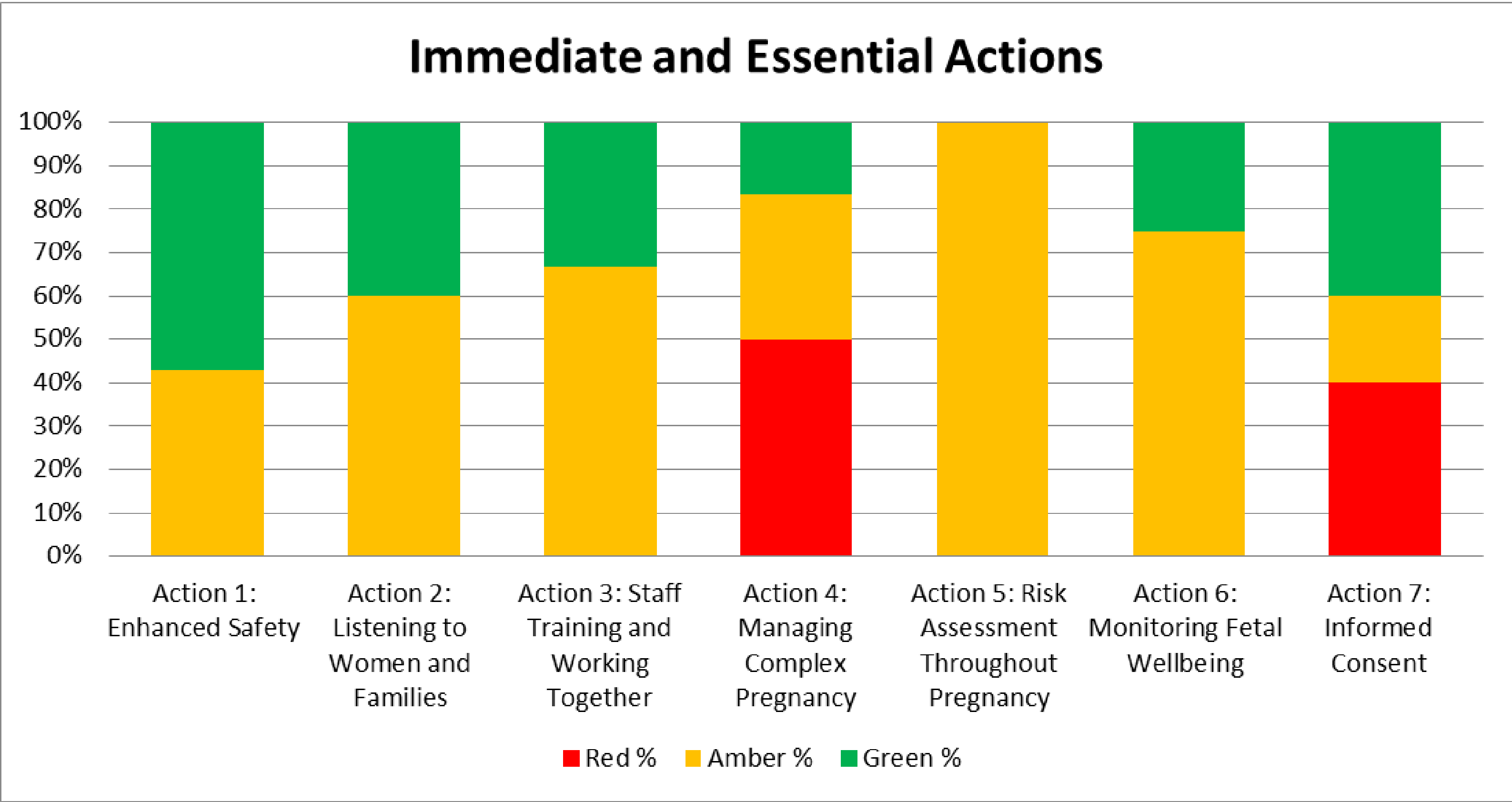
Evidencing Obstetric and Neonatal workforce plans</td></tr>
</table>

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Ockenden Highlight Report May 2022 – Appendix E

Project Aim: To enact the 7 Immediate Essential Actions arising from The Ockenden Report	**Project Lead**: Michala Little /Sara Collier-Hield	Blue – completed action Red – significant risk Amber – in progress Green – on track

IEA 1	IEA 2	IEA 3	IEA 4	IEA 5	IEA 6	IEA 7
⟺	⟺	⟺	⟺	↑	⟺	⟺



Summary of Progress (April 2022);

IEA1 Enhanced Safety: The elements within this section are in progress. Outstanding is full evidence of the implementation of the Perinatal Surveillance Framework and this piece of work will require agreement and sign off from the ICS

IEA 2 Listening to Women and Families: The NED job description needs to include details of the dedicated role within maternity. Meeting with commissioners and LMS Chair on 29th April to see what support is needed to embed regular meetings for York MVP and Coast and Country MVP. Ambition to have MVP representation at Care Group meetings not progressed.

IEA3 Staff training and working together: TNA for 3 years is in place. Training compliance has been a key concern. Dialogue with NHS resolution on 28th April indicates we will have till Dec 2022 to achieve 90% compliance in PROMPT, NLS, fetal surveillance and Saving Babies Lives Care Bundle. The training trajectories are being worked on and compliance figures to be provided to reflect the MIS Year 4 period rather than a rolling year. MDT handovers and ward rounds on Scarborough site remain a major concern. Discussed at Labour Ward forum on 27th April 2022 and Obstetric lead and Clinical Director will discuss with anaesthetic colleagues.

IEA 4 Managing Complex Pregnancy: Awaiting the formation of a regional Maternal Medicine Network, the Care Group have a named Obstetrician on the working group. Local guideline needs a minor change to wording for ratification in May. Audits demonstrate women are referred and seen early when their pregnancies are complex.

IEA 5 Risk Assessment through Pregnancy: Audits around risk assessment and care planning are in place, proformas have been improved for use from January 2022. Compliance with first assessments and completion of management plan is consistently good cross-site (95-100%). The compliance with 2nd assessments and review/ revision of management plans is variable and so contact is being made with individual practitioners to offer support and the completion of risk assessments has been added to the stat/mand training programme.

IEA 6 Monitoring Fetal Wellbeing: Fetal Monitoring leads and training in place. Job description for the Obstetrician needs to be produced.

IEA 7 Informed Consent: Updates to website required to ensure information is offered to women around choices, Digital Midwife progressing. SOP around decision making processes required. Personalised Care Planning will improve once digital system in place (from April 2022)

Key risks:	**Escalations/support required with**:
Formation of Maternal Medicine network and associated audits Established local MVPs with strong evidence of co-production MDT attendance at Labour Ward handover Risk Assessment through pregnancy	Anaesthetic and Obstetric attendance at labour ward handovers in Scarborough.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
Final Ockenden 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

Advise the Quality Assurance Committee & Board of Directors as to the publication of the Ockenden Report – Final 30 March 2022 as required by NHSEI letter dated 1 April 2022.

Executive Summary – Key Points

- Care Group 5 continue to work on implementing the 7 IEAs from the initial Ockenden review. Work to do and key risks are highlighted below.
- Ockenden Report – Final has 15 new IEAs for Trusts that break down into 92 elements.
- The Head of Midwifery has done an initial review of the actions for Trusts in the Ockenden Report – Final but full MDT benchmarking required after the Ockenden assurance visit 23 June 2022 and following the East Kent review.
- NHSEI guidance and/or instructions for actions for Trusts following Ockenden Final is not expected until July 2022 following the East Kent review.
- There is a plan to establish a Maternity Transformation Board under the Building Better Care programme, to be jointly Chaired by the Chief Nurse and Non-Executive Director.

Recommendation

Quality Assurance Committee to recommend to Board that the on-going monitoring and assurance relating to Ockenden Initial and Final report is done through establishing a Maternity Transformation Board.

Author: Sara Collier-Hield, Head of Midwifery

Director Sponsor: Heather McNair, Chief Nurse

Date: 29 April 2022

1. Introduction

The Ockenden Report – Final was published on 30th March 2022 and a letter was received by the Trust on 1 April 2022 (Appendix 1) outlining the requirement for the Ockenden Report – Final to be shared at the next public Board meeting.
The report is accessible at: Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk)

The Board are asked to review the report and take action to mitigate any risks identified and develop robust plans against areas where the service needs to change, focussing particularly on the four pillars

- Safe staffing levels
- A well trained workforce
- Learning from incidents
- Listening to families

The national and regional NHSEI Maternity teams have advised that they will await the findings of the East Kent report at the end of June 2022 before issuing Trusts with tools for assurance and benchmarking in relation to Ockenden Report – final. The suggestion from NHSEI currently is to focus on the 7 initial IEAs published December 2020.

2. Progress against the seven IEA's from the first Ockenden report.

The full action plan that is monitored within the Care group is shared in Appendix 2. The Board were last updated on progress against the plan in March 2022 and the position was shared with region on 15 April 2022. The Ockenden assurance visit for the Trust is taking place on 23 June 2022, with a further evidence submission by the 9th June 2022.

On a monthly basis a highlight report goes to QPAS and Quality Committee to update progression and challenges.

IEA 1 Enhanced safety

- Work to do
    - External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death

IEA2 Listening to women and their families

- Work to do
    - Job description for non-executive director to show maternity focus
    - Evidence of co-production and MVP work programmes
    - MVP representatives to clinical governance and labour ward forum, need to secure and support their attendance
- Areas of risk
    - MVP Chair to recruit to York site – meetings not currently taking place

IEA 3 Staff training and working together

- Work to do

    - Confirm that funding allocated for maternity staff training is ringfenced
- Areas of risk
    - Labour ward rounds and MDT handovers twice daily – particularly challenging on Scarborough site in the evening
    - Achieving training targets outlined in Maternity Incentive Scheme – Year 4

IEA4 Managing complex pregnancy

- Work to do
    - Carbon monoxide monitoring compliance action plan required
    - SOP for maternal medicine network/ complex pregnancies to be ratified

IEA 5 Risk assessment throughout pregnancy

- Areas of risk
    - Need to demonstrate increased compliance with risk assessments at every visit, including place of birth discussion

IEA 6 Monitoring fetal wellbeing

- Work to do
    - Create and confirm job description for obstetric fetal monitoring lead

IEA7 Informed consent

- Work to do
    - Put an SOP in place to reflect how women must be enabled to participate equally in all decision making processes
- Areas of risk
    - Evidencing that women's choices following a shared and informed decision-making process must be respected
    - Updating the Trust website in a timely manner to include all local guidelines

At Care Group level fortnightly meetings continue to review and progress actions.

The Trust was asked to declare nationally our position in relation to the seven IEA's on 5 May 2022. See table below for submitted position.

	Compliant	Partially Compliant
1) Enhanced Safety		
A plan to implement the Perinatal Clinical Quality Surveillance Model	YES	
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	YES	
2) Listening to Women and their Families		
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	YES	
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion		YES
3) Staff Training and working together		
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week		YES
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	YES	
Confirmation that funding allocated for maternity staff training is ringfenced		YES
4) Managing complex pregnancy		
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place		YES
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	YES	
5) Risk Assessment throughout pregnancy		
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance		YES
6) Monitoring Fetal Wellbeing		
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.		YES
7) Informed Consent		
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.		YES

3. Ockenden Report – Final

The Ockenden Report – Final contains a further 15 IEAs for Trusts, divided into 92 points. At this point, the Head of Midwifery has done an initial assessment as to the Trust's current position against the points, see Appendix 3. This is simply to give some context for Board today and requires further benchmarking with an MDT approach, inclusive of anaesthetics and neonatal representation.

4. Next Steps

Board opinion is sought as to whether or not a detailed benchmarking is requested ahead of the East Kent report or if the Board is satisfied for maternity services to await NHSEI guidance on next steps in July.

Continued efforts to complete the 7 initial IEAs continue. Preparation for the regional and LMNS assurance visit on 23 June 2022 is underway.

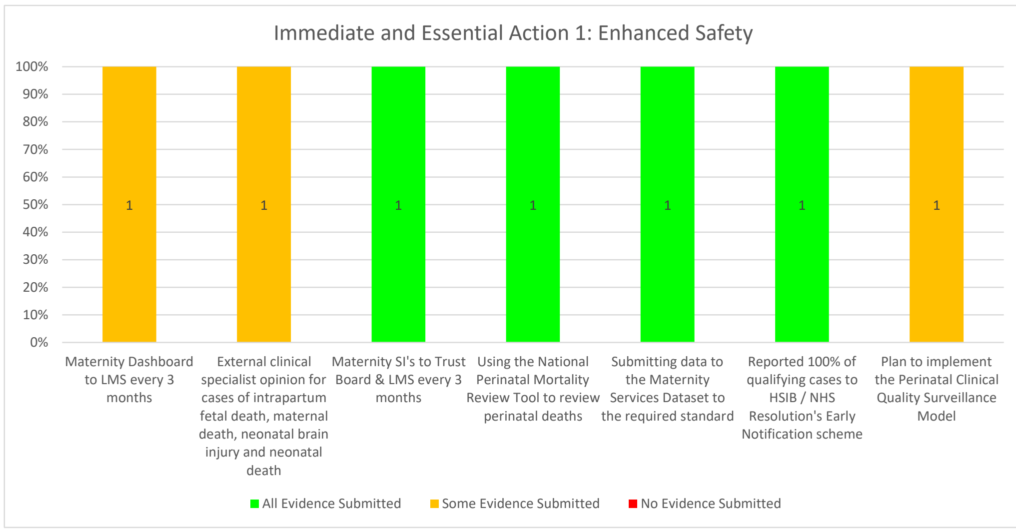
Care Group 5 to consider if enough staffing resource is in place to support working through all the Ockenden recommendations.

Following discussion with the Chief Nurse it is seen as beneficial to establish a Maternity Transformation Board, under the Building Better Care programme, to be jointly chaired by Chief Nurse and Non-Executive Director.

Question Number	Category	Question Number	All Evidence Submitted	Some Evidence Submitted	No Evidence Submitted	December 2021 action plans	leads & timeframe	January 2022 progress	February 2022 progress	March 1 2022 progress	March 15 2022 progress	April 12th 2022 LMS meeting	April 26th August 2022	May 10 2022			
IEA1	Q1	Maternity Dashboard to LMS every 3 months		1		confirm dashboards are submitted to LMS - ?paper required	Q&G team - ongoing oversight	MEETING NOT MDT QUORATE AND DID NOT GO AHEAD	Evidenced via PQSAG report and discussed bi-monthly with LMS	no update today	Y&H dashboard submitted quarterly and then shared with the LMS	Becky Case has confirmed the LMS is receiving this		MEETING NOT QUORATE AND NOT FULLY			
IEA1	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death		1		Audit to demonstrate this takes place - to audit the year (2021). Policy or SOP which is in place for involving external clinical specialists in reviews.	JF - March 2022		Reported via PQSAG, cases discussed as an LMS, minuted by LMS. Audit underway	no update today	no update today - email to JF for update	2 of 3 LMS Trusts engaging in this, still work to do	No change				
IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	1														
IEA1	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	1														
IEA1	Q5	Submitting data to the Maternity Services Dataset to the required standard	1														
IEA1	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	1														
IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model		1		Full evidence of full implementation of the perinatal surveillance framework by June 2022.LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	SCH - June 2022		ML liaising with LMS PMO - awaiting update from ICS for March meeting	02/03 Updated to compliant follwing advisement from national team as we have done as much as we can organisationally, awaiting formation of ICS	no update today						
IEA2	Q11	Non-executive director who has oversight of maternity services		1		NED JD required to be maternity specific	TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022		JD obtained, maternity specific role updating in progress	Awaiting update from TR	no update today - sitting with JM, email sent for update	Update required - email Jo Mannion today	Email Jo Mannion for update				
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	1														
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions		1		SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	ML - to add into doc re.SOP. March 2022 (?TOR for SafCh)		ML has completed role descriptor information. TOR for Safety Champions meetings underway,	TOR done, for agreement at SCH 8 Mar 22	Completed						
IEA2	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	1			One matron linked to each MVP (once new one into post), to collate evidence	SCH - March 2022		DS and AM aware they need to obtain evidence of co-production. There is challenge around this as 2 of the 3 MVPs are not fully functioning. AM and DS to liase with regional lead for supporting evidence LMS wide and update at next meeting	DS to contact RP at LMS to understand how they can regionally support. Evidence of co production and how we can obtain detail around women feeling involved in their care choices	DS - York MVP, C&C is AM, ER is VH. RP contacted and will support. There is however, risk here in terms of co produciton	Ruth Prentice to meet with Debbie to talk about the co-production element for CNST in the absence of a York group. Meeting cancelled yesterday. Alex to get in touch with C&C	Meeting for C&C in the diary. Ruth Prentice meeting with Debbie cancelled, to reschedule				
IEA2	Q16	Non-executive director support the Board maternity safety champion		1		Role descriptors - NED JD	(as above) TR to obtain JD and liaise with SG, action to be picked up by LB - March 2022		as above, Q11		no update today - sitting with JM	Update required - email Jo Mannion today	Update required - email Jo Mannion today				
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	SCH to forward figures to JF who will escalate and support medical staff with training- January 2022		TNA in place. Trajectories in progress for the next 6 months. Challenges continue around training all staff who have fallen out of date quickly while maintaining requirements of MDT across the training period	All staff expevced to be up to date by June 2022. Monthly oversight meetings in place with training teams	In place and ongoing	Trajectories are now developed. Concerns re medical training compliance for obsteterics and anaesthetics	Email sent by SCH to anaesthetic and obstetric leads to request a meeting around this				
IEA3	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	1			Observe audits cross-site and speak with LM managers	ML - audits to chase and paper requested		Audits completed on new assurance proforma for January. ML has contacted the areas to request increased assurance. To update at next meeting and escalate via PCQS	Assurance required - CD working with MDT leads to ensure attendance.	BA liasiing with LH to consider a handover 0f 20.30 or 20.45 to allow anaesthetics attendance. Midwifery happy with this. To update at next meeting. LW handover proforma that has been developed at York has been shared with Scarb	Audits continue cross site. On going issue with 9pm handover SGH especially. LMS asked to share some info re handovers. Needs prioritising at LW forum on the 27th April 2022.					
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only		1		Confirmation from Directors of Finance. Evidence from Budget statements.Evidence that additional external funding has been spent on funding including staff can attend training in work time.MTP spend reports to LMS	SCH March 2022		Reported spends to LMS upon request, LMS developing annual timetable for financial reporting and will share once completed. Ringfenced budget evidence received	No further update	No further update today. Awaiting update from LMS regarding annual timetable	LMS have not had confirmed info and assurance from finance team but will contact them again.					
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	All staff expevced to be up to date by June 2022. Monthly oversight meetings in place with training teams	Attendance records to be put into evidence folder. Confirmation by next meeting.						
IEA3	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	1														
IEA3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	(as above) Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	Awwaiting trajectories.	All staff expected to be up to date with training by June 2022. Attendance records into evidence file	TNA is in place, in line with the core competencey framework, compliance addressed in qu 21					
IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre			1	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians. SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	LF - March 2022		LF, MMN named consultant, updated the group that a pathway has been developed and will be published once finally agreed. Working group progressing at pace. SOP to be developed	gathering information from triage attendance cross-site to try and determine how many women attend that will benefit from the new pathway. No update from region	02/03 Update - following advisement from national team, to declare complaicne with this element as the organisation has done all it can to be compliant. Awaiting national formation of MMN						

IEA4	Q25	Women with complex pregnancies must have a named consultant lead		1		SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	JH to undertake audit for compliance - March 2022		DS to undertake audit and update March 2022	100% of notes identified as intermediate or high risk is reviewed. Audit to be presented next meeting	PMH and 18-20 are not being added to CLC because outside of local guidance. Signal has been down, resulting in inability to access data. Audit into evidence file, results showed 29/30 were appropriately referred. SOP for April	SOP for maternal medicine networks/complex pregnancies to be ratified	One line to be adjusted, then for ratification
IEA4	Q26	Complex pregnancies have early specialist involvement and management plans agreed			1	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	LF- March 2022		100% of notes identified as intermediate or high risk is reviewed. Audit to be presented next month (JH)	100% of notes identified as intermediate or high risk are reviewed. Audit of women attending ANC (diabetic etc) to be presented next meeting . DS updating AN appts guideline with SOP. JH to undertake reptrospective audit, update at next meeting	02/03 Update - following advisement from national team, to declare complaicne with this element as the organisation has done all it can to be compliant. Awaiting national formation of MMN		
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	1			evidence of Co monitoring at 36/40. audits and action planning	DS and JH - Feb 2022						CO monitoring audits underway. Action plan required. Compliance is over 80% but as under 95% action plan required
IEA4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.		1		SOP that states women with complex pregnancies must have a named consultant lead.	JH to undertake audit for compliance - March 2022		Audit to be presented next month	DS updating AN guideline, to add in.	PMH and 18-20 are not being added to CLC because outside of local guidance. Signal has been down, resulting in inability to access data. Audit into evidence file, results showed 29/30 were appropriately referred. SOP for April	SOP for maternal medicine networks/complex pregnancies to be ratified	
IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres			1	Agreed pathways. Criteria for referrals to MMC. The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	LF - April 2022		LF, MMN named consultant, updated the group that a pathway has been developed and will be published once finally agreed. Working group progressing at pace. SOP to be developed	02/03 Update - following advisement from national team, to declare complaicne with this element as the organisation has done all it can to be compliant. Awaiting national formation of MMN	02/03 Update - following advisement from national team, to declare complaicne with this element as the organisation has done all it can to be compliant. Awaiting national formation of MMN		
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional		1		Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. SOP that includes definition of antenatal risk assessment as per NICE guidance.	DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed.	This action is compliant. Audits ongoing	Audits show areas for improvement particularly the second risk assessment	
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.		1		Evidence of referral to birth options clinics. Out with guidance pathway.Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed. Audits ongoing, for escalation via PCQS	Birth Options clinic not in place however de=brief service is available. VBAC clinics running York and to be developed in Scarb by May 2022	Audits show areas for improvement; see action plan	
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.		1		Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	JH and DS -March 2022		>90% notes are reviewed every month to ensure compliance with care planning. Monthly audit is escalated via PCQS from January 2022. SOP to be developed by JH and DS	SOP developed. Audits ongoing, for escalation via PCQS	JH contacted to put evidence into files of audit and any action planning. Some concerns that disucssions that take place are not well documented as notes not conducive to this. JH to send out to all to request plans are discussed upon admission and documented	Audits show areas for improvement; see action plan	
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring		1		Copies of rotas / off duties to demonstrate they are given dedicated time. Incident investigations and reviews	JF to send to ML JD and job plan for medical leads - February 2022		Awaiting job plans to evidence this action. JF to update next meeting	no update today	Awaiting to appoint an Obstetric fetal monitoring lead at Scarborough. BA working with SG around being involved in training sessions, to update April	Claire Jordan now in post at SGH	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health		1		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision. Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	BA and JF - March 2022		Evidence required around clinical supervision and Medical staffing JD. To progress and update next month	Obstetric leads need to be involved in training. BA to identify lead at SGH and to support York to include in training - to liaise with RMc	Awaiting to appoint an Obstetric fetal monitoring lead at Scarborugh. BA working with SG around being involved in training sessions, to update April		
IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	1			evidence of Co monitoring at 36/40. audits and action planning	(as above)ML - audits to chase and paper requested						
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?		1		A clear trajectory in place to meet and maintain compliance as articulated in the TNA.Attendance records - summarised	Q&G team - March 2022 (attendance records will need anonymising). Training highlight report to clinical governance		TNA in place for 3 years. Training data is collected monthly and escaalted via the PCQS. Trajectories in progress, for update at next meeting	as above	as above		
IEA7	Q39	Trusts 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	1			Website requires updating	ML to support JH to work with MVP once fully in post - March 2022						

IEA7	Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care															
IEA7	Q41	Women must be enabled to participate equally in all decision-making processes			1	An audit of 1% of notes demonstrating compliance.CQC survey and associated action plans. SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	SCH to support action planning between matron (DS) and obstetrician (JF) - March 2022 (see below)		Discussed at length as challenges around identifying complex women via the system. JH will undertake a baseline audit and present next month	Audit underway - JH working with MB to support information gathering	Risk identified with compliance with this element. CQC survey received, requires action planning. SOP to include offering choice of birth and how we talk about this with women and where they can find addiotonal information, confirmation of birth plans upon admission. SOP for next meeting	SOP on DS list to do					
IEA7	Q42	Women's choices following a shared and informed decision-making process must be respected			1	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	SCH to look at CQC survey with matrons and support action planning between matron (DS) and obstetrician (JF). Audit and SOP to include 41 and 42 - April 2022		Discussed at length as challenges around identifying complex women via the system. JH will work with MB to try and obtain these specific notes and undertake a baseline audit and present next month. Action planning to include liaising with LW leads around highlighting women to review	Audit underway - JH working with MB to support information gathering and will develop a SOP	Audit in progress, notes reviewed from April 2021, approx 200 will be reviewed (120 so far) - for completion and into evidence file April	Look to LMS and MVP to support with this					
IEA7	Q43	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?	1										3 MVP groups across geography.				
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.		1		Co-produced action plan to address gaps identified. Gap analysis of website against Chelsea & Westminster conducted by the MVP	JH May 2022		Website requires significant update, JH liaising with comms. Agreement required aournd the publication of all guidance	JH has met with comms team to update website, new member of staff to support from April. Benchamrking ongoing against C&W hospital. Review of guidelines to be linked on. Different formats, links. 02/03 update to compliant upon advisement from national team as we are working on it	no further update today - JH working with comms to update website						
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard		1		Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	BA - March 2022		Paper under development, BA to update at next meeting	BA to meet with ML to progress this for next month	Meeting in 16/03 to do this. No update today	Increased establishment of obstetricians in line with recommendations, working to recruit to this. Confirmation required of neonatal workforce plans	No update today				
WF	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	1			Workforce paper underway. CoC paper to Board in January	SCH - January 2022		workforce paper to Exec committee, Board and LMS January 2022		No update today						
WF	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	1										Head of Midwifery professionally accountable to Chief Nurse but reports to Associate Chief Nurse within the Care Group. Head of Midwifery is not part of the Senior Nurse Management team in the Trust, this is the ACN				
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:			1	Action plan where manifesto is not met. Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	SCH - March 2022		GAP analysis completed and presented to exec committee and Board January 2022. Action planning involves the production of a business case	No further update	HoM to work up business case over the next few months - risks around staffing vacancy						
WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.			1	Audit to demonstrate all guidelines are in date.Evidence of risk assessment where guidance is not implemented. SOP in place for all guidelines with a demonstrable process for ongoing review.	Q&G team - March 2022		NICE baseline assessments and guidance monitored by Q& G team and escalated via clinical governance. For update at next meeting	No further update	Regular meetings - to be evidenced in file		Trust and Care Group process in place, confirmed by Simon Hearn. One baseline assessment to complete.				


Immediate and Essential Action 1: Enhanced Safety
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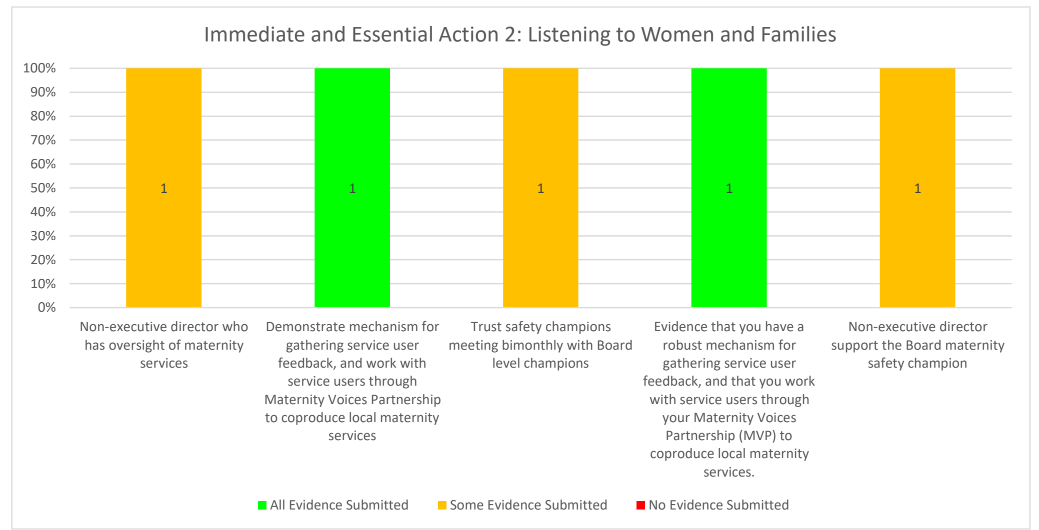
Maternity Dashboard to LMS every 3 months
External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death
Maternity SI's to Trust Board & LMS every 3 months
Using the National Perinatal Mortality Review Tool to review perinatal deaths
Submitting data to the Maternity Services Dataset to the required standard
Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme
Plan to implement the Perinatal Clinical Quality Surveillance Model
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 2: Listening to Women and Families
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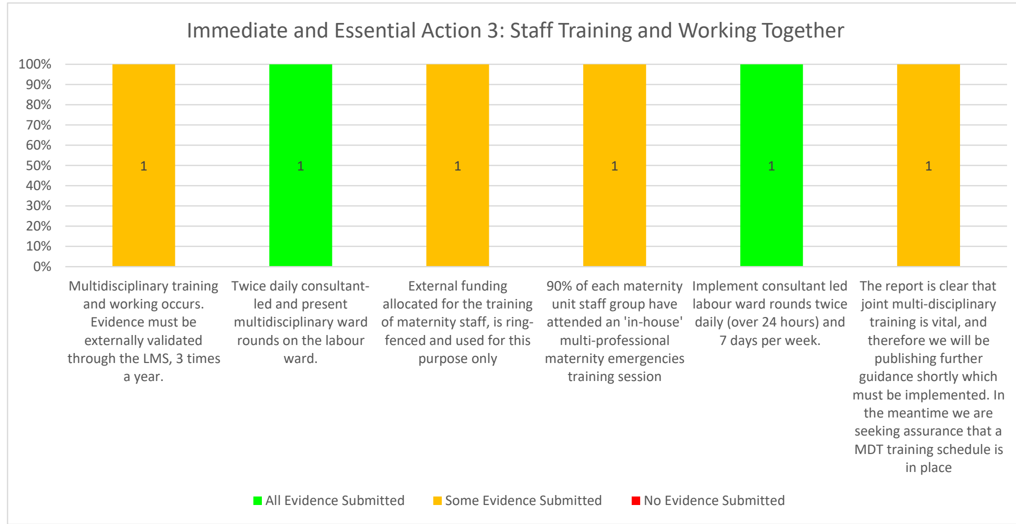
Non-executive director who has oversight of maternity services
Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services
Trust safety champions meeting bimonthly with Board level champions
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
Non-executive director support the Board maternity safety champion
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 3: Staff Training and Working Together
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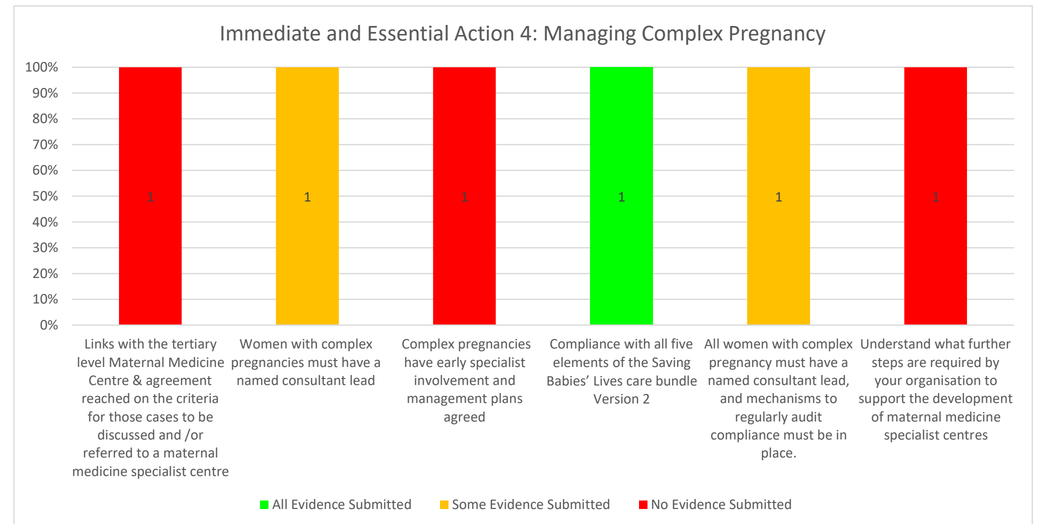
Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.
Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.
External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only
90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 4: Managing Complex Pregnancy
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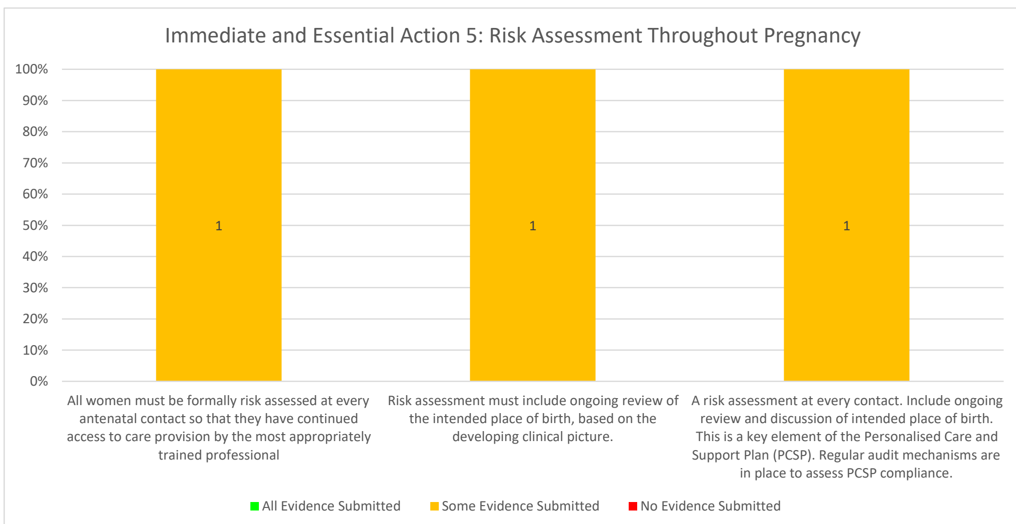
Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre
Women with complex pregnancies must have a named consultant lead
Complex pregnancies have early specialist involvement and management plans agreed
Compliance with all five elements of the Saving Babies' Lives care bundle Version 2
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy
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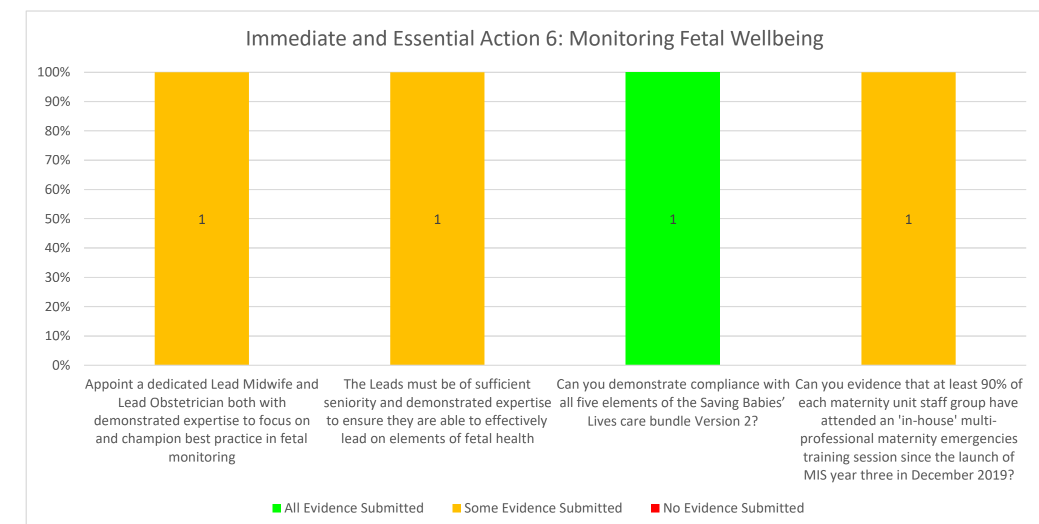
All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential Action 6: Monitoring Fetal Wellbeing
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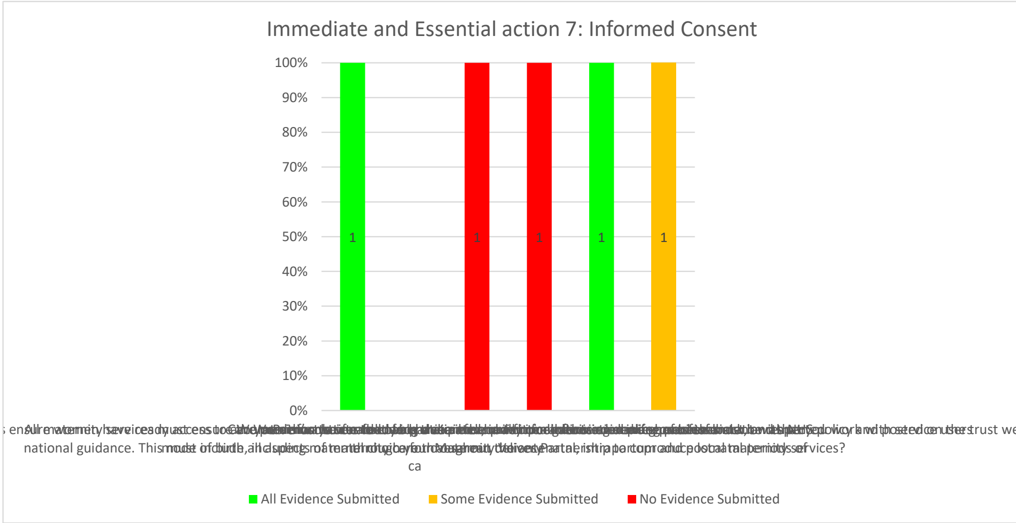
Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Immediate and Essential action 7: Informed Consent
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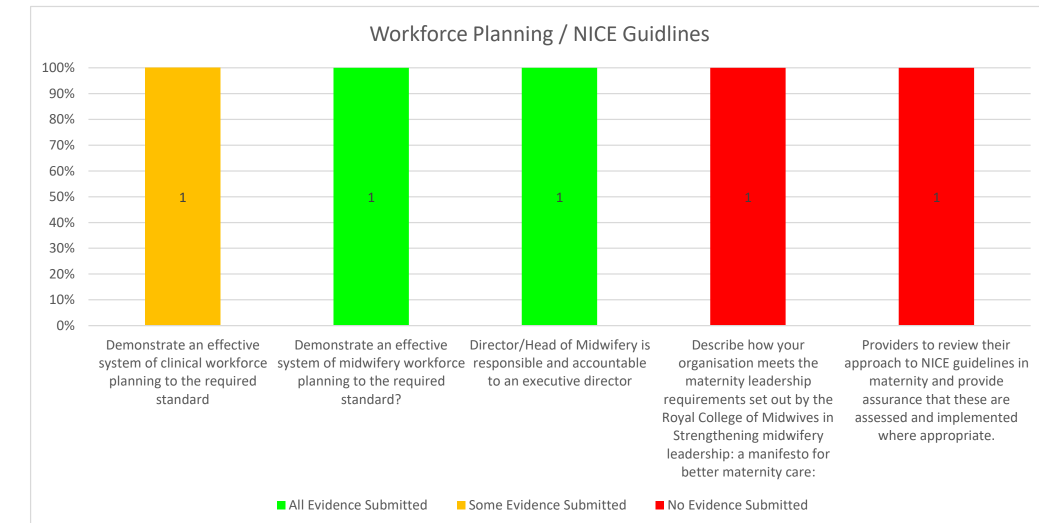
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted


Workforce Planning / NICE Guidlines
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1
Demonstrate an effective system of clinical workforce planning to the required standard
Demonstrate an effective system of midwifery workforce planning to the required standard?
Director/Head of Midwifery is responsible and accountable to an executive director
Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:
Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.
All Evidence Submitted
Some Evidence Submitted
No Evidence Submitted

Reuslts of Phase 2 Audit **York and Scarborough Teaching Hospitals NHS Foundation Trust**

IEA	Question	Action	Evidence Required	York and Scarborough Teaching Hospitals NHS Foundation Trust
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%
			Submission of minutes and organogram, that shows how this takes place.	0%
		Maternity Dashboard to LMS every 3 months Total		75%
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		50%
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%
			Submit SOP	100%
		Maternity SI's to Trust Board & LMS every 3 months Total		100%
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		100%
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%
		Submitting data to the Maternity Services Dataset to the required standard Total		100%
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		100%
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	0%
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	0%
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		33%
IEA1 Total				75%
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	0%
			Evidence of link in to MVP; any other mechanisms	100%
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%
			Name of NED and date of appointment	100%
			NED JD	0%
		Non-executive director who has oversight of maternity services Total		67%
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		100%
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%
			Log of attendees and core membership.	100%
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	0%
		Trust safety champions meeting bimonthly with Board level champions Total		75%
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		100%
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%
			Name of ED and date of appointment	100%
			Role descriptors	0%
		Non-executive director support the Board maternity safety champion Total		67%
IEA2 Total				76%

Section	Question	Requirement	Evidence	Score
IEA3				
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		60%
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%
			SOP created for consultant led ward rounds.	100%
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		100%
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%
			Evidence from Budget statements.	0%
			Evidence of funding received and spent.	100%
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	0%
			MTP spend reports to LMS	0%
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		20%
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			Attendance records - summarised	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		33%
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		100%
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		50%
IEA3 Total				50%
IEA4				
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	0%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	0%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		0%
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	0%
		Women with complex pregnancies must have a named consultant lead Total		50%
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	0%
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	0%
		Complex pregnancies have early specialist involvement and management plans agreed Total		0%
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		100%
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	0%
			Submission of an audit plan to regularly audit compliance	100%
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		50%

Section	Question	Standard	Evidence	Score
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	0%
			Criteria for referrals to MMC	0%
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	0%
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		0%
IEA4 Total				36%
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	0%
			What is being risk assessed.	100%
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		60%
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	0%
			Out with guidance pathway.	0%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	0%
			SOP that includes review of intended place of birth.	100%
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		25%
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%
			How this is achieved in the organisation	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	0%
			Review and discussed and documented intended place of birth at every visit.	100%
			SOP to describe risk assessment being undertaken at every contact.	100%
			What is being risk assessed.	100%
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		83%
IEA5 Total				60%
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	0%
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%
			Incident investigations and reviews	0%
			Name of dedicated Lead Midwife and Lead Obstetrician	100%
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		50%
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	0%
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	0%
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%
			Keeping abreast of developments in the field	100%
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	0%
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		63%
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%
			Guidelines with evidence for each pathway	100%
			SOP's	100%
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		100%
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%
			Attendance records - summarised	0%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		33%

Section	Question	Requirement	Evidence	Score
IEA6 Total				61%
IEA7	**Q39**	Trusts 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	Information on maternal choice including choice for caesarean delivery.	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Trusts 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 Total		100%
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	0%
			CQC survey and associated action plans	0%
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	0%
		Women must be enabled to participate equally in all decision-making processes Total		0%
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	0%
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	0%
		Women's choices following a shared and informed decision-making process must be respected Total		0%
	Q43	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?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%
		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? Total		100%
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	0%
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	0%
			Information on maternal choice including choice for caesarean delivery.	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		50%
IEA7 Total				50%
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	0%
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%
			Most recent BR+ report and board minutes agreeing to fund.	100%
		Demonstrate an effective system of clinical workforce planning to the required standard Total		67%
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		100%
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%
		Director/Head of Midwifery is responsible and accountable to an executive director Total		100%
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	0%
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	0%
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		0%
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	0%
			Evidence of risk assessment where guidance is not implemented.	0%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	0%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		0%
WF Total				40%

Ockenden Report - Final: Action plan Published 30 March 2022

1. Workforce planning and sustainability

Action	Action points	initial review Sara Collier-Hield 10 May 2022	
Essential action – financing a safe maternity workforce. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe matenirty and neonatal care across England.	Needs national and regional support	
	minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirments.	The Trust have used birthrate plus as a guide. If this is to be superseded, or a different national agreement reached the Trust could then benchmark again. Staffing levels are not currently agreed with the LMNS but they are cited on the midwifery workforce paper. Work in neonatal workforce planning is ongoing	
	Minmum staffing levels must include a locally calculated uplift, representative of the three previous years data for all absences including sickness, mandatory training, annual leave and maternity leave.	Would require work to understand three year data. Current uplift not based on this.	
	The feasibility and accuracy of the birthrate plus tool and associated methodology must be reviuewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	National action required	
Essential action - training We state that the Health and Social Care select committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	All trusts must implement a robust preceptorship programme for newly qualifed midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	A preceptorship programme is in place but could be strengthened and will be helped by the support gained by the new recruitment and retention midwives	
	All NQMs must remain within the hospital setting for a munimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	This will be reasonably implement from a practical point of view. Given the learning and feedback from local experience of putting Band 5 midwives in teams we will aim to implement this as soon as possible	
	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, leanring through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Will plan to support once module is available	
	All trusts to ensure newly appointed labour ward coordinators receive an orienation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Needs developing	
	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift 24/7.	This is an action to start. We link with the regional MEACC group and work but have not developed staff yet. Reduced courses available during Covid.	
	All trusts must develop a strategy to support a succession planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those help by specialist midwives and obstetric consultants. This must include supportive organisational processess and relevant practical work experience.	A succession planning programme needs developing. Gaps in	
	The review team acknowledges the progress around the creation of maternal medicine networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	All action that can be taken at local level so far has been done. Regional maternal medicine centre in development.	

2. Safe Staffing

Action	Action points	Inital review	
	When agreed staffing levels across maternity services are not achieved on a day to day basis this should be escalated to the services senior management team, obstetric leads, chief nurse, medical director and patient safety champion and LMS. • In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Monday to Friday office hours escalation is to senior management team. Out of hours Trust on call to support. Regional daily sitrep re staffing completed daily Monday to Friday. No regional or LMS escalation in place so work required to achieve this standard.	

Action	Action points	initial review	
All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Work to be started	
	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Complete. JD & PS updated Novemeber 2021	
	All trusts must review and suspend if necessary the existing provision and further roll out of midwifery continuity of carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all staff. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Done April 2022 and pause in place.	
	The reinstatement of MCoC should be withheld until robust evidence is avilable to support its reintroduction.	Plan to recruit a continuity lead midwife to look at plans again and put the building blocks in place before teams could be re-introduced	
	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirments change.	To work through	
	All trusts must ensure there are visible supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Clincal skills midwives in post. Ambition in midwifery workforce plan would be to increase the hours	
	Newly appointed band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	To work through but feels like this is achievable	
	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Links between community and hospital are in place, including the staffing hudles. Would need to evaluate what issues staff identify in hospital and community bi-directional communication first before action could be taken	
	All trusts should follow the latest RCOG guidance on management of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on management of locums. This included support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Needs works to achieve	
3. Escalation and Accountability			
Action	**Action points**	**initial review**	
Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obsetetrician should attend.	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical conerns regarding a woman's care in case of disagreement between healthcare professionals.	Would need to develop a policy.	
	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	We follow RCOG entrustability guidance	
	Trusts should aim to increase resident consultant obsterician presence where this is achievable.	Done to match findings following review of obstetric staffing linked to first Ockenden report	
	There must be clear local guidelines for when consultant obstetricians attendance is mandatory within the unit.	Completed	
	there must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on call should be informed of activity within the unit.	Escalation policy updated Nov 2021 outlines this. No midwife manager on call 24/7 - Trust on-call manager used out of hours.	
4. Clinical Governance-Leadership			
Action	**Action points**	**initial review**	

Trust boards must have oversight of the quality and performanace of their maternity services. In all maternity services the director of midwifery and clinical director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regulary review progress of any maternity improvement and transformation plans.	Some mechanisms in place to support some of this: papers via QPAS aand Quality Committee and Safety Champions meetings. Improvement and transformation moving forward could have more oversight	
	All maternity service senior leadership team must use appreciative inquiry to complete the national maternity self assessment tool if not previously done. A comprehensive report of their self assessment including governance structures and any remedial plans must be shared with their trust board.	Self assessment tool completed Decemebr 2021. Areas of red and amber still to progress.	
	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Would need a post developing	
	All clinicians with responsibility for maternity must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Obstetricians have adequate time in job plans as recently reviewed by clinical director. Some midwifery managers work 80:20 clinical:management and the ambition would be to increase thenm to 60:40 management:clinical	
	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagment.	Would need work	
	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guidline agenda and have links with audit and research.	Would need work - not currently how guidelines are managed/developed.	
	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Not in place	

5. Clinical Governance - incident investigation and complaints

Action	Action points	initial review	
Oncident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely mannor.	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	We achieve this	
	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	PROMPT scenarios are based on themes from datix and SI's in previous year.	
	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Embedding this action currently	
	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred,	Needs monitoring	
	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	May need to develop a SOP here to ensure such an incident was not missed	
	All maternity serives must involve servuce users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Not in place	
	Complaints themes and trends must be monitored by the maternity governance team.	Not in place	

6. Learning from maternal Deaths

Actions	Action points	initial review	
Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiologies and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	NHS England and Improvement must work together with the Royal colleges and the chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	Await national steer	
	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Await national steer	
	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Await national steer	

7. Multidisciplinary training			
Action	**Action points**	**initial review**	
Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labopur ward without appropriate regular CTG training and emergency skills training.	All members of the multidisciplinary team working within maternity should attend regular joint training governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Terms of Reference in place for Clinical Governance meetings, could provide evidence of MDT attendance	
	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Embed in PROMPT training	
	All trusts must mandate annual human factor training for all staff working in a maternity setting, this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are anabled to escalate clinical concerns. the content of human factor training must be agreed with the LMS.	In PROMPT training	
	There must be regular multidisciplinary skills drills and on site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardica arrest and the deteriorating patient.	All covered in PROMPT training. Live skills drills reduced since Covid, need to increase frequency.	
	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to cistently deliver kind and compassionate care.	Need to improve. Some things in place including psychology support and professional midwifery advocates.	
	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Training in place, compliance to improve	
	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Training offer in place. Need to develop some assurance to confirm we meet this standard	
8. Complex antenatal care			
Action	**Action points**	**Initial Review**	
Local Maternity systems, maternal medicines networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guideance. Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hyperension must have access to preconception care with a specialist familiar in managing that disorder and who understand the impact that pregnancy may have.	No pre-conceptual care provided in maternity services	
	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Named obstetrician and midwife link on both sites	
	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Trust guidance aligns with NICE guidance	
	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Confident, would need audit to confirm	
	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	No specialist clinc but guidance ensures they have early consultant review. Aspirin is prescribed via GP	
9. Preterm birth			
Action	**Action points**	**initial review**	
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS saving babies lives version 2 (2019)	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when presnancies are at the thresholds of viability.	Pre term birth clinic now in place	
	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Via pre term birth clinic	
	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Needs developing	
	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Off pathway births reported and audit tool completed.	

10. Labour and birth			
Action	**Action points**	**initial review**	
Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obsteric units.	• All women must undergo a full clinical assessment when presenting in early or established labout. This must include a review of any risk factors and consideration of wheather any complicating factors have arisen which might change recommendations about place of birth. these must be shared with women to enable an informed decision re place of birth to be made.	Patient records facilitate this' would need an audit to confirm if this is happening 100% of the time.	
	• Midwifery-led units must complete yearly operational risk assessments.	Not applicable in our Trust	
	• Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Not applicable in our Trust	
	• It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Not in place would need to develop information package with YAS	
	• Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Guideline needs review	
	• Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi professional review of CTGs.	In place on York site, ordered for Scarborough to fit with new monitors as the previous system now expired	
11. Obstetric Anaesthesia			
Action	**Action points**	**initial review**	
In addition to routine inpatient obstetric anaesthesia follow up a pathway for outpatient postnatal anaesthetic follow up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthestists must improve. the detemination of core datasets that must be recorded during every obstetric anaesthetic intervention would results in record keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia muct be highlighted and updated guidanace for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	• Conditions that merit further follow-up include but are not limited to postdural puncture headache, accidental awareness during general anaesthesia intraperative pain and the need for conversion to general anaesthesia during obstetric intervention, neurological injury relating to anaesthetic interventation and significant failure of labour analesia.	Needs development, no postnatal outpatient anaesthetic clinic or pathways	
	• Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Needs development, no postnatal outpatient anaesthetic clinic or pathways	
	• All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC.	Needs review	
	• Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	Needs review	
	Obstetric anaesthesia staffing guidance to include:		
	• The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Needs review	
	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Needs review	
	• The competency required for consultant staff who cover obstetric services out-ofhours, but who have no regular obstetric commitments.	Needs review	
	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	The difficulties in achieving this have been escalated via QPAS and Quality Committee. Contiues to be worked on	
12. Postnatal care			
Action	**Action points**	**Initial review**	

Action	Action points	initial review	
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times.	• All trusts must develop a system to ensure consultant review of all postnatal readmission and unwell postnatal women, including those requiring care on a nonmaternity ward.	Clinical Director is confident this happens but would need an audit to support	
	• Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Would need an audit to confirm but clinical director believes this is in place	
	• Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Achieved as women admitted to either triage or labour ward, not ED.	
	• Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Birthrate plus acuity tool in place to monitor this. Further conversation needed with Birthrate plus to understand the scoring better. If a negative score, escalated to labour ward and co-ordinator to make staffing plan to mitigate deficit.	
13. Bereavement care			
Action	**Action points**	**initial review**	
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	• Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be avilable daily, not just Monday to Friday.	Limited availability of specialist advice out of hours. Pathways in place to guide staff caring for women and training in place to support	
	• All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	In place, may need audit. Training sessions 1 -2 times a year to keep numbers of trained staff up.	
	• All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	In place	
	• Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	We were a pilot site for the National Bereavement Care Pathway. Some ambitions still to achieve; rainbow clinic, new bereavemnet suite for York site and continuity of carer	
14. Neonatal care			
Action	**Action points**	**initial review**	
There must be clare pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal critical care review)december 2019) to expand neonatal critical care, increase nornatal cot numbers, develop the workforce and enhance the experience of families. this work must now progress at pace.	• Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Review of unit designation being undertaken by region	
	• Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Reporting in place. Goes to LMNS, need to confirm how commissioner sees this.	
	Maternal and neonatal systems must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU	Needs work at LMNS level	
	• Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	To do	
	• Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	To do	
	• Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Needs review	

	• Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		
	• Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Neonatal workforce review underway	
15. Supporting families			
Action	**Action points**	**initial review**	
Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.	• There must be robust mechanisms for the indentification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	PMH midwife in place, ambition to achieve more hours. TEWV hav an acute perinantal mental health service. The Maternal Mental Health Service is in development and will initially focus on psychological support for women following pregnancy loss.	
	• Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Perinatal Psychiatrist as part of the TEWV service	

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NHS

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
Care Quality Commission (CQC) Update

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

The purpose of this report is to provide the Trust Board of Directors with an updated position of communication between the Trust and the Care Quality Commission (CQC), as well as action plan progress for regulatory requirements and outlining next steps in achieving excellence.

Executive Summary – Key Points

On Wednesday 30th March 2022, the CQC arrived at York Hospital to undertake an unannounced focussed inspection. The inspection focussed on Medical wards and the fundamental basics of care delivery. The inspection lasted 1.5 days, spanning across wards 25, 26, 28, 29, 32, 34, & 36. The draft report is currently going through the factual accuracy process and is likely to be published within the next 8 weeks. It is likely that a full inspection will follow in the next 6 months, which could include a well-led review. An interim action plan has been developed, outlining the Trust's short, medium, and longer terms plans to address the issues identified within the inspection. This will feature through a fortnightly operational delivery group and a monthly strategic oversight group.

Two actions are behind delivery-ongoing; one of which will be addressed through the Quality Strategy when launched in the next 2 months. The second of the 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.

The release of the CQC Insight report (Appendix A), scheduled for the end of March 2022 was delayed. This was received in early April and has now been summarised below.

Classification of Indicators	Number of Indicators – May 2021	Number of Indicators – July 2021	Number of Indicators – September 2021	Number of Indicators – January 2022	Number of Indicators – March 2022
Much Worse	5	6	8	7	9
Worse	25	23	24	27	25
About the Same	174	175	179	167	175
Better	7	5	5	6	2
Much Better	2	3	2	2	2

Table 1: CQC Insights Metrics

Responsive and caring deep dives within the Care Groups were presented to Quality & Regulations Group in April 2022. This concludes the initial baseline self-assessments across the key lines of enquiry for all specialities. The tables below outline the aggregated ratings.

Aggregated Ratings					
Area	**Safe**	**Effective**	**Responsive**	**Caring**	**Well-led**
York – Urgent & Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Scarborough – Urgent & Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Community Services (Adult)	Good	Good	Good	Good	Good
End of Life Care	Good	Good	Good	Good	Good
York – Medical Care (Including Care of the Elderly)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good
Scarborough – Medical Care (Including Care of the Elderly)	Good	Good	Requires Improvement	Good	Good
Critical Care	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good
Cancer and Support Services – Medical	Good	Good	Good	Good	Requires Improvement
Cancer and Support Services – Diagnostics	Good	Requires Improvement	Good	Good	Good
Gynaecology	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Requires Improvement
Maternity Services	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Paediatrics (Including Neonates)	Requires Improvement	Good	Good	Good	Requires Improvement
Sexual Health	Good	Good	Good	Good	Good
Outpatients	Good		Good	Good	Good

Table 2: Approximated ratings based on self-assessments

Recommendations

- Recognise the initial feedback and response in relation to the unannounced inspection from March 2022.
- Accept this report as an updated position for the Trust in relation to CQC action plans.
- Recognise the key regulatory risks identified within the report.

Author: Shaun McKenna – Head of Compliance & Effectiveness

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

Date: 18-05-2021

1. Inspection Activity

1.1. Unannounced Inspection

On Wednesday 30th March 2022, the CQC arrived at York Hospital to undertake an unannounced focussed inspection. The inspection focussed on Medical wards and the fundamental basics of care delivery. The inspection lasted 1.5 days, spanning across wards 25, 26, 28, 29, 32, 34, & 36. The initial feedback highlighted the following:

- Positive interactions with staff and patients were noted.
- Staff did not always have time to spend with patients to meet their needs.
- Wards did not have their planned staffing levels in relation to nursing workforce.
- Staff were distressed at their inability to deliver fundamental standards of care in a timely way.
- Staff felt undervalued and not listened to; they felt there was a lack of visibility from the senior leadership team.
- Staff were not appropriately or consistently assessing and managing risk to service users for nutrition & hydration, pressure areas, falls & mental capacity.

The draft report is currently going through the factual accuracy process and is likely to be published within the next 8 weeks. It is likely that a full inspection will follow in the next 6 months, which could include a well-led review.

1.2. Response

The Trust was required to submit an immediate response to the CQC, outlining any immediate safety measures and mitigations. The seven inspected wards had a baseline audit undertaken by the Corporate Nursing Team, Patient Safety Team and Care Group Teams to assess their position in relation to fundamentals of care. The findings demonstrated a lack of risk assessment and action in response to findings, with the main causation being less staff than required / planned. This information was used to drive additional resource into areas of concern to enhance the safety of patients at the earliest opportunity. Following the audit, a debrief was held with the Chief Nurse Team and a decision was made to close 5 beds on Ward 28 due to the level of risk identified on the ward. On Monday 4th April 2022, AHP workforce was utilised to complete outstanding risk assessments on the seven identified wards. In addition a baseline assessment was undertaken for the remainder of the Trust inpatient bed base. Again, these results were used to drive resource towards areas identified as ‘at risk’.

Daily staffing meetings have been revised by the Chief Nurse Team to ensure more robust documentation and escalation takes place. The escalations must have a documented response which may include the redeployment of staff, services being steeped down, or bed closures. The deployment of volunteers and those who are

able to support over meal time periods will be deployed based upon the escalations from Matrons.

An interim action plan has been developed, outlining the Trust's short, medium, and longer terms plans to address the issues identified within the inspection. This will feature through a fortnightly operational delivery group and a monthly strategic oversight group.

2. Regulatory Action Plan Update

2.1. Outstanding Actions

- PEM Consultant

The recruitment of a Paediatric Emergency Medicine Consultant for Scarborough Hospital has been overdue since November 2020. 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 Deputy Medical Director is progressing conversations with the Clinical Director for York Emergency Department to identify an appropriate solution.

- Safe-Care Re-Launch

The Assistant Chief Nurse has advised that the Safer Nursing Care Tool (SNCT) audit was scheduled to be undertaken in January 2022 with training from NHSE having taken place in November 2021; this has been delayed due to operational pressures. The SNCT Lead Nurse is now in post to further drive this work-stream. The action in itself is part of several bigger requirements which are reliant upon establishment reviews, rosters, and budgets. Safe staffing and skill mix will feature in the Quality Strategy which is scheduled to be rolled out from July 2022; in addition to the overarching CQC action plan.

3. CQC Insight Report

3.1. Overview (CQC National Comparison)

The release of the CQC Insight report (Appendix A), scheduled for the end of March 2022 was delayed. This was received in early April and has now been summarised below.

Classification of Indicators	Number of Indicators – May 2021	Number of Indicators – July 2021	Number of Indicators – September 2021	Number of Indicators – January 2022	Number of Indicators – March 2022
Much Worse	5	6	8	7	9
Worse	25	23	24	27	25
About the Same	174	175	179	167	175

Classification of Indicators	Number of Indicators – May 2021	Number of Indicators – July 2021	Number of Indicators – September 2021	Number of Indicators – January 2022	Number of Indicators – March 2022
Better	7	5	5	6	2
Much Better	2	3	2	2	2

3.2. CQC Insight Summary

- **Whistleblowing Alerts**

Since the last update report, three whistleblowing notifications have been received. Five whistleblowing concerns remain open with the CQC. A full summary of received whistleblowing alerts can be found in Appendix B.

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

The data used for this metric was accurate as of February 2022 and demonstrate a decrease in performance from 70.8% in February 2021 to 48.7% in February 2022, compared to the national average of 60.9 % and an overall aim of 95%.

- **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 February 2022 and demonstrate a decrease in performance from 43 breaches in February 2021 to 583 in February 2022. 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 February 2022 and demonstrate a decrease in performance from 79.3% in February 2021 to 71.9% in February 2022, compared to the national average of 70.3% and the overall aim of 95%.

- **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 when the first audit report is published.

- **Risk adjusted 30 day mortality rate (National Hip Fracture Database)**

The data used for this metric was accurate as of December 2020 and demonstrates an increase in mortality from 8.5% in December 2019 to 9.8% in December 2020, compared to the national average of 8.3%. The #NOF improvement group are aware of the information and are considering this within their improvement plan.

- **Crude proportion of patients aged 80 and over OR aged 65+ and frail who were assessed by a geriatrician. (York Hospital)**

The national average for this metric is 28.4%, with York Hospital compliance at 19.4%. This data is from the time period of December 2018 – November 2019.

- **Crude proportion of patients aged 80 and over OR aged 65+ and frail who were assessed by a geriatrician. (York Hospital)**

The national average for this metric is 28.4%, with Scarborough Hospital compliance at 13.6%. This data is from the time period of December 2018 – November 2019.

4. CQC Benchmarking Self-Assessments

4.1. Update Report

Responsive and caring deep dives within the Care Groups were presented to Quality & Regulations Group in April 2022. This concludes the initial baseline self-assessments across the key lines of enquiry for all specialities. The tables below outline the aggregated ratings.

Aggregated Ratings					
Area	**Safe**	**Effective**	**Responsive**	**Caring**	**Well-led**
York – Urgent & Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Scarborough – Urgent & Emergency Care	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Community Services (Adult)	Good	Good	Good	Good	Good
End of Life Care	Good	Good	Good	Good	Good
York – Medical Care (Including Care of the Elderly)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good
Scarborough – Medical Care (Including Care of the Elderly)	Good	Good	Requires Improvement	Good	Good
Critical Care	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good
Cancer and Support Services – Medical	Good	Good	Good	Good	Requires Improvement
Cancer and Support Services – Diagnostics	Good	Requires Improvement	Good	Good	Good
Gynaecology	Requires Improvement	Requires Improvement	Inadequate	Inadequate	Requires Improvement

Aggregated Ratings					
Area	**Safe**	**Effective**	**Responsive**	**Caring**	**Well-led**
Maternity Services	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Paediatrics (Including Neonates)	Requires Improvement	Good	Good	Good	Requires Improvement
Sexual Health	Good	Good	Good	Good	Good
Outpatients	Good		Good	Good	Good

Table 1: Aggregated Ratings (Majority percentage)

Executive Committee approved the commissioning of 'InPhase Oversight' quality module for the next 12 months. This will enable all self-assessment information and evidence to be in one singular location, with oversight dashboards for use at any relevant meeting. Actions in relation to the self-assessments will be captured in the module. The anticipated roll out date for the platform is June 2022 with a review schedule for further self-assessment activity.

5. Key Risks

S1. How do systems, processes and practices keep people safe and safeguarded from abuse?

Given the Trust outlier status with Infection, Prevention & Control, the risk of non-compliance with regulatory requirements are high. Assurance is provided through the IPC assurance reports on a monthly basis.

S2. How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

Staffing establishment reviews should be undertaken every 6-12 months across Acute Hospitals. The last establishment reviews resulted in partial investment, but now to the required amount. Actual staffing levels are often less than planned staffing levels which place the Trust at high risk of regulatory action. Assurance and requirements are provided through the monthly nurse staffing report.

S3. Do staff have all the information they need to deliver safe care and treatment to people?

Risk assessment and management for service users are not consistently completed. In addition care records are not consistently completed in a contemporaneous. The Digital Documentation work-stream should be prioritised to enable staff to undertake the required risk assessments and documentation in a timely and legible way.

E1. Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?

Nutrition and hydration needs are not consistently identified, monitored and met. In addition access to dietary and nutritional specialists is not always available within the required timescales due to staffing constraints. There have been serious incidents in relation to nutrition and hydration and this continues to be a risk for regulatory action.

The Nutrition Steering Group provides a monthly update to QPAS in relation to the ongoing improvement plan. It has been proposed that the monthly report is provided to Quality Committee for continued assurance.

E3. How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?
Staff training to meet their learning needs in relation to their scope of work is not consistently delivered within required timescales. Oversight of training compliance, with the exception of statutory & mandatory training, is lacking. This creates a risk of regulatory action. Further assurance is required around this prompt, including the identification of training needs, how this is delivered, and competency records. This will be included in the CQC action plan.

E6. Is consent to care and treatment always sought in line with legislation and guidance?
Mental capacity assessments are not consistently undertaken for all service users who require them. Subsequently best interest decisions are not always documented in line with national requirements. The Safeguarding Team will generate a programme of ward visibility to support with requirements surrounding Mental Capacity and Best Interests Decision Making. Assurance will follow through the Safeguarding reporting structure.

R2. Do services take account of the particular needs and choices of different people?
Equality Impact Assessments, known as Due Regard Assessments, are not frequently undertaken when planning or changing services. This includes the completion of Due Regard Assessments when creating policies and processes. This is being managed through the Chief Nurse Team with recruitment underway for dedicated resource.

R3. Can people access care and treatment in a timely way?
Performance within Urgent & Emergency Care including time to initial assessments and time to treatment is not in line with national expectations or Trust aspirations. In addition, elective care lists are cancelled due to staffing levels which impacts on the ability to deliver care in a timely way. Building Better Care transformation work-streams are in place to improve this key line of enquiry.

Well-Led
A formal assessment of the well-led framework is required. Executive Committee have commissioned an independent review based on national recommendations. Timescales are yet to be agreed and will be included within the CQC action plan.

- **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.

The Section 31 warning notice remains in place for York Hospital Emergency Department and Scarborough Hospital Emergency Department, both of which have been in place since January 2020. Audit results are not consistently demonstrating compliance with the Trust target of 85%. In the last 8 weeks, the risk assessment tool has been updated to better reflect operational requirements. Further work is required which will be led through the Mental Health Steering Group.

6. Recommendation(s)

- Recognise the initial feedback and response in relation to the unannounced inspection from March 2022.
- Accept this report as an updated position for the Trust in relation to CQC action plans.
- Recognise the key regulatory risks identified within the report.

Appendix B – Whistleblowing Summary – Apr 22

York and Scarborough Teaching Hospitals NHS Foundation Trust

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
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. Care Group 1 Associate Chief Operating Officer has provided a written update which has been shared with the CQC in March 2022. The response from the CQC is awaited.	Open
February 2022 ENQ1-12664158941	1	York Theatres – General concerns have been raised surrounding staffing levels, changes in management and subsequent patient safety implications. The information provided was extremely vague	Care Group 3 have generated a response to this concern, the CQC response is awaited.	Open
March 2022 ENQ1-12759957551	1	York Hospital, Ward 26 – Concerns raised from a whistle-blower about patient safety following conversion into a COVID positive ward with nine amber head and neck patient beds. "We have heard following this ward change there was a lack of staff to safely care for patients. In addition, patients were reported to be crying, calling out, wandering and absconding, falling out of bed, incontinent, in soiled clothing, not washed until late in the day, confined to bed and only the very disabled are assisted with feeding due to the lack of staff. We heard that staff do not have time for toilet or refreshment breaks."	Investigation undertaken and information provided. Formal response submitted to CQC. Subsequent unannounced inspection.	Open

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Enquiry Number & Dates	Total no. of Concerns	Concern Summary	Response	Status
April 2022 ENQ1-12865168926	1	York Community Stroke Rehab - Concerns received regarding fundamentals of care, staffing levels, and low staff morale.	Data demonstrates concerns to be founded in relation to staffing levels. Staffing decisions taken on a day to day basis factoring in risk levels across the organisation. Data submitted to CQC, further information requested. Meeting to be established with CQC to discuss concerns.	Open
April 2022 ENQ1-12994760681	1	York Hospital Ward 28 – As part of the short term actions in response to the CQC inspection, beds were reduced from 30 to 25. Over the bank holiday period the beds were increased to 32 with only two nurses which had an impact on patient safety.	Response provided to CQC. It summarises that the staffing levels reported were correct, and below the planned establishment.	Open

H1

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Minutes

Quality Assurance Committee
22 March 2022

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

/ Attendees: Sue Glendenning (SG), Shaun McKenna (SM), Ed Smith (ES), Nicola Topping (NT – observing)

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

/ 2. Declaration of Interests

There were no declarations of interest.

/ 3. Minutes of the meeting held on 15 February 2022

The minutes of the last meeting held on 15 February 2022 were agreed as a true and accurate record.

/ 4. Matters arising from the minutes

Action 135 – MT and HM to pick this up outside of the Committee and it was agreed to close this on the action log as it will be covered on a separate IPC agenda.

Action 149 – MT confirmed that the Associate Chief Operating Officers are now arranging for the LLP to be included in all Care Group Boards so that feedback is directly received in terms of facilitating work. SH asked how the Committee could monitor progress and MT agreed to discuss this with Liz Johnson-Betts. HM agreed to take on executive responsibility re providing updates on whether the LLP are being responsive around IPC needs, and agreed to include this in future IPC updates.

Action 156 – CJ said the SAFER group is being changed to full 7-day services standards and the discharge group that JT chairs will feed into this group. The Committee agreed a further update from JT in April and CJ said they would also bring a paper around this.

Action: HM to include update on LLP responsiveness around IPC needs as part of IPC report going forward

/ 5. Escalated Items

There were no items for escalation.

/ 6. IBR Overview to look at Performance

This was discussed in conjunction with the Chief Operating Officer Report.

/ 7. Chief Operating Officer Report (including Performance Update & Restoration and Recovery Update) and ED Assurance presentation

February position remains similar to December and January in terms of operational performance. Challenges continue to be around workforce absence and impact on service delivery, closure of empty beds due to the need to isolate Covid patient and Covid contacts and the rising number of Covid-positive inpatients (252 as at 22 March). Once the number of Covid cases start to reduce then it will be possible to de-escalate the Covid surge plan operational pressures will reduce. WS said there is some positive work being undertaken to support recovery in 22/23.

SH asked about the split between symptomatic and incidental Covid-positive patients and LS said c.10% of the 252 are being actively treated for Covid. There was a group discussion about managing Covid from an IPC perspective going forward. The current guidance is to test non-elective patients on admission (and at certain points during their stay) and manage positive patients in a Covid ward or side room in isolation. However clinicians are advising that there is a risk of harm as they are not receiving care from trained staff on wards in their speciality areas. WS said there is a working group currently reviewing current IPC guidelines and they hope to conclude this week re whether any changes can be made around managing Covid-positive patients, which could potentially free up beds and improve flow and long waits in ED. ES said he was a member of said working group and said the current suggestion is to test symptomatic patients only and manage vulnerable patients safely. JM asked if we are permitted to change our process. HM said that regional draft guidance has been circulated and the feeling is that Trusts are not being discouraged from interpreting guidance locally. WS said she hoped to have some positive progress by the next Committee meeting.

LS said that we remain broadly on track with our elective plan as well as our 104 week position, which must be at 0 by the end of June 2022. LS said there was a high level of confidence that we would achieve this and said we have sustained the long wait position through outsourcing, off-site work and mutual aid. The diagnostic position will become a major focus for the next financial year with reinstated targets.

LS referred to P5-30 in the Blue Box as assurance on active schemes (through Building Better Care and via care groups) to contain demand, increase capacity and improve efficiency in terms of operational performance.

There was a discussion about our diagnostic position. LS said our biggest risk is workforce and the Care Group is leading a significant piece of work around recruitment, retention and developing new roles. The hope is that the development of the community diagnostic hubs and the significant government investment in these will help to divert any diagnostics that do not need to go via the acute sector and relieve demand on acute services. This work will continue into the new financial year. Our biggest piece of work is collaborating with the entire healthcare community and patients to manage demand into diagnostic centres. SH asked if lessons learnt around staff skill mix could be applied to diagnostics and WS said there is already evidence of this within reporting radiographers. WS said Hull is establishing a radiographer school to allow us to locally train our own but it will be 3-4 years before we see the results of this.

LS discussed our plan for 22/23 and noted the significant levels of risk in this plan. We have been given a set of planning assumptions and our principles remain the same – a separation of electives as much as possible, maximising cold sites and productivity from elective perspective and trying to contain non-elective demand as much as possible. P13 of the Blue Box refers to proposed performance trajectories submitted as part of the draft plan and the only anticipated (positive) change is that we will reach 0 104 week waits by the end of June. Hull colleagues are still reporting 300+ forecast for the end of June so we will likely offer mutual support on this basis.

The waiting list is our main area of concern and we have seen a 37% increase this year. Validation is nearly complete and these are all true waiters. Whilst we are the only Trust in our patch signalling a waiting list growth, LS said this was in line with government statements on waiting lists due to unmet need in the pandemic. There will be a focus on refocusing outpatient transformation work in particular to refresh on clinical pathways and the interface with primary care and patients. We are not anticipating diagnostics to return to the national target (120% of 19/20 activity) but we will show improved levels on colonoscopy and gastroscopy as we did not have the Endoscopy unit in 19/20. SH asked about system partner recovery and WS said the national discharge funding is being discontinued at the end of March. There are ongoing conversations around whether any elements of the current funding could be funded via the ICS to maintain good practice but there is nothing conclusive as yet. This led to a group discussion about our responsibility to deliver a balanced plan but also high quality safe care. HM said there is tension about how we spend the money we have and whether it is appropriate to over-spend to deliver safe care. The Committee agreed that ability to maintain safe care should be stated as a risk to delivery of the operational plan.

SH asked to what extent the Trust plans for high levels of agency staff as opposed to reconsidering the ways in which we utilise existing staff. There was a group discussion about staffing and the financial implications of bank, agency, locums and financial incentives. The Committee noted that staff are working less by accepting incentivisation for the same amount of money, which only results in a short-term gain for the Trust – this is a cycle that needs to be broken. Agency staff are also choosing SGH over YH as a result of the nursing establishment investments on SGH site, which is unprecedented. HM said this would mean converting some bank and agency funds into base establishment funding, which has been discussed at Corporate Directors. CJ added that many incidents and whistleblowing concerns are also related to staffing pressures, which could raise CQC concerns in terms of not being able to provide a safe working environment.

LS shared a presentation on issues relating to Quality and Safety in ED and talked through the key points considering our current position against performance standards and the impact of current operational and workforce pressures on quality and safety. The 15 minute time to assessment was discussed and SM said we need further assurance on consistency of application of system and processes across both EDs.

SH asked ES about his main concerns for ED, what needs to change to rectify long stays and which factors are preventing positive change. ES said a particular concern was around unassessed and undifferentiated non-elective patients. There was a discussion about the Vocare contract at SGH as all walk in patients present at the UTC and are triaged by Vocare. Those requiring ED are streamed to ED. It is difficult to manage the time to assessment standard as Vocare provide the initial assessment service for walk in patients. ES said they are failing to fill shifts and in turn this creates a risk as they are unable to deliver a consistent and effective service. ES noted the historic cultural differences of both Trust EDs and supported a more focused approach on a more

consistent approach to delivery of services. He said that CG2 historically divided the improvement programme into three sections - people (staffing and avoiding reputational damage), processes (focus on fewer areas in more detail with an adaptive approach) and premises (space and estate). WS asked if having a ring-fenced member of staff at the front door to ensure patients are assessed (and documented) would help to improve performance against the time to initial assessment standard. ES said there was evidence of this working in SGH. ES said there are not currently consistent processes in place on both sites and the Committee agreed that this poses a significant risk to quality and safety.

ES shared three anecdotal stories about ambulance delays and said we are getting to the point where these are causing the biggest harms (as ambulances can't then be redeployed to respond to system risk) as well as delays in assessing patients (15 minute time to assessment standard) upon walk-in. ES said we need a better process within the hospital to allow ambulances to offload and provide emergency care. There was a discussion about placing a marquee outside YH as this is being considered by some EDs and WS said the resistance had always been around insufficient staffing. WS said we can potentially create a temporary space for this, if this is considered a viable option and asked ES to discuss this with Dr Gary Kitching, ED Clinical Director YH, to establish whether this could be a consistent process to improve ambulance handover delays against the 15 minute standard.

JM gave feedback that the deep dive on ED had been useful and suggested a monthly focus on one area in depth and discuss other items by exception.

Action: WS/LS to provide briefing paper on how Covid will be managed going forward

Action: WS/LS to provide quarterly update via dashboards on active schemes to contain demand, increase capacity and improve efficiency in terms of operational performance – as described in BBC Programme

Action: WS/LS to provide detailed ED assurance paper to next Committee

Action: ES to discuss standardisation of front door processes on both sites with Gary Kitching

Action: SH and MT to discuss potential deep dives on agendas going forward with other items by exception

/ 8. IBR Overview to look at Quality and Safety

There were no further points for discussion.

/ 9. Ockenden Update

Perinatal Clinical Quality Surveillance Report (incl. Ockenden and Continuity of Carer), PMRT Q3 Report & Ockenden Report Update

SG gave an overview of the reports and highlighted the following key points:

Recruitment remains an issue. The level of received continuity of carer increased in January 2022. SG said to anticipate variation in figures as our continuity teams are

working differently in order to manage the deficit in midwifery staffing across the Trust. SG and ML met with the national team to describe our challenges and the aim is not to progress further in July 2022 until core midwifery staffing has stabilised.

The CNST programme remains paused but there is continued work towards compliance.

The Ockenden action plan is in place. Prompt training figures for medical staff is improved and training trajectories suggest additional sessions will support greater compliance over the next 4 months. Face to face training is now being undertaken.

HM noted that there is not always significant month on month against the Ockenden actions but that it is a mandated requirement to provide monthly updates through to Board. HM said the national team had asked whether our midwifery team attend Board of Directors to present on Ockenden and SH asked MT and HM to discuss further.

SH asked about closure protocol and whether this is based on staffing or judgement from a senior staff member at the time. SG said it can be due to a number of things including staffing and acuity. SG gave assurance that there is a comprehensive escalation policy and decision-making lies with the two consultants on call and two delivery suite coordinators. SG said there had recently been a prolonged divert from 17-21 March due to SGH staffing issues (patients were diverted to YH) and whilst it worked relatively well with good cross-site working, there is still learning to be taken e.g. a skeleton crew at SGH could have allowed some patients to be assessed in triage prior to travel. SH asked for clarity that units cannot be closed unless there is a safer alternative for patients. HM confirmed this and added that the maternity units are very supportive of each other but that it can be a stressful environment. SG asked the Committee to note the difference between closing and diverting, and said that we mostly divert rather than close units due to having two sites.

LB asked for assurance on our PPH outlier status in the IBR as there had previously been improvement in this area. SG said this was raised often and that the governance team had previously confirmed that we are not outliers but the data suggests otherwise. SM confirmed that there is a PPH audit scheduled for April/May, which can be brought forward for assurance. SH noted concern that the initial issue was down to the wrong metrics but that we are still showing as outliers with new revised metrics.

SG highlighted bereavement as a key theme in the PMRT report and agreed that more support is needed as we currently only have a 30 hours post across both sites. Other themes included risk assessment and use of partograms, particularly in premature labour.

The Committee noted the Ockenden report update that is required to go to Board and were supportive of this.

Action: MT and HM to discuss Ockenden updates to Board by the midwifery team on a monthly basis (as raised by national team)

Action: SG to review PPH data to confirm outlier status and update at next meeting

Action: SM to bring forward PPH audit for discussion and assurance at next meeting

/ 10. Nurse Workforce Report

HM highlighted the following key points:
January figures show a significant number of wards below the 80% average RN fill rate. HM said there is significant risk at the front door but also in our inpatient wards on a daily basis. Quality indicators show a direct correlation with patient harms (falls, pressure ulcers, missed medications).

There has been positive progress with international recruits and HM said she would bring a trajectory of new starters and potential leavers (including anticipated retirements) against planned recruitment to the next Committee.

37.54% of HCAs have left last year within their first year in post, which is a significant attrition rate. Our vacancy rate has not moved significantly but sickness absence continues to be a concern.

JM noted concern that the staffing challenges are affecting our ability to provide basic care and HM agreed that this can be evidenced in complaints and PALS. Despite best efforts to move staff around, there simply are not always enough staff to provide the level of care we would aspire to provide, particularly enhanced supervision. CJ added that the harms also extend to staff and said she had met with a ward sister whose staff had been physically assaulted by patients. The Committee discussed the fact that had there been more staff available to observe and spend time with these patients, the assaults may have been avoided. HM said we should not underestimate the psychological damage staff may suffer knowing that they did not do their job to their best ability, and said it is possible this is contributing to the significant sickness levels post-Covid.

/ 11. IPC Monthly Report - February

HM highlighted the following key points:

Following the NHSE/I visit they are happy with our progress against our action plan following their report and ask that this becomes business as usual.

C.Diff numbers are still very high. There are still issues with MRSA screening (both elective and non-elective) and CG3 have been asked to investigate this, although the current pressures will likely delay this. ANTT practical compliance has improved but levels are still low. An extension of the line service provision would be beneficial.

The biggest challenge for the IPC team to work proactively is the size of the team. We have gone out to advert for a lead IPC nurse but there has been no interest. NLAG and Bradford are also advertising at a band higher but the regional team have said that this is an unattractive job and the lack of interest is not likely to be related to banding. Further work is needed to explore how we offer senior support to the team.

YH site is looking possible for a decant ward but the only option in SGH is for a modular build. JM asked if there is a financial implication for the modular build and HM said work needs to be done to establish costs but that space would not likely be an issue. JM asked for this to be kept on the Committee’s radar.

SH said our C.Diff numbers are extreme given the size of our sites and that the trajectory is hiding the depth of the issues. HM agreed. SH asked ES if there was any medical accountability around IPC given concerns around lack of engagement in PIRs. ES said this is a historical issue and there continues to be challenges around engagement but the reasons for this are not clear.

/ 12. Patient Experience Update

Patient Experience Team Quarter 3 Report

HM highlighted the following key points:

FFT responses are quite positive but the number of returns are very small numbers. However the FFT responses from ED are poor and triangulate to long waits in ED.

The Fairness Forum now has been relaunched and is chaired by Simon Morritt (CEO) so HM said she was hopeful that there would be positive progress going forward.

HM was disappointed that nursing attitude was highlighted as a complaints theme. There was a discussion about staff attitude as a longstanding cultural issue and the Committee recognised that this is a difficult forum given the current staffing pressures. LB noted concern around poor communication, particularly around patient medical conditions, deterioration and cancer diagnosis and asked for assurance that end of life care was being effectively recognised. This was further discussed under item 14.

PET Action Plan

The Committee received this for information but SH said it did not provide enough information on the outcomes of completed actions. HM said it ties into the inpatient survey results (due to Committee in April) and agreed to bring these back in relation to the survey.

Action: HM to include PET action plan with results of inpatient survey

/ 13. Medical Director Update

Serious Incidents Report

ES said overall numbers of SIs are gradually increasing but that this was to be expected in the current circumstances. Work is being done to close off some SI actions, which remain a challenge for all clinical areas. Escalation challenges continue and were discussed at the weekly Quality & Safety meeting as a Trust-wide issue rather than care group specific.

HSIB Maternity Report

This was received for supplementary information in the Blue Box and no further discussion was required.

/ 14. End of Life Care Update

HM said the report demonstrated the challenges that the sector faced, including hospices having to close beds due to staffing issues, which had a direct impact on the organisation and patient care. HM said the hospital palliative care team has worked hard but are limited to 5 days service a week. This, combined with the consultant gap, has resulted in a fragmented service and HM said we are performing at a less than gold standard.

The Committee noted that two new consultants will join the Trust in May, which will close the consultant gap. ES said that the palliative nursing team at SGH have been consistently excellent, which is a testament to having a consistent team, and added that increasing the team to 7 days is a key part of any investment.

HM addressed LB's point (see item 12) about communication in end of life care and said it is possible that we do not always recognised deteriorating patients or communicate with relatives as it depends on staffing levels and ward environment. LB said this was not just limited to cancer patients.

/ 15. QPaS Quality & Safety Update

Escalation and Assurance Report

SM noted that all QPaS escalations had already been discussed earlier in the meeting, including End of Life Care for CG1, staffing issues and long waits and potential harms in ED.

LB noted the length of alerts for Quality Assurance Committee within the escalation report and asked if these were just for information or if the Committee was expected to provide further input. SM said the alert section was intended more for information and that it was the escalations list that was more important. SM confirmed that he has worked with the care groups on a new report template to streamline the alerts and escalations and hoped to see improvement in the next two months.

QPaS Minutes – February

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

/ 16. CQC Compliance Update Report

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

There are two actions behind delivery – use of safe care for nurse staffing and the recruitment of a PEM Consultant for SGH ED. SM gave assurance on positive progress re safe care use for nurse staffing, which has been covered in the quality strategy ambitions. JT is due to meet with Gary Kitching, Gerry Robins and potentially Ed Smith to discuss the PEM requirement and how best to utilise resources across the Trust. SH expressed disappointment that the PEM Consultant action is still outstanding.

SM advised that self-assessment ratings for the "responsive" deep dive were summarised in the paper but noted that individual areas such as staffing and performance could result in inadequate ratings. SH expressed concern around End of Life care in the deep dive being marked as outstanding which can't be the case given the palliative care staffing situation. SM said the deep dive work is guided by questions within the framework, which can be subjective given it is a self-assessment. Executive Committee have approved funding for a CQC dashboard module, which will allow improved oversight for the Quality Assurance Committee.

The CQC has resumed inspections. SM said we are at increased risk of an unannounced visit due to two whistleblowing concerns noted in the report and a further two since then.

/ 17. Risk Management Update

MT gave an update on progress to date. He was working with the Executive team to provide assurances and evidence to compile into the BAF as a final year end position. The BAF was currently being reviewed by Internal Audit as part of the year-end processes feeding into the Annual Governance Statement which will follow into the annual report, and then we will consider risks for the next financial year in terms of strategy and current pressures. MT said there will be a Board session shortly to discuss this.

In terms of the CRR updated position, MT said he is working with care groups to clarify the escalation processes in place via Risk Committee but there is further work to do on this. MT noted one additional risk to bring to the Committee's attention around Reinforced Autoclaved Aerated Concrete (RAAC), which has been found at the SGH Pathology Lab. This building material has a life of 30-40 years, which we are now in excess of. This is a recognised national issue across a number of Trust sites so there are actions in place via the national team as well as a budget to tackle this.

/ 18. Integrated Business Report

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

/ 19. Quality Account 2021-2022

This report was received for assurance that we are on track for delivery. SM confirmed it is on the agenda for the Executive Committee on 06 April for approval to share with stakeholders, noting that we have aligned this year's report to our quality strategy objectives to align and avoid over-promising of actions.

/ 20. Consider other potential or new emerging risks

There were no potential or new emerging risks to discuss or consider.

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:

- COO Report - Continuing concerns over management of emergency admissions with delays at every stage and evidence of harm resulting from poor ambulance availability consequent on prolonged handover times. Imperative for sufficient staffing levels to ensure timely patient triage at all times. Access times for non-emergency care continue to cause concern

- Nurse Staffing - Insufficient levels of staffing are causing rising concerns exacerbated by current sickness levels. Vicious spiral of staffing levels

necessitating redeployments with knock-on effects on recruitment and retention all risk quality and safety of patient care

- IPC - Continued concern over outlier status with regard to high levels of HAIs. Difficulties over recruitment to senior leadership positions despite funding availability. Work in progress to improve coordination with LLP over issues involving estate

- End of Life Care - Concern over 5 day cover for service and low staffing levels in this key service

- CQC - Routine escalation to Board. No significant changes to report. To note on-going vulnerabilities including lack of appointment to PEM Consultant role in Scarborough

/ 22. Any other business

There was no further business to discuss.

/ 23. Time and Date of next meeting

The next meeting will be held on 19 April 2022 at 2pm via WebEx.

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Quality Assurance Committee
19 April 2022

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

/ Attendees: Sue Glendenning (SG), Liam Wilson (LW)

/ 1. Apologies for Absence: Mike Taylor (MT), Caroline Johnson (CJ, Shaun McKenna (SM), Donald Richardson (DR)

/ 2. Declaration of Interests

There were no declarations of interest.

/ 3. Minutes of the meeting held on 22 March 2022

The minutes of the last meeting held on 22 March 2022 were agreed as a true and accurate record.

/ 4. Matters arising from the minutes

There were no matters arising from the minutes or the action log. SH expressed concern around our operational position, aspects of the Ockenden update, particularly the post-partum haemorrhage report, as well as our CQC position and the inpatient survey.

/ 5. Escalated Items

There were no items for escalation.

/ 6. IBR Overview to look at Performance

All elements were covered in the COO Report and no further discussion was required.

/ 7. Chief Operating Officer Report (including Performance Update & Restoration and Recovery Update) and ED Assurance presentation

As at 19 April we had 199 Covid-positive patients – 116 in YH, 54 in SGH and 29 across community beds. Ward 28 on YH site is being used as the sole formal Covid ward and the remainder of patients are being managed through specialty wards. Aspen and Beech are

the designated Covid wards on the SGH site. We have reviewed our IPC guidance, which has supported a different approach to managing Covid patients and therefore supported de-escalation of formal Covid wards and in turn helped us manage workforce staffing and patient flow. WS said the changes around Covid patients and testing and the 'Living with Covid' guidance were formally discussed and agreed at Board of Directors and Gold Command on 30 March. Only high risk vulnerable patients are being treated in dedicated Covid areas. SH asked if Covid patient numbers have risen and HM said there had been no further outbreaks.

The Committee noted the challenging workforce position ahead of the Easter bank holiday and WS said there were a number of difficult decisions made around balancing risk i.e. trying to reduce ambulance handover times and also regarding the concerns from CQC around staffing rotas and wards. The challenging decision was made to close some bed capacity on YH site to ensure a sufficient nursing workforce over the weekend. ED pressures over the weekend did mean that some beds were opened back up but the plan for the rest of the week is to close capacity and manage workforce accordingly. HM noted the current medical staff sickness levels. WS said the risk was that closing bed capacity could exacerbate ambulance handover times so the decision to close beds in order to manage nursing staffing challenges was mutually made with the support of our NHSE/I colleagues.

There was further discussion about ambulance handovers. WS said an approach with CIPHER (a company that deploys trained paramedics, advanced care practitioners and nurses with urgent care backgrounds to support ambulance cohorting) was trialled over the Easter weekend. CIPHER supported the cohorting of ambulances. The feedback from YAS was that this did help as there were more trained staff available and it allowed ambulances to be redeployed quicker. WS said that there has been a regional suggestion that ED departments create cohorting spaces e.g. marquees or similar due to the concerning ambulance handover times, noting that there has been some resistance from the Royal College of Emergency Physicians. There was a group discussion about modernising and adapting ambulance processes as well as practicing intelligent conveying. WS confirmed that this was discussed in detail on the weekly regional and ICS calls. The Committee noted that ECIST reviews supported the view that many patients are conveyed to ED unnecessarily. However YAS have said they need alternative pathways in order to not convey and that these are not well established yet. SH expressed concern that there seemed to be a lack of senior ownership for these issues. WS said it was important that all parts of the system have a collective understanding of this and HM confirmed that this was also relayed to the CQC.

LS highlighted the following key headlines:

Our waiting list growth remains a concern with almost 40,000 patients on the elective waiting list and a target of 26,000.

Cancer and fast track targets remain a challenge. Whilst we are not achieving national targets, we do have a target for the number of patients on a fast-track pathway waiting over 62 days. The target is 178 and we are currently at 138.

We are seeing improvement from a long wait position although this is countered by the growth of the total waiting list. 81 104+ week wait pathways have been declared for the end of March and the aim is to get to 0 by the end of June and 0 78 week waits by the end of this financial year.

There was a discussion about how staffing and reduced weeks due to bank holidays may affect delivery of the recovery plan. LS said the plan is seasonally profiled but does not take significant workforce changes into account, adding that our workforce planning has never been under so much scrutiny. A deep dive into theatre staffing has been requested as that is currently our biggest risk with WS confirming that 30 lists were lost in March due to staffing issues. LS said our biggest growth area is the extended wait for an initial appointment and noted that the changes around IPC guidance and being able to utilise outpatient facilities and the diagnostic waiting list should help to improve this.

Our endoscopy surveillance backlog has halved. There is a plan for FIT testing to provide more capacity but this has not yet been rolled out. JT said the system has produced a document indicating that FIT capacity should be mandated in acute trusts whilst GPs have been told it is a contractual issue. We are currently negotiating with GPs about moving to mandated testing.

Regarding position against our 19/20 position we have achieved 99.5% of day cases, 75% of ordinary electives, 93% of first appointments and 105% of follow-up appointments. Diagnostics and ordinary electives remain a challenge and ED pressures remain the single biggest concern.

There was a group discussion about ward space and staffing issues. The Committee noted that creating a larger SDEC area would relieve pressure on ED but that there are not enough staff for this. HM said there is a lot of work to do around staffing and confirmed that a deep dive has been requested to review the ACP workforce and a perceived lack of autonomy. SH said a process to separate elective from emergency care is needed and LS confirmed that a bid has been submitted (TIF II) create this on the YH site.

WS said that consultant ownership of specialties in ED would drastically improve things by accepting their patients and if there is no bed capacity, clinics or follow-up outpatient appointments could be arranged as an alternative.

/ 8. ED Long Stays Assurance

The report was received for assurance that the lengths of long stays in ED are being investigated. HM said the main risk is appropriate staffing but that we can see some improvement and understand where the improvements are required.

SH asked for clarity on what is restricting specialty in-reach with regards to patients in ED that require specialist care. JT said that many clinicians have conflicting priorities and typically would focus on their patients on the wards first. SH asked if a consultant for each specialty could do a daily ward round on ED and see the patients identified as having specialty needs. WS agreed that there is resistance at times around specialty in-reach and that we are not of that mind-set yet as a Trust. JT said he had seen some improvement but agreed that there is more work to be done.

/ 9. IBR Overview to look at Quality and Safety

All elements were covered on the agenda and no further discussion was required.

/ 10. Ockenden Update

Perinatal Clinical Quality Surveillance Report (incl. Ockenden, PMRT and Continuity of Carer)

SG gave an overview of the report and noted 3 unit closures on both sites and one divert on the YH site in the reporting period due to staffing and acuity. The Escalation Policy was appropriately utilised. SH asked if sickness was the main cause of staffing issues and SG said it was, some of which still due to Covid. SH said the figures suggest that midwifery staffing is better than other areas and SG said that, whilst it was better than other general acute areas, there are still currently 29 WTE vacancies. SH confirmed with SG that the staffing ratios outlaid in the report (1:26 at Scarborough site and 1:30 at York site against a national target of 1:28) were baseline figures not actual and SG agreed that the safe staffing aspect of the report needs to be expanded. SG said that whilst the report covered 1:1 care in labour and supernumerary status of the delivery suite coordinator it did not reflect the day to day operations. SG added that Datix reports do not always come through so this is being discussed with the maternity teams.

There was a discussion about diverts and SH expressed concern around these. SG said that some diverts are due to staffing but also acuity depending on the ward status at the time. SG said that diverts are not a new phenomenon but that we are more transparent around them now with more focus on safety parameters. LB said it was important to be clear on how staffing looks on a daily basis and the implications around low morale and Continuity of Carer (CoC). SG said recruitment of midwifery staff remains challenging nationally and locally. The recruitment of overseas midwives is underway and interviews took place in mid-April 2022. We hope to recruit three out of the cohort. SG said that she and Sara Collier-Hield (SCH - Head of Midwifery) will work to update the workforce plan to focus more on retention with the aid of the CG5 workforce lead.

Ockenden action planning is in place and fortnightly meetings are being held for key clinicians as of February 2022. Some areas of progress have been identified following feedback from the regional team, one of which was around managing complex pregnancies.

PROMPT training figures for medical staffing have improved on the York site but deteriorated on the Scarborough site. Training trajectories suggest the additional sessions will support greater compliance over the next 4 months. SG said that we should meet CNST compliance by July if we continue as we are against our midwifery trajectory but that medical training remains a concern. This has been escalated to the Clinical Director and Care Group Director.

There was a discussion about CoC and the Committee noted that the level of received CoC had decreased in February 2022. There was a review of the model by SCH, HM and staff and the general consensus was to pause CoC. SH said that we expected to see a decline in CoC and asked when we should start considering it again. HM said the priority is to ensure both labour wards are safe and anticipated reintroduction of CoC in October 2022. The Ockenden suggestion is to review BAME communities and look to introduce CoC in these communities to ensure better outcomes for families. LB added that when CoC is reintroduced we need to ensure the service can support and sustain the model.

There was a brief discussion about HSIBs and SG said it would be helpful to provide a more detailed progress report around these cases. This will be reviewed within the care group.

SH asked for an update on concerns around sonography and cardiotocography (CTG). SG said there are foetal monitoring midwives in post and compliance is being included in the new quality and governance spreadsheet. There is still work to do on this to ensure compliance is completed monthly to then feed up to Quality Assurance Committee for escalation to Board. With regards to sonography, there have been issues within the care group around job descriptions for midwife sonographers, which have now gone through the job matching panel. SH noted the potential issue with promoting midwives and in turn creating further vacancies.

SH asked for an update on medical staffing and where the problem is with training. JT said part of the issue with obstetrics training is that there is a significant amount of additional training such as PROMPT, Ockenden and CNST to be undertaken. JT said he will continue to support training compliance improvement.

Post-Partum Haemorrhage (PPH) Audit

SG confirmed that the PPH audit was undertaken following concerns raised. Whilst January and February 2022 saw a rise in PPH, the dashboards show a decline for both sites in March. SH said he was concerned because we had been running above respective levels over various times with areas for improvement still being identified. SG said because there had been a high number of interventions being run simultaneously it made it hard to distinguish between what was and was not working well. The action plan has since been updated and circulated to both delivery suites. The improvement target has been highlighted for re-audit in 3 months' time.

HM said the process needs to be more systematic and ensure that risk assessments are being carried out in a timely manner rather than reactively. SH agreed that the issues are not being approached in the right way and SG said that this was due in part to leadership on the delivery suites. There was a discussion about leadership and SG gave assurance that there is now a substantive delivery suite manager on YH site as well as SGH whereas previously staff were unclear of their leadership roles. There has since been a consultation for the band 7s to better establish roles. The Committee agreed that a fundamental part of being a midwife or obstetrician is being able to recognise and manage a PPH.

SH asked SG if she felt confident that the maternity wards are safe. SG said we need to proceed with the actions raised from the audit and re-audit in 3 months' time as discussed to gauge effectiveness. SG said she was hopeful that by establishing the band 7 staff into permanent roles, it will promote a sense of leadership and ownership.

Action: SG to provide update on further PPH audit and results of agreed actions at September meeting

/ 11. Nurse Workforce Report

HM asked the Committee to note the conclusion in the report for escalation. The Committee acknowledged the significant staffing challenges and that senior nurses are spending the majority of their time ensuring staffing is as safe as it can be with appropriate mitigation. This also impacts on their ability to perform their core matron responsibilities. HM said the Matron of the Day post is unpopular with staff for these reasons and a review is needed, but there is reticence to raise expectations in case there are no available funds for this. The Committee agreed that it was important to escalate this and JM said it was unsurprising that so much effort is required to spread resources.

JM noted the positive feedback around the new Patient Service Operative roles. HM agreed but added that these were instead of HCA's not additional posts. HM said these roles tend to be from Monday to Friday and there was a concern that there is not enough weekend cover, but added that they have made a positive difference to wards in terms of supporting fundamental care delivery. Establishment reviews are currently being undertaken so staff have been encouraged to include these in their reviews as core staff roles.

There was a discussion around retention and the Committee agreed that there is a big piece of work to do on this. JM said it was better to spend money in a planned way rather than reactively and HM agreed that we spend more on bank and agency than we do on getting the establishments right. WS asked if there is any forecast on when to expect improvement and HM said realistically it would be next year based on calculations using staffing numbers expected attrition and overlaid with expected new starters. SGH is in a slightly better position because of the supply of students from Coventry University but YH is under more pressure as the University of York do not necessarily see themselves as a graduate supplier for the local trust. SH asked if a conversation was needed and HM confirmed that Simon Morritt (Chief Executive) meets with them regularly. York St John University only offers a community nursing course and this is the first year it has been offered. WS said that, in light of the forecast that we are potentially facing another year of workforce challenges, a more sustainable approach is required. Whilst closing capacity and offering incentives has worked in the short term, it is not tenable and a broader system conversation is required to improve retention.

Action: HM to bring an update on our nurse workforce and retention position

/ 12. Infection Prevention & Control Update

IPC Monthly Report – March

This report was discussed in conjunction with the Q3 report. HM identified the lack of clinical engagement and the size of the IPC team as key issues, and added that there had been no applicants for the IPC Lead Nurse post.

SH asked how clinical engagement could be improved and HM said that JT and Damian Mawer (Microbiology Consultant and IPC Doctor) had spoken with the care groups about a lead clinician for IPC to engage in relevant conversations e.g. C.Diff. JT said that he would follow this up with the relevant Care Group Directors.

IPC Q3 Report – Oct-Dec

The report was discussed alongside the monthly report and no further discussion was required.

/ 13. Newly Declared Clinical Serious Incidents – March 2022

JT gave an overview of the report, highlighting 5 clinical SIs completed in March 2022.

SH was concerned by the ongoing issue of radiologist diagnosis feeling remote from clinical scenarios. SH said it seemed as though the way in which radiology integrates with the clinical service could be improved to encourage a link of clinical coordination.

LW confirmed the more detailed quarterly SI report would follow in May.

/ 14. QPaS Quality & Safety Update

Escalation and Assurance Report

LW confirmed escalations of the current staffing position and noted that the fill rates for establishments are based on historic not current requirements. There is work ongoing around this. ED ambulance waits, falls and pressure ulcers were also escalated. Performance in Datix incidents with SI actions now total over 300 overdue and there are plans to further review these soon. LW confirmed that not all the SIs are clinical, with some being fall and pressure ulcer-related, but said it remains a disappointing position.

There was a discussion about the increase in falls and pressure ulcers and the associated patient harm. HM said if this is triangulated with unfilled shifts, it is clear that many patients require enhanced supervision but are not receiving it due to staff shortages. WS added that some of these patients are fit for discharge, which results in even more supervision requirements due to higher numbers of patients that should have been discharged. WS said she was in favour of exposing this position to system partners to demonstrate the harm associated with delays, noting that framing this in terms of numbers is very different to framing in terms of harm. The Committee agreed that we have reached a position where we need a supportive and collaborative approach and agreed that it would be a useful discussion at Board, noting that there may be some reputational risk involved.

QPaS Minutes - March

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

/ 15. CQC Compliance Update Report

SH asked for an update on our acute position, which was covered in the executive summary of the report. LW asked the Committee to note some of the risks identified as a result of these points, all of which are known to us (see P117). Responsive and caring deep dives within the care groups are due to be presented to Quality & Regulations Group in April 2022. This will conclude the baseline self-assessments across the key lines of enquiry (except Well Led) for all specialities. The May 2022 report will provide a dashboard of metrics for all areas at speciality level.

There has been an increase in whistleblowing to note. There were some CQC recommendations to acknowledge feedback and recognise the continued risk associated with the lack of a PEM consultant in SGH.

HM confirmed that we have sent three letters to the CQC, including a more robust response re medical and nursing staffing on 14 April. We have linked in with NHSE/I colleagues to give feedback following the visit and this was received with thanks. There were no timescales attached to the CQC report but a follow-up inspection is to be expected.

LW confirmed that we have procured a package called 'InPhase' that will monitor our CQC compliance, which is expected to launch in the next few weeks pending further updates from the CQC.

/ 16. Integrated Business Report

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

/ 17. Consider other potential or new emerging risks

There were no potential or new emerging risks to discuss or consider.

/ 18. Learning from Deaths & Mortality Report

JT gave an overview of the report and noted that the crude mortality for Q3 stands at 2.54% of all admissions. Crude mortality was 3.8% during Q4 last year. There was some variation reported in diagnostic groups that are reviewed every so often.

SH was concerned by the fluid and nutrition-related deaths and JT agreed to look into this further, noting that there are also some SIs around nutrition and hydration.

JM was concerned that themes from Learning from Deaths (LfD) remain consistent compared with previous reports as it suggests learning is not being taken. JM said there have been lengthy conversations in the LfD group about the benefits of tackling one issue at a time rather than taking on too much. JT said he was working on an improvement plan around managing deteriorating patients as this is a key risk that regularly emerges. JT confirmed that Phil Dickinson (Consultant) will be starting in his new clinical leadership role in May and his first major project will be around deteriorating patients.

Action: JT to provide further information on fluid and electrolyte deaths at next meeting

/ 19. Sepsis Q2 Report

JT gave an overview of the report and said there has been a significant deterioration on both sites in terms of both screening and treatment. The decision was made to stand down the formal Q3 and Q4 reports to focus on improvement work, which is being managed by the Deteriorating Patients Group. SH asked why it had deteriorated and JT said it was likely due to human factors and the congestion issues within ED. JT said there has been some improvement on triage times and ambulance handovers but that there is still work to do.

There was a discussion about ED and nurse staffing as nurses are most likely to be the first to identify sepsis. The Committee noted that ED is generally well-staffed but that it is common to then move nurses out of ED to reinforce the wards, reducing the staff in ED and lowering morale. HM said there is work to do on how ED use their staff, noting that on average there tends to be c.16 RNs on shift, which is a significant amount.

/ 20. Falls and Pressure Ulcer Serious Incidents Process and Learning

The report was received for assurance on how falls and pressure ulcers are assessed as SIs. There has been an increase in both falls and pressure ulcers and HM said the Trust has recorded a risk on the Corporate Risk Register due to the Advanced Clinical Specialist (ACS) Falls and Frailty practitioner leaving the Trust in mid-October 2021. Due to failure to recruit to this role the focus of it has changed to supporting community services only therefore a business case will be developed for a corporate falls practitioner post for the acute areas.

There was a discussion about lapses in care. The Committee noted that to date for falls there have been 14 SIs declared this quarter and 6 After Action Reviews (AARs) identified no lapses in care. HM explained that even with a risk assessment and clear execution of a care plan, falls can sometimes be inevitable despite staff doing all they can. This would not be defined as a lapse in care as the process was followed. HM gave assurance that there is a robust system in place. Lapses in care were generally identified due to staffing challenges.

/ 21. Inpatient Survey Outcome

The report was received for assurance and the Committee noted that discharge is our biggest issue at present. The Patient Experience Team is going through a consultation process, which is almost complete. HM said that Michael Mawhinney (Head of Nursing, Research and Patient Experience), who has been leading on this agenda, will be leaving the Trust and added this will leave a significant gap. SH said the report was lacking detail on patient interactions with clinical staff and HM agreed to bring an update back in June.

Action: HM to bring an update on the inpatient survey to June meeting

/ 22. Annual Clinical Audit Plan - review

The report was received for information and LW confirmed that each care group has a plan with an agreed methodology from different elements of the portfolio from SIs to complaints. As chair of Audit Committee, JM said she needed to know that there is a process in place for preparation and delivery of a plan. JM asked for an update on this years' plan and LW agreed to report back on this outside of the meeting.

Item for discussion or escalation

/ 23. Consideration of items to be escalated to the Board or other committees

There was a group discussion about how to generate an effective Board discussion. JM suggested combining the escalations to better illustrate the situation e.g. the relationship between staff shortages and the number of patients and beds, and the risk this poses to patient and staff safety and harm.

The Committee agreed the following items for escalation/information/assurance to the Board:

- COO Report - Continuing concerns over management of emergency admissions. Access times for non-emergency care continue to cause concern. Large numbers of

delayed discharges are putting enormous pressure on ward capacity. Staffing levels have necessitated bed closures on certain occasions – for escalation.

- Maternity Services (Ockenden Report) - Routine report to Board for information. No significant movement in metrics in month.

- CQC - Unannounced visit to 6 medical wards on background of concerns about staffing levels. Assurances to CQC sent and responses awaited.

Action: SH to compose a letter to Simon Morritt expressing concern about issues with discharge process and associated patient harm

/ 24. Any other business

There was no further business to discuss.

/ 25. Time and Date of next meeting

The next meeting will be held on 17 May 2022 at 2pm via WebEx.

Minutes
Group Audit Committee
17 March 2022

York and Scarborough
Teaching Hospitals
NHS Foundation Trust

Attendance:

Jenny McAleese, Non-executive Director (Chair); Lynne Mellor, Non-executive Director; Stephen Holmberg, Non-executive Director; Denise McConnell, Non-executive Director; Andy Bertram, Finance Director; Steve Kitching, Deputy Finance Director; Polly McMeekin, Director of Workforce and OD; Jim Taylor, Medical Director; Helen Higgs, Managing Director (Head of Internal Audit); Jonathan Hodgson, Internal Audit Manager; Emma Shippey, Senior Internal Auditor; Marie Hall, Local Counter Fraud Specialist; Mark Dalton, Engagement Lead, Mazars; Mark Outterside, Senior Engagement Manager, Mazars; Sarah Hogan, Head of Corporate Finance; Alan Downey, Trust Chair (observing); Mike Taylor, Associate Director of Corporate Governance and minute taker.

Apologies for Absence: Penny Gilyard, LLP Director of Resources

21/126 Chair's Introduction and Welcome

The Chair welcomed everyone and declared the meeting quorate. The Committee noted that the meeting was being recorded for the sole purpose of taking the minutes and will be destroyed once the minutes had been completed.

The Chair welcomed Alan Downey, Trust Chair, as an observer to the Committee meeting and Helen Higgs as Managing Director of Audit Yorkshire and introductions were provided for those in attendance that had previously not met Alan and Helen.

21/127 Declaration of Interests

There were no further declarations of interest.

21/128 Minutes of the last meeting

The minutes of the meeting held on the 9 December 2021 were agreed as a correct record, subject to the following change:-

- The correction of the Finance Director name on page 7 of the minutes.

21/129 Action Log

All due actions were noted by the Chair to be either closed or due on the agenda of the meeting.

The Committee:

- **Acknowledged that all actions due had been completed and closed.**

21/130 Matters arising from the minutes

The Committee received the Data Quality Plan update and the members commented that it was too early to work on as a further update to the plan was to be drafted by May 2022.

The clinical audit data was discussed at the Data Quality Group and it was agreed previously at that group and at the Committee from Andy Bertram's comments on concerns in the data submission process of those responsible for data to NHSE&I not signing-off the data prior to submission.

It was agreed by the Committee that there we should not wait for a full implementation plan before addressing the weaknesses that have been identified. Internal Audit reported that this had been acknowledged by the Deputy Director for Patient Safety and Governance.

The Committee:

- **Received and noted the plan with further days noted in the Internal Audit plan to work on data quality issues if required.**

21/131 Medical Director Issues

Jim Taylor gave an update on Dr Donald Richardson, Deputy Medical Director who is to retire and return to the Trust on a 3 days a week (7 PAs equivalent) basis. This will be divided into four PAs as Chief Clinical Information Officer and three PAs as Deputy Medical Director.

Steve Holmberg asked on the retire and return payment terms and Polly McMeekin commented that the Trust doesn't have a policy insisting on a fixed term contract and staff can return substantively. Lynne Mellor enquired on any succession plans in place and Jim Taylor commented that there is a succession plan across Care Group Directors, clinical directors and lead clinicians as a leadership framework, with specific reference to digital succession in clinical colleagues showing interest in this area in the future.

Jim Taylor continued on Care Group governance and stated he has been working with the Associate Director of Corporate Governance on the quality and safety agenda at the Quality and Patient Safety Group, Executive Committee and Quality Assurance Committee for example.

On serious incidents a new SI framework is due in the Spring of 2022 following a pilot and the Trust in the meantime has refreshed its policy. A follow-up Internal Audit review on SIs is underway and improvements are noted from last year. It was noted that the Trust has at times been over ambitious on SI actions that have not been able to have delivery evidenced. It is planned to use a quality improvement process combined with specific actions to achieve improvement in SI investigation outcomes.

The Committee:

- **Received and noted the update.**

21/132 Medical Staffing

Polly McMeekin explained the doctors' low sickness absence rates recorded was potentially an accuracy concern and she had asked Internal Audit to review as recording of absences is a good indicator of general management issues. The review focused on who was responsible for doctor placements on rotation of absence management, training compliance etc. The report has generated 10 recommendations, 7 of which have already been implemented following the review been concluded in September 2021. Roles and responsibilities have subsequently been clarified for the Care Groups' absence management processes and it has been clarified that the rota team is not responsible for line management of doctors.

An outstanding matter is the contract with Heath Education England (HEE) as the Trust, being a host employer for GP trainees at GP sites overseen by Practice Managers, is providing notice to leave the contract as from April 2023. An overarching issue remains in terms of how the Trust overall is being inclusive with doctors who work with us and their reliance on us for support in line with the Trust's culture and behaviours.This concern was echoed by the Non-executive directors.

Jonathan Hodgson noted that, as a low-assurance report, a follow-up review will follow in future and it was good to see the steps that had been taken so far to address the recommendations.

The Committee:

- **Received and noted the update.**

Action:

- **The Director of Workforce and OD to provide a further update to the Audit Committee at December's meeting.**

21/133 YTHFM Internal Audit Progress Report

Jonathan Hodgson gave an update highlighting the management of contractors as a limited assurance report with a full re-audit to take place next year. This was linked to the HPV investigation previously undertaken. Andy Bertram commented that Mark Steed from the LLP had been leading on improvements with approximately 90 staff trained which disappointingly resulted in the audit of the training not been practically implemented. The LLP health and safety team are subsequently now undertaking spot checks on implementation.

Lynne Mellor expressed disappointment after the assurances provided of the HPV incident at Board

No further changes to the Internal Audit Plan have been requested and the plan is being delivered in 2 of the 3 KPIs with delays on the sustainability audit. 74 days of 95 have been concluded including 15 days transferred from the Trust plan with the overall YTHFM plan on track to be concluded by year end.

Denise McConnell commented on the poor management responses received from audits undertaken. Jonathan Hodgson noted that this was in relation specifically to staff absence and annual leave with sustainability being the only one in question. Response times have been generally good on management responses. She also referred to the sustainability

report and commented from the Resources Committee that the Trust didn't have the resources to implement the sustainability agenda. Andy Bertram commented that we do have a budget for sustainability in starting small rather than the big schemes with the agenda developing and we can start to manage the smaller things firstly such as managing food waste and other waste that comes through the hospital site. He also mentioned the £9m grant that has been received for the York and Bridlington sites for solar panels and cladding for example. There are however challenges with the larger schemes and the Trust and wider NHS have a big challenge to meet the zero carbon emissions target.

The Committee:

- **Received and noted the update.**

21/134 YTHFM Internal Audit Outstanding Recommendations

Jonathan Hodgson commented that this was the lowest number of outstanding recommendations for the LLP. The Chief Executive had also commented previously that it was pleasing in what the LLP had achieved.

Jenny McAleese commented that there were two outstanding actions in the report with no update and Jonathan Hodgson replied that this was due to the Internal Audit system MKInsight with action owners not being able to provide updates. Andy Bertram provided assurance that by the next meeting in his discussions with the LLP that these actions would be concluded.

The Committee:

- **Received and noted the update.**

21/135 YTHFM Draft Strategic and Operational Internal Audit Plan

Jonathan Hodgson presented the report and explained that an engagement exercise has taken place with LLP colleagues reported through the LLP Management Group, EPAM and the Executive Committee at the Trust. The plan is fully compliant with public sector internal audit requirements.

A number of reviews were noted to take place across the year with a £346 day rate agreed. Denise McConnell asked that the name of the Executive that was responsible for that area be added to the plan. She also asked why there wasn't anything on the plan for staff and wellbeing given that workforce was such a significant risk. Jonathan Hodgson noted that the revised programme would detail all Executives by their portfolios and would be brought back to the next Audit Committee. Regarding staff health and wellbeing the LLP staff are to be included in an audit review done of the Trust in this area. The results of that should be with the Audit Committee at the next meeting.

Lynne Mellor asked about the wider digital aspects and cleanliness KPIs across the Trust. The Internal Audit Manager would look again at the former and would seek to bring forward the latter if the opportunity presented itself in delivering the plan. Jenny McAleese commented that the Resources Committee should see the Audit Plan firstly before coming to the Audit Committee in future, which was agreed by the members for next year.

The Committee:

- **Received and noted and approved the plan.**

Action:
- **The Internal Audit Manager to bring back to the next Committee a revised programme presenting the Executives against their portfolios.**
- **The Internal Audit Plan for 2023/24 to be presented to the Resources Committee for comment prior to the Audit Committee for approval.**

21/136 Counter Fraud Annual Plan

Marie Hall referred to the plan and asked for any questions or comments from which Denise McConnell noted that the proposed resources for the plan were as per last year and queried whether, with the potential increase in fraud with for example the situation in Ukraine, this should be reviewed.

Marie Hall commented that the plan is thorough and they work closely with the IT team and inform staff of any changing situations on an ongoing basis. Andy Bertram added that there are situations of bank payments attempting to be diverted and fraudsters posing as members of staff in changing bank details. Challenge does come from NHSE&I on counter fraud resources and the Trust is on par with other Trusts with the day rate being in the lower quartile by comparison according to the Model Hospital Data with by counter fraud days in the third quartile and internal audit in the fourth quartile in being above average. Internal Audit planned days have been reduced slightly in 2022/23 with counter fraud remaining the same.

In response to a question from Denise McConnell, Marie Hall reported that the Counter Fraud Policy would be reviewed in 2023.

The Committee:
- **Received the report and approved the annual plan.**

21/137 Counter Fraud Progress Report

Questions and comments were invited by the Chair on the report. Lynne Mellor commented that the Counter Fraud team were doing a good job and drew the Committee's attention to the instances of fraud and asked if this was all or just the 'tip of the iceberg'. Marie Hall commented that perhaps there was under reporting of instances of fraud and staff are continually educated on what fraud is with a policy of if in doubt - report. The Trust has the largest attendance of all the Trusts worked with by the Counter Fraud on Fraud Awareness Master Classes with no concerns on further fraud training by staff.

Denise McConnell noted that there was no cyber security training in staff inductions to the Trust and Marie Hall agreed that she would look further at this in future.

The Committee:
- **Received and noted the update.**

21/138 Corporate Committee Report

The Corporate Committee reports were noted by the Audit Committee.

Andy Bertram updated the Committee on the Data Quality Working Group which last met in February.

This meeting discussed the CQC insights report diving down into the data which noted some further controls improvement audit work to conclude around the reconciliation of data on the National Reporting Learning System and Datix systems. Further areas looked at included discharge data, heath inequalities in working with the ICS, virtual wards, staffing and acuity data.

The Committee:

- **Received the report and noted its contents.**

21/139 External Audit Strategy Memorandum (ASM)

Mark Dalton presented the report for 2021/22. This had been discussed and agreed with management before presenting to the Committee. Highlights were the responsibilities of the external auditors in auditing the Trust's financial statements and that of forming a view of value for money in use of available resources. Further outline was provided of the scope, timelines and audit strategy to address the risks identified.

It was explained that the national timetable for submission for draft and audited accounts has been agreed as 22 June 2022. Fees were noted to the Committee in line with no non-audit fees proposed, thereby ensuring that the audit team is independent and objective.

Mark Outterside outlined the risks identified in the plan including management override of controls, revenue and income expenditure recognition in potentially managing future financial positions and in valuation of land and buildings. In addition the preparation for the Trust's position regarding IFRS 16 compliance from 1 April 2023 was also noted. Following a question from Lynne Mellor, Mark confirmed that the risks identified were in line with other similar sized Trusts and the auditors clarified that IFRS16 was in relation to the value for money work.

In was also noted that from the previous year's report the audit will take into account the significant weakness and recommendation of CQC's inspection of the ED department at York and Scarborough.

It was noted regarding the stock on inventory balances that some stock take attendances have taken place this year with a limitation on scope of the audit being less likely for the closing balance. That limitation of scope however is to be applied to the opening balance and therefore likely to appear in the final audit report.

The Committee:

- **Received the report and approved the ASM.**

21/140 External Audit Progress Report

Mark Dalton confirmed that the Audit for 2021/22 is on track and there was nothing else to report.

The Committee:

- **Received the report and noted its contents.**

21/141 Internal Audit Progress Report

Jonathan Hodgson presented the report and highlighted points, including five reports that had been concluded since the last committee with one limited assurance report concerning the management of formal staff concerns and complaints. The Health and Safety controls improvement audit was also reported as concluded with the LLP and was a significant assurance outcome with an amber risk in outstanding actions.

Three reports had received significant assurance: whistleblowing, cancer information follow-up and the IT assets management of disposals follow-up. Seven reports have been reported in draft with the cancer 28 day diagnosis as a limited assurance opinion in context of services being stepped down during the pandemic. Over 75% of the plan had been concluded and the plan is on track for completion with the Head of Internal Audit opinion by 16 June Audit Committee.

Jenny McAleese noted that there were some instances of staff raising whistleblowing concerns direct to CQC when the whistleblowing report of Trust procedures had received a significant opinion. Jonathan Hodgson stated that some staff are not using the procedures in going straight to CQC and that on the Trust's procedures Emma Shippey commented further that the Freedom to the Speak Up Guardian wasn't aware of these reports at the time. The significant assurance was provided on the procedures in concerns being dealt with appropriately via the Trust route to raise concerns. Steve Holmberg commented that this was a deliberate action to avoid the Trust processes in referring to the organisation's culture.

Jonathan Hodgson presented that there had been change requests to the programme of work such as reviewing the OPEL framework and that deteriorating patients review will be looked at again imminently.

The Committee noted the progress report and supported its current format.

The Committee:

- **Received the report and approved the changes to the plan.**
- **Noted the lower assurances meetings that had taken place.**

21/142 Internal Audit Outstanding Recommendations Report

Jonathan Hodgson presented the report and further improvement on the recommendations, with only 6 outstanding, 11 revised and 146 concluded in the last 12 months.

Lynne Mellor noted the outstanding disaster recovery recommendation of CPD and the outage recently in the Trust. Jonathan Hodgson commented that the team were progressing with that.

The Committee:

- **Received and noted the update.**

21/143 Recommendation Benchmarking report

The report was noted by Committee members.

The Committee:
- **Received and noted the update.**

21/144 2022/23 Annual Draft Plan and Fees

Jonathan Hodgson presented the plan in looking at a three year period and the engagement that had taken place across the Trust and reported to the Executive Committee. An operational programme had also been prepared for 2022/23.

The overall programme has reduced by 40 days in relation to the model hospital data. It was suggested by Jonathan Hodgson that the Trust values report be looked at as a controls improvement audit this year in development as a formal assurance review later in the year or early 2023/24. Members of the Committee agreed to that approach.

Comments were made by members and the Internal Audit team in relation to the number of days and costs that the Trust incurred regarding the programme of work. It was noted that the non-direct auditing and administration time had been reduced in relation to the overall reduction in days. It was agreed by the Committee that the Trust internal audit programme in the context of the model hospital data was at the right level.

A controls improvement audit was proposed around the work of the CDIO as it was too early for full audits of the service particular around future EPR. It was noted around the ICS work that the internal auditors are involved in their audit programme and so have that internal perspective to the Trust and external regarding the ICS and the provider collaboratives in developing crosscutting audits.

It was also agreed by members that future audit plans would be shared with the Non-Executive Directors prior to Audit Committee approval.

The Committee:
- **Approved the Annual Plan and Fees for 2022/23**
- **Agreed to a Trust values review being delivered as a controls improvement audit and consideration of work across the CDIO portfolio in 2022/23.**

Action:
- **That future years' annual plans be shared with the Non-Executive Directors ahead of Audit Committee approval.**

21/145 SHYPS Update

Andy Bertram gave an overview of the Scarborough, Hull and York Pathology Service in notification of the income and expenditure change in numbers reported in the accounts this year in entering into the collaboration which went live on 1 November 2021. The update was brought for assurance.

The Committee:
- **Received and noted the update.**

21/146 NXG Update

Andy Bertram provided an update on the NXG Forensics risk management platform as the Trust is one of 30 Trusts across the North East collaborative and one of the first to implement the software across our accounts payable service.

The report it was explained was brought to note and for information in checking all invoices in picking up any issues identified.

The Committee:

- **Received and noted the update.**

21/147 IFRS 16 Update

Sarah Hogan provided an update on the International Financial Reporting Standard (IFRS) 16 regarding how organisations present their leasing costs in their accounts.

These are currently accounted for in revenue, with annual leasing charges via a revenue budget. IFRS 16 changes this so that operating leases are now accounted for on the balance sheet as a whole life lease asset cost created with a liability for the same amount in what is owed.

In terms of our Care Groups' lease budgets these will now be moved from Care Group revenue budgets to a central depreciation and revenue budget to the balance sheet. This currently amounts to £19m with no changes to PBC dividend charges. This will sit out of the current capital department expenditure (CDEL) limits. The LLP have been implementing IFRS 16 for the last two years with 95% of leases accounted for via the LLP. Consequently, the Committee was assured that the implementation of this for the Trust should not cause any problems.

External Audit will audit the figures in the Trust's accounts and report any errors back to the Audit Committee.

The Committee:

- **Received the report and noted its contents.**

21/148 Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

Mike Taylor presented the Board Assurance Framework and the Corporate Risk Register report explaining that the Trust has moved in its assessment of the strategic risks via the BAF over the last three months reflecting the operational pressures of the Trust. The Executive through the Risk Committee have demonstrated the management of the BAF and CRR. Mike reported that the intention is to appoint a Risk Manager in the new financial year and this will allow further improvements and refinements to be made. The Committee noted the report.

The Committee:

- **Received the report and noted its contents.**

21/149 Committees Reporting Lines Report and Organisation Chart

Mike Taylor gave a verbal update on the ongoing review of the Trust's committees and how this worked alongside the review of the governance across the organisation in reviewing all working groups and their role in operational performance, assurance and decision making.

Terms of reference for all these groups are in the process of being reviewed in order to ensure, amongst other things, that decisions come to Executive Committee when they need to.

The Committee:

- **Noted the update.**

21/150 Annual Governance Statement process

Mike Taylor explained that the drafting of the Annual Governance Statement was underway which will be concluded in line with the annual reporting process and the BAF and CRR internal audit review currently underway. The draft Statement will come to our next meeting.

The Committee:

- **Noted the update.**

21/151 Committee Objectives for 2022/23

Jenny McAleese explained that the committee objectives are to be drafted and she will pick up with the other Non-Executive Directors on the Committee in advance of the next meeting.

The Committee:

- **Noted the update**

Action:

- **The Chair to bring back to the next committee a draft of the 2022/23 Committee objectives for consideration**

21/152 Any Other Business

Jenny McAleese brought to the attention of the Committee the AQR report which was in the purple box.

Andy Bertram explained the change in the Trust's Standing Financial Instructions concerning changing procurement legislation regarding a formal tender required above £50,000 not £25,000 at present.

The Committee:

- **Approved the change to the Trust's scheme of delegation.**

It was agreed from Jenny McAleese's suggestion that Heather McNair be invited to the September and Polly McMeekin to the December meetings respectively.

21/153 Items to be escalated to Board

- Standing Financial Instructions change in tender amount
- Quality of clinical audit data
- Management of sub-contractors
- Internal Audit and Counter Fraud plans for 2022/23
- Board Assurance Framework (BAF) and Corporate Risk Register (CRR) improvements
- External Audit plan on track

21/154 Review of Meeting

- Further time for external visitors to the meeting
- Good discussions and positive challenge on audit plans
- IT improvements needed for virtual meetings
- Good pace of the meetings and pertinent points drawn out

21/155 Date and Time of Next Meeting

The next meeting of the Group Audit Committee will be held on 3 May 2022, 09.00 – 13.00, venue TBC.

Group Audit Committee - Action Log

No.	Meeting Date	Action	Owner	Due Date	RAG rating	Comments
21/89	16.09.21 09.12.21	Link with each other on the work being undertaken around governance of data, quality of data, and produce a plan of actions to be taken to correct the identified gaps.	Caroline Johnson	Dec 2021 March 2022	Completed 17/03/21	At Dec meeting it was agreed that a plan would be produced and presented at March 2022 meeting.
21/106	09.12.21	Add a comments column to the action log for any updates and RAG rate the actions.	Tracy Astley	Dec 2021	Completed 16/12/21	
21/106	09.12.21	Bring a data quality plan to the next Audit Committee meeting.	Caroline Johnson	March 2022	Completed 17/03/21	On March agenda.
21/108	09.12.21	Update Lynne Mellor on LLP actions once he had met with the LLP directors.	Jonathan Hodgson	Ongoing	Completed 23/12/21	All outstanding actions completed. Jonathan informed Lynne/Jenny.
21/109	09.12.21	Invite Polly McMeekin, Director of Workforce, to the next meeting in March 2022.	Tracy Astley	Dec 2021	Completed 15/12/21	Changed meeting date to accommodate.
21/116	09.12.21	Give 6 month update on progress made with LLP Procurement compliance.	Andy Bertram	June 2022		
21/120	09.12.21	Feedback to Lucy Brown, Director of Communications, the changes in branding so the Trust website can be updated to reflect this.	Jenny McAleese	Dec 2021	Completed 17/12/21	Jenny emailed Lucy Brown asking for the changes to be made.
21/121	09.12.21	Review Committee/Group structures and update Committee at next meeting.	Mike Taylor	March 2022	Completed 17/03/21	On March agenda.

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21/132	17.03.22	The Director of Workforce and OD to provide a further update to the Audit Committee at December's meeting on doctors low sickness absence rates.	Polly McMeekin	Dec 2022		
21/135	17.03.22	The Internal Audit Manager to bring back to the next Committee a revised YTHFM programme presenting the Executives against their portfolios.	Jonathan Hodgson	May 2022		
21/135	17.03.22	The Internal Audit Plan for 2023/24 to be presented to the Resources Committee for comment prior to the Audit Committee for approval.	Mike Taylor	March 2023		
21/144	17.03.22	Future years' annual internal audit plans be shared with the Non-Executive Directors ahead of Audit Committee approval.	Mike Taylor	March 2023		
21/151	17.03.22	The Chair to bring back to the next committee a draft of the 2022/23 Committee objectives for consideration.	Jenny McAleese	May 2022		

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NHS
York and Scarborough
Teaching Hospitals
NHS Foundation Trust

Minutes
Resources Assurance Committee
22 March 2022

Attendance:
Lynne Mellor (Chair) NED: Jim Dillon, NED: Denise McConnell, NED: Andrew Bertram, Finance Director: Polly McMeekin, Director of Workforce & OD: Dylan Roberts, Chief Digital Information Officer: Michael Taylor, Assoc. Director of Corporate Governance: Tracy Astley (for minutes)

Apologies:

Ashley Clay, Assoc. NED

Welcome and Introductions

It was noted and agreed that the meeting would be recorded for the purpose of the minutes and destroyed following the approval of the minutes. Any requests to listen to the recording must be made through the Chair of the Committee. The meeting was declared quorate.

22/27 Declaration of interest

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

22/28 Minutes of the meeting held on the 15 February 2022

The minutes of the last meeting held on 15 February 2022 were agreed as a correct record.

Action log

- **Action 97 (Digital Intelligence & Insight Team Priorities):** Separate this into two actions.

22/29 Draft Income & Expenditure Plan 2022/23

Andy Bertram informed that the draft I&E Plan had been submitted to the ICS and NHSE/I, in line with the paper presented in the pack, showing a £40m problem at the moment between income and expenditure. The Trust was in constant discussion with commissioners and all of the network partners to try and close the gap. The final plan was

due for submission on 28 April and the Board will receive the final plan beforehand for approval.

Andy Bertram moved on to the presentation and highlighted the following points: -

- Forecast outturn will be a balanced outcome this year.

- The 2022/23 plan showed a £40.2m deficit due to income reducing between years by £13m and expenditure increasing.

- There was a loss of £22m worth of non-recurrent income, i.e., ERF income, Covid funding, TIFF income.

- There was a loss of £28m of resources between financial years if the non-recurrent CIP delivered last year was included.

- Prediction on gas costs will increase to £4.2m for next year. The positon in the plan was an increase of £2.8m but this has been superseded now we have the March spend information and latest price prediction data.

- The Trust will receive an allocation of £10.8m for covid. However, the Trust will spend £11.5m, producing a £700k pressure as the Trust was spending more than it was receiving.

- There will be a £660k spend on the ICU Pod for heating, lighting, rates, cleaning and maintenance. This is before the required funding of £500k per each planned two bed opening and associated running costs.

- The Trust had benefitted significantly from the covid capital funding. However, there were charges attached of 3.5% PDC interest totalling £1.6m for the Trust. It also increases the Trust's depreciation. The total cost of capital increase is £3.2m.

- There will be a change to the IFRS16 for next year. There was almost £5m worth of pressure on the Trust's plan because of the extra capital that has been pushed into the system. He was hopeful that there will be some support for this.

- Andy identified the essential schemes that were not in the plan. The figure will be increased to £11m to implement phase 2 of the nurse investment scheme. None of the essential schemes were included in the £40m deficit. However, if the schemes were not implemented then there will be an issue. He was hoping that the ICS would give some support.

Andy went on to explain how the Trust had spent the £28m non-recurrent resources this year and referred to the £9m spend on other investments. He said that to get to £40m deficit the Trust will need to deliver a £15m efficiency programme. It represented 2.4% of operational spend.

With regard to the covid spend and the £700k pressure. Discussions will be ongoing at the Executive Committee on how the Trust can mitigate this. It will be particularly relevant with the likely change in the infection prevention control guidance as the country moved away from the testing regime currently taking place. The ICS had given the Trust two weeks to close its position and if the Trust cannot then the ICS will step in. Andy was clear

that the resource envelope provided to the Trust is the maxium funding available from the ICS's allocations and there was a clear expectation of delivering a balanced financial plan.

Referring to the ICS draft plan 2022/23, it showed a £143m deficit. Looking at the various Trusts, Hull & East Yorkshire was at £48m deficit, York & Scarborough Trust was at £40m deficit, North Lincs & Goole was at £32m deficit. All of the CCGs were running at a deficit apart from Hull CCG which had received and was holding £55m worth of ERF for distribution amongst the group. Andy was hoping that £14.5m would be allocated to the Trust which should improve its financial position.

Andy then moved on to describe the latest working draft position and explained some of the adjustments that could be made to reduce the deficit to £22.2m. He gave an explanation of the activity related investments, and the plan produced by the Chief Operating Officer and the Care Groups, to deliver 104% of elective work in order to receive extra ERF.

Lynne Mellor commented that the government was expecting to suspend Gazprom Trading and asked if this would affect the Trust. Andy replied that the Trust did not use Gazprom Trading.

Denise McConnell referred to the grant received for international recruitment and asked if this would continue. Andy replied that it will continue but discussions were ongoing as to how much additional cost still needed to be provided in the plan. Polly McMeekin added that a lot of the costs were associated with visas, UK border agency fees, initial 8 weeks accommodation, NMC registration, and they were debating how to curtail this whilst still offering an attractive recruitment package.

Denise McConnell referred to the ICU beds and asked if the Trust could continue using the old beds as well to give extra income. Andy replied that they needed commissioner agreement to increase the ICU capacity. At the moment, the ICS could not afford it.

Denise McConnell asked if all the Trusts in the ICS delivered over 104% elective work, would there be extra ERF. Andy replied that there would be. The assumption was that if the Trust did more, it would be paid more. However, it was going to be really difficult to do that from an operational and staffing perspective.

Lynne Mellor referred to the £52m Service Development Fund (SDF) allocated to the HCV and asked why only £1.15m had been allocated to the Trust for mental health. Andy replied that the Trust's allocation totalled £2.6m. The £1.15m was extra. The vast majority of the ICS fund will be going to primary care and mental health. The ICB had to meet the mental health investment standard and the SDF will be used for that.

Denise McConnell asked what the role of the ICS was in allocating funds given that it was not a statutory body yet. Andy replied that all the Trust and CCG Finance Directors within the HCV were collectively managing this with oversight being provided by the transition executive and finance support. It was reasonably straightforward to agree individual organisational shares on a fair basis and by adopting a following the national allocation assumptions. The issue for individual organisations and the ICS is simply the overall affordability and funding has dropped in real terms and the operational ask has grown.

Jim Dillon referred to the £15m efficiency delivery and asked if this was actual or projected. He also asked if this had been planned out through agreed business cases or was this an expected target. Andy replied that it was a bit of both. It was the expected

target but there are currently around £9m worth of plans to secure delivery. However, there was £6m remaining outstanding with no plans identified yet. Work is continuing with the Corporate Efficiency Team, Care Groups and Corporate Directorates to advance the planning work.

Jim Dillon referred to the ICS stepping in if the Trust did not deliver and asked what the ICS could do that the Trust had not thought of. Andy replied that it was the duty of the Trust Board to deliver a balanced financial plan within the resources available. If the Board could not do that then it could be considered that the Trust Board had failed in its duties. The Committee discussed this point and acknowledged its responsibilities with finance but that these triangulated with performance and safety of services.

Lynne Mellor referred to the efficiency plan and asked if the Trust could approach Transformation differently to deliver recurrent benefits. E.g. all parties involved in transformation to come together to deliver an e2e plan across the whole Trust. Andy replied that all parties had come together under the Chief Operating Officer's Building Better Care programme.

In summary, Andy was working with the Care Groups to look at the plan, see if anything can be scaled back, whether covid spend could be reduced, etc. He was having a meeting next week with CCGs to share the Trust's plan and will be pushing for further income. In terms of the Efficiency Delivery Programme, the corporate efficiency work will restart, the Corporate Efficiency Delivery Group will be reinstated and the IBR Finance Report will be revised to include the efficiency delivery updates. The Efficiency Panel meetings will be chaired by the Chief Executive.

The Committee:

- **Thanked Andy and his team for a comprehensive presentation and noted the contents of his report.**
- **Noted the need to discuss how the Trust could approach transformation differently so that it could ramp up transformation efforts which would deliver recurrent benefits**

22/30 Draft Capital Programme 2022/23

Andrew Bertram stated that this was the first draft. The appendices showed each of the Care Group's priorities totalling £13m. There was around £5.7m discretionary capital in the programme. His major concern at the moment was York ED which stood at £18m and at the moment the Trust only had £15m. He will meet with the ICS Capital Lead to support the Trust to find ways of reducing the spend without reducing the benefits of that scheme.

He had received all the information from the Care Groups and the Corporate Directorates and the group was currently working with everybody to understand the position. Some of the schemes will require revenue, some of them will be suitable for charitable funding and hopefully others will be suitable for external funding. He hoped to be presenting an updated version at the April Board.

Once the position was clear with regards to resources, prioritised projects, funding streams, the Executive Committee will undertake a prioritisation exercise and make recommendations to the Board.

Denise McConnell commented that she had only undertaken one patient walk around but what was clear to her was the condition of the estate. She wanted to know what process

the Trust had gone through in prioritising one project over another because it was quite clear that an absolute fortune had been spent in certain areas of the hospital. Andy replied that the Care Groups and the Corporate Directors do the prioritising and then the Executive Committee look at the business cases and make a recommendation to the Board. Denise asked if the Trust invested in a certain project, apart from it improving patient care, could it be used to deliver more income to the Trust. Andy replied that the Trust's clinical income was largely fixed but there were other initiatives ongoing such as partnering with the Ramsay Group and accessing ERF funding to support that. However, clinical income was not an area that could be improved outside of the ERF process. The Trust had such limited resources. The other constraint was the CDEL limit which was heavily regulated and controlled.

The Committee:
- **Noted the contents of the report.**

22/31 Integrated Business Report – Finance

Andy Bertram gave an overview of his report and highlighted the following: -

- The Trust was on month 11 and the I&E was broadly balanced.
- It was predicted that at year end the Trust's I&E would be balanced.

The IBR will be reviewed to add the efficiency program updates.

Lynne Mellor referred to the LLP being under IFRS16 for the last couple of years and noted some issues. She asked if there was any learning that could be taken forward which would be of benefit to the Trust. Andy replied that he would hope so. Because the LLP was incorporated in Companies House its accounts had to be prepared using IFRS16. The Trust Group accounts did not use IFRS16 but the Finance Team did have an insight into this and have been using for the past few years which puts the Trust in a better position for lobbying and explaining what the consequences of this policy was.

Referring to risks, Andy advised that the scores will be increasing on the BAF and he will be discussing this with Mike Taylor going into the next financial year.

The Committee:
- **Asked Andy to thank the Finance Team for all their hard work.**
- **Noted the contents of the report.**

22/32 Annual Staff Survey Results

Polly McMeekin gave an overview of her report and highlighted the following: -

- The document was the weighted and full benchmark report.
- It showed the benchmark group the Trust had been placed in and how the Trust had performed against the 9 themes. The 7 that had logos against them were the ones that matched the Peoples Promise as detailed in the People Plan, and the other 2, staff engagement and morale, were carried over from previous surveys.
- In particular, staff engagement had been protected. There were 9 questions which related to staff engagement and there was a direct link to the Trust's staff engagement score and patient quality of care, productivity and staff retention.

Previously, the Trust had compared itself to the previous years. However, it was important to compare against other Trusts within the benchmark group. The Trust was marginally above average in 1 theme "We work flexibly" and below average in 7 of the themes against its benchmark group.

Working through some of the key themes:

- We are compassionate and inclusive – deteriorated faster than the benchmark group. However, in the subgroup around inclusivity, the Trust was below average (better) in racial discrimination but was above average (worse) in the other 8 protected characteristics.

- We are recognised and rewarded – staff were quite positive about pay, reflecting on the incentives and initiatives the Trust had offered. However, the Trust was underscoring in staff feeling recognised and appreciated.

- Staff engagement – there were three sub themes, motivation, advocacy and involvement, and in all themes the Trust was under achieving. Only 47.8% of the workforce looked forward to coming to work.

- We are always learning – the Trust scored average. The staff felt they had access to learning, training and development, they thought it was readily available and there was a high number of staff who had had an appraisal. The Trust fell down on the quality of appraisals.

- We are safe and healthy – there were 7 new questions relating explicitly to burnout because of the pandemic. On all 7 the Trust was below the benchmark average. That speaks to the Trust's staffing numbers and its establishments.

Denise McConnell asked if there was a difference in responses between the various sites. Polly replied that the breakdown was by Care Group directorate and not site.

Denise added that when she did a walk around at Bridlington the comments were around how much staff enjoyed working there, there was good staff retention, and the many negatives of the staff survey did not seem to connect with Bridlington. It would be interesting to know. Polly replied that phase 1 of the nursing investment scheme concentrated on international recruitment, predominantly focusing on the East Coast, and the feedback was that the Trust was reaping the rewards of that. SGH was coping better than YH right now. Agency workers were happy to work at SGH but not at YH in case they were left on their own on a shift.

Denise commented that the staff at Bridlington did not want to work at SGH so she wondered whether Polly's team could break down the survey by location to ascertain on which sites staff were unhappy. Polly replied that it was not possible to breakdown by location. Care Groups 1 and 2 responses were quite negative, not quite as negative as Care Group 3, with Care Group 6 responding the most positive.

Denise commented that the results were very generic covering a wide geography and it did not highlight where the pockets of discontent were. On the flip side, there could be some really positive results which were masking the problematic areas. Polly agreed that there were some pockets of really good practice and good experience and the results were an average so they were diluted to some degree.

In summary, Polly stated that there will be a presentation at Board this month and there was a need to have a challenging discussion as to how much of a priority fixing this was. She felt strongly that the professional leads needed to review the clinical establishments.

Jim Dillon thought it was important to discover where the pockets of discontent were and the extent of the problems on each site. It was important to do this in order to resolve the issues.

Jim alluded to the Trust's past performance and commented that the results were consistently worse than anyone else apart from the 1 measure. That did not depict a good picture at all. He would like to see a direction of travel to ascertain if the Trust could improve or will continue to worsen.

Jim referred to the appraisal system and commented that the Trust was measuring activity in relation to the number of appraisals carried out within the timeframe. He believed that appraisals were the key to a lot of the issues highlighted in the survey and that should be built into the appraisal system. There was also a need to measure the outcomes on the appraisals to establish whether they were having an effect on staff performance and motivation.

Jim asked how the Trust was going to deliver a response plan, who was going to manage it and what the timeframe was as it was quite a negative picture. Polly referred to staff engagement which was average but had dropped to below average in the 2020/21 survey. She described the Clever Together project which was carried out during 2019/20 and staff engagement was good, lots of staff enjoyed taking part in it. From this, a new set of values and behaviours were devised which were ratified at the February 2020 Board meeting and then for 9 months there was silence whilst the Trust dealt with the second wave of covid. She believed that silence had had an impact on the results. She went on to explain that feedback from the Care Groups around the Command & Control structure, which was established solely to manage the pandemic, was potentially having an impact and there was a need to get back to where the workforce felt they had an influence and involvement in changes rather than it being escalated to senior management.

Polly referred to previous staff survey action plans that were quite transactional and had been developed and owned by HR. She believed that the Board would need to discuss where this would sit and then come up with a really ambitious non-transactional action plan. Some of this would require financial investment but others, such as empowering staff to make their own decisions, values and behaviours; everyone should lead on and talk about in day-to-day interactions with staff.

Denise McConnell referred to Board approval for capital investment and asked if there was any investment available for this. Andy Bertram replied that Polly had put a small number of requests forward which were detailed on the investment schedule previously presented in the meeting.

Lynne Mellor referred to a discussion that took place at the recent Audit Committee and believed there were systemic issues, one major one being around performance management and staff engagement, and the Board would need to take a look at this to see what was needed. Culturally, she did not see the Trust values displayed day in day out throughout the Trust. She agreed that a Board session was needed to discuss the workforce including issues raised, actions, finance and investment needed, to implement changes.

Jim Dillon referred to the discussion sessions with staff (Clever Together) but the Trust was slow in responding and taking action. The Trust was not benefitting from the valuable information gained in engaging staff in conversations. Generally speaking, people love to be engaged with but if they are then ignored it tends to have a negative effect and any benefit there was from talking to them in the first place actually starts to become a negative engagement. The Trust needed to demonstrate the outcome from those conversations and engagements. Dylan added that, because of the circumstances, a lot of the promises made were false promises. Should the staff not be told the reality and be honest about whether their requests can be done. Polly agreed that the Trust should get better at communicating the journey that was needed to facilitate their requests. Lynne agreed. On the flip side, the Trust should speak up about all the positive things that were being done and communicate this out to staff.

The Committee:
- **Noted the disappointed results of the staff survey.**
- **Noted the linkage of issues highlighted in meetings elsewhere.**
- **Noted the need to discuss the action plan at Board level.**
- **Noted the contents of the report.**

22/33 Gender Pay Gap

Polly McMeekin gave an overview of her report and highlighted the following: -

- Median gap had increased, and will continue to increase, with 21.6% reported.
- When the medical and dental workforce was stripped out the median gender pay gap reduced to zero.
- The Trust had a workforce of 80% female and 20% male. The medical and dental workforce was 61% male. That increased to 70% male at the consultant body and that was where the Trust needed to target the work.

Nationally, Health Education England (HEE) was making sure that proportionate gender balance entered the medical training system. The Trust's responsibility was that during their training journey that there was not workforce practices that made it harder for women than men.

On a positive note, the Trust scored above average on the staff survey for "We work flexibly", and the Trust's action plan supported this in their flexible/agile working work life balance. This was a great step achieved during the pandemic and the Trust wanted to keep this going and drive the flexible working agenda going forward.

Lynne Mellor referred to females applying for the Clinical Excellence Awards (CEA) and commented that as per last year the latest results showed an obvious skew towards male applications. Polly replied it was the third of a 3-year transitional period to a new CEA allocation system and this year, as in the previous 2 years, the Trust had evenly allocated to the senior medical body. Nationally, negotiations around the revision of the CEA application process had broken down and she was waiting for further information.

The Committee:
- **Noted contents of the report**

22/34 Integrated Business Report - Workforce

Polly McMeekin gave an overview of her report and highlighted the following: -

- Staff absence stood at 8.2% with 33% relating to covid of which 22% of staff had tested positive.
- The restrictions to manage covid appeared to be having more of a detrimental impact more than the disease itself. From Monday (28/03/22) some of the IPC rules will be relaxed which will make a significant difference.
- LAMP testing was now ending and staff did not need to isolate due to covid if they were well enough to come into work.

Denise McConnell commented that if staff were working in a geriatric ward, they may be very reluctant to come to work if they had covid. Polly agreed. It was something they needed to work on.

Lynne Mellor said it would be useful to know how many of the 254 covid patients were critically ill with covid. Andy Bertram replied that today's figures showed 261 covid patients in the hospital, with none in the ICU and 16 requiring oxygen therapy. Polly added it was a different disease from what it was and it should be treated the same as flu.

The Committee:

- **Noted the contents of the report.**

22/35 Integrated Business Report – Digital

As Dylan Roberts was leaving the Trust at the end of March, the Committee thanked him for the contribution he has made to the Digital agenda in the trust including basic infrastructure and the redesign of the operating model and organisation..

Dylan gave an overview of his report and highlighted the following: -

- The report very much focused on the asks from the last meeting and wanted to provide assurance that on handover everything would be in order for his successor.
- Projected year end spend will be 95 – 97% of the available funds.
- Projects have been prioritised with the Care Group Directors/Chief Operating Officer and have been approved by the Executive Committee.
- The report lists the projects that were not going to take place together with the associated risks. Discussions were ongoing with the Care Groups to decide what mitigations could be put in place to address those issues without digital input.
- CPD was a big issue that had been exacerbated due to maintenance/development issues. During the past 6-9 months IT staff have left and the Trust had been unable to recruit a new developer. There was a need to move away from CPD and a business case was currently being made to the centre.
- Office 365 had been rolled out to a small cohort of users. From that it was evident that the Trust had a number of databases and spreadsheets in use that did not work with Office 365 and it will be difficult to mitigate those risks. Despite efforts to engage with the Care Groups to obtain feedback on what tools they were using, due to operational pressure, they were not responding.

Lynne Mellor referred to two areas from his report 1) the cyber desk top exercise still needed to be conducted for the LLP. Dylan agreed his successor would need to cover this area 2) the budget allocation process needed to be clear. Andy Bertram confirmed to Dylan who in his team would be the first point of contact, so that the 'card' allocation

process in the desktop exercise is clear for finance and budgeting in the event of a cyber-attack.

Lynne Mellor referred to the nursing documentation and asked if the timeline had been defined. Dylan replied that the telephony aspect had been sorted. There was an action plan for the roll out across the Trust which he will share with the Committee. Lynne added that it would be good to have a benefits realisation update, especially around efficiency.

The Committee returned to an earlier discussion on transformation, and the nursing documentation was a good example of a project aiming to transform ways of working with potential recurrent benefits. The Committee agreed that a workshop around key transformation programmes would be beneficial.

The Committee:

- **Noted the contents of the report.**

22/36 EPAM Minutes and assurance escalation report

Andy Bertram commented that there were no issues he wanted to highlight.

Lynne Mellor noted:

- the pressure on staff at 10% in terms of stress
- cleanliness issues
- IFRS16 issues

No further comments were made.

22/37 Board Assurance Framework (BAF)

Mike Taylor gave an overview of his report and highlighted the following: -

- The risk scores had not fundamentally changed
- Year-end processes were ongoing: -
    - There was an Internal Audit review taking place to ensure the Head of Internal Audit Opinion can be given.
    - AGS was being drafted.
    - The year-end process will be discussed at the next Risk Committee which will feed into the start of the 2022/23 BAF.
- A Board session will be planned to discuss the risks around the 2022/23 BAF.

22/38 Corporate Risk Register (CRR)

Mike Taylor gave an overview of his report and highlighted the following: -

- A risk had been added around Reinforced Autoclaved Aerated Concrete (RAAC) on the Scarborough site where material needed replacing. Discussions were ongoing to secure national funding.

22/39 Documents for consideration:

There were no further IBR issues to note that were not already covered on the agenda.

22/40 Any Other Business

There was no other business discussed.

22/41 Items for Escalation to Board

Lynne Mellor will summarise the items for escalation to the Board and distribute to the Committee.

22/42 Reflections on the Meeting

The following comments were made:

- Pressurised time with the landing of the Staff Survey and Finance plans together.
- Need longer to discuss finance plans.
- Robust discussions.
- Ensure key items are discussed at next Board.
- Did well to discuss the issues presented at the Committee.

22/43 Time and Date of next meeting

The next meeting will be held on 19 April 2022, at 9.00am by Webex.

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Resources Assurance Committee
19 April 2022

Attendance:
Lynne Mellor (Chair), Jim Dillon NED (online), Denise McConnell NED, Andrew Bertram Finance Director, Polly McMeekin Director of Workforce & Organisational Development, Simon Hayes (for Digital Update), Ashani Rathnakeerthi Honorary Clinical Fellow (observing via online)

Apologies: Michael Taylor Associate Director of Corporate Governance, Andy Williams Interim Chief Digital Information Officer, Ashley Clay Associate NED

Welcome and Introductions

The meeting was declared quorate.

22/44 Declaration of interest

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

22/45 Minutes of the meeting held on the 22 March 2022

The minutes of the last meeting held on 22 March 2022 were agreed as an accurate record.

22/46 Matters arising from the minutes and any outstanding actions

The action log was not included in the meeting papers therefore not discussed. The Committee noted the action log was missing again. It noted the need to review actions in the meeting from previous months at the next committee.

22/47 Escalated Items

Nil.

22/48 Research and Development Update Report

Polly McMeekin gave an overview of the report which summarises the last six months of activity. The report highlights a number of positive initiatives the Trust have commenced including the opening of the multi-morbidity research Hub at on the East Coast, it is hoped this will support recruitment and retention. The Trust continues to work constructively with HYMS, including an agreement to recruit to five clinical academics posts. Polly McMeekin

described how the Trust is benefiting from an enthusiastic research team and is continuing to progress albeit, in a challenging environment. Research nurses have been redeployed to deliver direct clinical care which is slowing the progress of the research agenda down. The Clinical Regional Network advised that the Trust is the only Trust in the region who is deploying research nurses into direct clinical care however it is uncertain if this is accurate. Dave Yates, Clinical Lead for Research, has completed his three year term and will subsequently step down from this role. He has, however, agreed to remain in post until a replacement has been sourced.

Matt Morgan requested clarity on research activity, asking how much is externally led and how much is Trust led, as well as how much research income is there outside of Clinical Research Network accrual. Polly McMeekin could not provide exact proportions but stated there is more Clinical Research Network support externally which is why the HYMS partnership is important. As a Teaching Hospital, the Trust has been performing at a lower level than expected and is trying to reverse this.

Matt Morgan also asked how much research PA time the Trust is funding and are there targets associated with it. Polly McMeekin obtained information from the job planning system and stated that Trust-wide, 2.7% of consultants have research time but it is unclear how this is funded. Denise McConnell added that any successful research programme would be lucky to recover, through bids, 50% of the costs as research is a loss making exercise, although extremely worthwhile. In response to this, Matt Morgan commented that unless the Trust knows what their figures are and what the aim is, there would be a need to benchmark. It would be unlikely to reach profit making level for the Trust but it would be helpful to have an idea of where the balance lies.

A final question from Matt Morgan was in relation to the Commercial Research Manager and what their role involves. Polly McMeekin explained it is to co-ordinate research projects around the Trust, giving the research team oversight to identify the associated benefit and to support the income generation.

Denise McConnell advised it would be helpful to understand the finances and what projects are ongoing which have a financial return and those which are positively impacting patient care.

Lynne Mellor complemented the succinct report and commended the team for meeting their target. Lynne Mellor asked that dates of when grants are expected and the outcome, to be provided. Polly McMeekin agreed to ask the team to include a table with timescales within the next report. There are two new steering groups; Health and Wellbeing and Digital. Lynne Mellor noted it would be beneficial to receive outcomes from these groups and how they are progressing.

Lynne Mellor also asked if the Trust has benchmarked against successful Trusts to understand how we can accelerate research, given the changes in cycle time since the pandemic (e.g. speedier delivery of new vaccinations). Polly was unaware of wider benchmarking review but did note the Research team are in the process of arranging a critical friend review, a review by external Research & Development staff to review services, governance and processes, to receive observations and opportunities for share learning, an update of which, will be included within the next report.

The importance of communicating research was noted by Denise McConnell and the added value this can bring to the Trust, such as motivating staff and making the Trust an attractive employer to prospective employees. Each Care Group has a research lead,

Denise McConnell asked how they communicating down to staff as this will help to engage employees at all levels and positively impact retention.

The Committee:

- **Noted contents of the report**
- **Recommended inclusion of a succinct table with timescales in the next report**

22/49 Integrated Business Report – Workforce

The Trust is currently under considerable pressure. The validated sickness absence is included in the IBR and over Easter weekend, an initiative to help mitigate staff absence was implemented which offered staff an extra day off in lieu if they offer to come into work and are needed. Polly McMeekin described the challenges with offering workforce initiatives and explained how they each have a limited effective timescale.

There are a number of employee relation cases currently, mainly due to cost of living and the impact this is having on staff. One initiative implemented to help with this is a 'school uniform exchange' for staff. A pilot for sanitary products through staff shop is also underway whereby staff can call and request a parcel and collect. The Trust is also exploring how to support staff with the escalating cost of food and included within this working with LLP colleagues around leftover food from canteens and how this could be donated. Jim Dillon explained that local authorities are addressing similar issues and looking at schemes which provide items such as food at a highly reduced cost, something in which the Trust could consider an option.

A further comment on the reliance of bank staff was made, on the reasons why staff choose this flexible approach to work and if this can be adapted to substantive posts. Polly McMeekin informed the committee that most staff with a bank contract also work substantively, but there is a need to drive the agile and flexible working agenda forward.

A half day with Board of Directors is planned in May 2022 to discuss the staff survey action plan and the workforce culture. Discussions are ongoing with York and Scarborough Charity to establish what level of funding there is available to 'fix the basics'.
In response to this discussion Lynne Mellor asked if the ICS have had involvement, Polly McMeekin confirmed not. The committee suggested contacting the ICS to share concerns as other Trusts may have the same experiences, therefore resolutions and ideas could be shared within the system for an efficient approach. Polly McMeekin will share these findings with ICS colleagues for comment.

Many international nurses are joining the Trust but currently there is a backlog of Visa applications. NHS staff are prioritised through the UK Border Agency however at present the priority is Ukrainian refugees. This may cause a delay in international recruitment, there is commitment from NHSE/I to receive funding if 90 international nurses commence in post within the calendar year, however if the Visa issue becomes problematic it is hoped NHSE/I will take this into consideration.

The Trust have partnered with the Improvement Academy who have conducted research on the impact of the pandemic on the wellbeing of staff and team dynamic. The Trust were asked to select a clinical team to work with the Improvement Academy and Ward 15 has been selected. This will be observed by ODIL who can then provide similar resource to other areas.

Denise McConnell questioned why the Workforce IBR does not contain information on the significant increase of Pressure Ulcers and Falls incidents due to workforce shortages. Also stating that the vacancy percentage in March is the lowest it's been since October 2021 and there is no indication of workforce shortfalls. Polly McMeekin advised the vacancy rate is separate to staff sickness absence, around 30% of daily absence is Covid-19 related. Denise McConnell therefore asked what data within the IBR reflects the considerable pressure Trust are reporting to be under. The committee acknowledged this is a reasonable question and agreed this should be actioned to discuss at Board regarding safe staffing levels.

Polly McMeekin informed the committee that adult inpatient nurse establishment review has been undertaken and Phase 1 of 2 is implemented.

Matt Morgan asked if the unfilled temporary nurse staffing requests being at its highest since 2021 is evidencing an accurate reflection of the staffing shortfalls, which is leading to the clinical incidents, to which Polly McMeekin agreed.

Lynne Mellor noted she was pleased to see 92 Mental Health First Aiders are now established in the workforce and asked what impact they are having i.e. how this is measured. Responding to this, Polly McMeekin feels it's a broader conversation including all health and wellbeing initiatives and has asked internal audit to help, focussing on whether the right staff are accessing the range of resources which are available to them. The internal audit report will be shared once received.

In relation to workforce pressures, Lynne Mellor asked if updated IPC guidance has had a positive impact on reducing absences and workforce gaps. Polly McMeekin responded to say its early days, but it is unlikely there will be a significant impact, staff are routinely testing and are required to isolate from work should they test positive.

The Committee:

- **Noted contents of the report**
- **Recommended the IBR linkage of operations and work force for safer staffing is discussed at Board level**
- **Recommended that the Board raise for discussion with the ICS any plans to alleviate at a system level the cost of living pressures which are starting to affect some staff now**

22/50 2022/23 Income & Expenditure Plan update

Andrew Bertram gave an overview of the report and confirmed there is still not an agreed Income & Expenditure Plan with the Integrated Care Board.

A key area to note is Appendix B within the report which details all the changes from the original £40.2m deficit to the current £21.766m deficit.

North Yorkshire System presented a programme of work to close the gap, focussing on three work streams detailed in the report at a Confirm and Challenge session with Integrated Care Board. Closing the residual £21.8m gap to an Income & Expenditure balanced position continues to prove challenging. The ICB have confirmed there are to be no new investments, unless approved by the ICB. Due to the unannounced CQC inspection at York Hospital recently, should investment be required, the ICB have confirmed they will work collaboratively with the Trust. The Trusts were thanked for

working together as a system and conducting cost reduction work. The ICB have accepted their responsibilities to assist system partners deliver efficiencies.

Andrew Bertram confirmed there are plans to target a substantial reduction on Covid-19 spend, reducing by approximately 30%. Andrew Bertram acknowledged this is a risk but based on the current situation and changing IPC guidance it is felt this is an appropriate action to take. Another risk identified is the removal of £1.1m winter contingency. The committee expressed concern over this, Andrew Bertram explained that if winter becomes challenging, the system will work together and escalate to the ICB what investment is required.

Denise McConnell suggested the finance team think about what information the committee will need next year to manage key risks. Andrew Bertram agreed and explained that the £7m cost reduction will only be confirmed with the ICB and Board of Directors if the Trust can achieve it.

Jim Dillon asked if the Trust have reached out to neighbouring and nationwide Trusts who have a balanced budget, to gain an understanding as to how they are achieving this and any lessons learned. In response, Andrew Bertram confirmed he has reached out.

The Committee expressed concerns around the potential risks, particularly on the operational plans, such as the potential removal of the £1.1M winter contingency and asked that the BAF is reviewed once the plans are finalised.

The committee agreed that the proposed 'Finance and Performance Committee' will be beneficial to enable operational and financial risk to be discussed together to make a direct correlation.

The Committee:

- **Noted contents of the report**
- **Expressed concerns around potential risks**

22/51 Capital Programme 2022/23 update

Andrew Bertram gave an overview of the report. The Trust has identified funding for approximately £40m of capital programmes, but significantly over committed with the programme. The capital programme will be sent to Care Groups, asking for each project to be scored, to enable a final prioritisation list to be compiled. The final list will go to Board of Directors for final approval.

The Committee received assurance that work is ongoing to reduce the estimated overspends of £3.7M on the York ED scheme with Kier following an update delivered by Andrew Bertram.

The Committee:

- **Noted contents of the report**

22/52 Integrated Business Report – Finance

Andrew Bertram described the year end position (March 2022) for the Trust and highlighted the following:

- The Trust is reporting an adjusted position of £102k surplus.

- CIP target of £8.1m exceeded by £0.9m.
- An increase in capital expenditure, spending a record £36m. The DIS team and LLP were recognised for ensuring that valuable capital programmes were committed by year end.
- Two schemes relating to Ramsay which were not accounted for at year end were: 1) £190k worth of work for the car park which Ramsay are funding, and 2) £230k worth of work at Clifton Park, which is now being discussed with Ramsay.

The Committee:
- **Noted contents of the report**

22/53 EPAM Minutes and assurance escalation report

Andrew Bertram did not have anything to highlight within this report, therefore asked for questions.

Lynne Mellor asked if the LLP staff survey results would be included within the next workforce report, ideally prior to the Workforce Board session, Polly McMeekin explained this could not be guaranteed but the team are following this up.

The Committee:
- **Noted contents of the report**

22/54 Sustainable Development Group minutes and assurance escalation report

Andrew Bertram did not have anything to highlight within this report, therefore asked for questions.

The Committee noted the Sustainable Development Group progress and the focus on digital innovation to help with net zero plans. Lynne Mellor advised it would be good to understand further how things are progressing, particularly around the £9m spend.

The Committee:
- **Noted contents of the report**

22/55 Integrated Business Report – Digital

Simon Hayes was welcomed to the Committee, to provide an update on the Digital agenda.

Simon Hayes gave an overview of the report and highlighted key points to the committee.

Firstly, the large scale programme delivery and planning work ongoing, whereby the Trust is developing project portfolios for 2022/23. There is an essentials services programme commencing, which is a large scale set of projects which encompass all aspects of IT over the next 6-9 months.

The interim CDIO, Andy Williams, is in post and will hand-over to the new substantive CDIO, interviews for which are planned for 28th April. Luke Stockdale, CTO, commences in post in May 2022, and Nik Coventry, CNIO, is now in post. Head of Delivery interviews were on 13 April 2022, the appointment of a successful candidate will be announced soon. There is a lot of operational work ongoing and the revenue and capital close down of finances for 2021/22 was noted as an achievement.

Lynne Mellor also commented on:
A) The new management tool and how it would be useful to report on the success of this and what aspect of cyber it is managing.
B) If the output of the action for the LLP Cyber desktop exercise could now be reported to the Committee in May.

Simon Hayes explained the IT Health Dashboard which is used at many Trusts nationwide for cyber, will be beneficial and the team can produce a presentation to showcase potential uses. He also agreed to review the LLP action and bring back the results.

The Committee:

- **Noted contents of the report**
- **Requested the output of the LLP Cyber desktop exercise could be reported to the Committee in May 2022**

22/56 Digital 2021/22 expenditure summary report

Simon Hayes provided an overview of the report, highlighting the following key points.

The Trust have supported a high level of capital and revenue investment, giving the team an opportunity to prioritise critical set up to reduce technical debt and spend on enabling digital. Funding exercises have also taken place which has produced several £m of capital investment which has enabled work to be undertaken to help to future proof the organisation.

Money has been spent on replacing CPD infrastructure and storage of systems and data. An upgrade to data centres and their infrastructure is also taking place to adhere to a recognised national standard. Investment has also gone into end user device to provide a better customer experience including devices to support digital documentation.

The report includes DIS Capital and Revenue Submission for 2022/2023, which Simon Hayes acknowledged may not be achievable due to the Trust's current financial position. As part of the UTF funding, a bid for £3m has been submitted and other funding requirements will be addressed throughout the year.

From an operating model perspective, the aborted holistic partner exercise has re-commenced and this will be driven forward between April – June 2022.

Lynne Mellor on behalf of the Committee applauded the DIS team for the work they had done to commit plans for the £8.8M. The next step was to ensure the project plans for H1 in particular showed the tracking of the benefits realisation. She suggested it would be useful to see a roadmap of planned future developments with dates to communicate . Simon Hayes agreed this is beneficial and will look to develop a simple roadmap.

No risks were identified which would impact the BAF at this current time.

The Committee:

- **Noted contents of the report**
- **Requested DIS review the cyber actions and produce a roadmap of developments for communication**

22/57 Board Assurance Framework

This item was discussed throughout the agenda.

22/58 Documents for consideration

There were no documents for consideration

22/59 Reflection on the Meeting and Any Other Business

There was no other business discussed.

22/60 Time and Date of next meeting

The next meeting will be held on 17 May 2022 at 9:00am via Face to face/Webex

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
NHSI Licence Self-Certification

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 discuss the paper and provide approval for the signing of the self-certification for G6, CoS7, FT4 and Governor Training.

Executive Summary – Key Points

NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider Licence which includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012. The Trust is also to self-certify to have regard to the NHS Constitution, have the required resources available if providing commissioner requested services, and have complied with governance requirements. These self-certifications are:

- Conditions G6 and CoS7 – by 31 May 2020
- Condition FT4 and Governor Training – by 30 June 2020

The Trust is not required to submit the certificates, but NHSI will carry out spot audits on Trusts to ensure they comply.

The attached report details the requirements, the evidence to underpin self-certification including a matrix showing compliance against NHSI Licence (appendix 1) and the certificates which need to be signed.

Recommendation

The Board is asked to discuss the paper and provide approval for the signing of the self-certification for G6, CoS7, FT4 and Governor Training.

Author: Mike Taylor, Associate Director of Corporate Governance

Director Sponsor: Simon Morritt, Chief Executive

Date: 16 May 2022

NHSI Licence Self-Certification

1. Introduction and Background

NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider Licence which includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012. The Trust is also to self-certify to have regard to the NHS Constitution, have the required resources available if providing commissioner requested services, and have complied with governance requirements. These self-certifications are:

- Conditions G6 and CoS7 – by 31 May 2020
- Condition FT4 and Governor Training – by 30 June 2020

This report details the requirements, the evidence to underpin self-certification and copies of the certificates provided by NHSI.

2. Self-Certification

Providers need to self-certify against the following conditions:

NHS Provider Licence Conditions

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

Condition G6 - This requires a provider to have in place effective systems and processes to ensure compliance with the licence, identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Appendix 1 provides an assessment against the licence conditions.

Condition FT4 - This requires that providers should review whether their governance systems meet the standards and objectives in the condition (*there are no standards or set model*). Any compliant approach would involve effective Board and Committee structures, reporting lines, and performance and risk management systems.

The Trust annually reviews the Board Committee terms of reference to ensure the structures in place are effective and provide underpinning support to the work of the Board together with clear lines of reporting. The Board Assurance Framework and Corporate Risk Register are reviewed by the Board and its Committees and provide the Board Committees with a focal point and framework for discussions.

The Head of Internal Audit Opinion for 2021/22 provides significant assurance for the Board Assurance Framework and the risk management systems and processes and their application Trust wide.

Training of Governors (not a licence condition) - The Health and Social Care Act states providers must take steps to ensure that the governors are equipped with the skills and knowledge they require. The Trust has taken the following steps to provide information and knowledge:

- Board to Council of Governor meetings;
- Council of Governors meetings (presentations) including updates from the Committee Chairs;
- Individual Induction sessions were carried out in October 2021 following the elections;
- Information – emails are sent to Governors to provide information and updates – the Governors have continued to receive staff briefings during the pandemic period including emails from the Chair;
- As the pandemic was at its height meetings with governors continued online;
- Development sessions are planned across 2022 to enable governors to fulfil their roles;
- Individual governors have attended training (such as interview training as part of NED recruitment) with learning disseminated to governor colleagues;
- Governor Training offerings through NHS Providers; and,
- Governor one to ones with the Chair.

Condition CoS7 - This requires that providers designated as providing Commissioner Requested Services will have the required resources to continue to provide these services; management, financial, facilities, personnel, physical and other assets.

The Trust can confirm that it has Commissioner Requested Services designation which is to provide services because either there is no alternative provider close enough, removing services would increase health inequalities or removing services would make other related services unviable.

Management have completed a full going concern assessment and it is recommended that the Board of Directors prepare the Group 2021/22 annual accounts on the basis of the going concern principle in having adequate resources, or access to appropriate support should this be necessary, to continue in operational existence and to continue to provide all licensed services for the foreseeable future.

3. Next Steps

The Trust is not required to submit the certificates, NHSI retains the option each year of contacting a select number of NHS Trusts and Foundation Trusts to ask for evidence that they have self-certified, by providing the completed or relevant board minutes and paper recording sign off. However, the G6 self-certification must be published within a month following Board sign off.

4. Recommendation

The Board of Directors is asked to discuss the paper and provide approval for the signing of the self-certification for G6, CoS7, FT4 and Governor Training.

APPENDIX 1

Assurance Report of Compliance with the Provider Licence Conditions
SECTION 1: GENERAL CONDITIONS

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G1	Provision of information	This condition requires licensees to provide NHS Improvement (NHSI) with any information they may require for licencing functions.	The Trust has robust data collection and validation processes andhas a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements. All information submitted to NHSI is accurate.	**All Directors**
G2	Publication of information	This condition contains an obligation for all licensees to publish such information as NHSI may require, in a manner that is made accessible to the public.	The Board meets in public and undertakes the majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website. The website contains a variety of information providing advice to the public who may require further information about services. Copies of the Trust's Annual Report and Accounts, Quality Account and the Trust's governance frameworks documents are published on the website and the Trust operates the model publication scheme.	**All Directors**
G3	Payment of fees to NHSI	The Health & Social Care Act 2012 ("The Act") gives NHSI the ability to charge fees and this condition obliges licence holders to pay fees to NHSI if requested.	No decision has yet been made by NHSI to charge fees. However, the obligation to pay fees is a condition and will be accounted for within the Trust's financial planning.	**Finance Director**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G4	Fit and proper persons	This condition prevents licensees from allowing unfit persons to become or continue as Governors or Directors (or those performing similar or equivalent functions).	Satisfying the Fit and Proper persons test is a requirement anchored in theTrust's Constitution and all Governors and Directors must satisfy this requirement upon appointment. They are also required to sign annual declarations that they remain a fit and proper person. The Trust operates a rolling programme of Disclosure & Barring Service (DBS) checks for front line staff and for staff with access to sensitive information. The Board of Directors and Governors are subject to DBS checks on appointment and every 3 years thereafter upon commencement of a new, 3-year term of office. The Board of Directors and Governors sign a Code of Conduct that identifies expected standards of behaviour. The Trust's constitution contains relevant clauses for governors and directors about eligibility, disqualification and removal which are incorporated into Board members' contracts and appointment terms and conditions.	**Chief Executive**
G5	NHSI guidance	This condition requires licensees to have regard to any guidance that NHSI issues.	The Trust has had regard to NHSI guidance through submission of required annual and quarterly declarations, self-certifications and exception reporting as set out in the Compliance Frameworks. The Board has consistently complied with the NHS Foundation Trust Code of Governance and has complied with all other guidance documents such as Annual Reporting and Forward Planning requirements and Annual Reporting Manual.	**Chief Executive**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G6	Systems for compliance with licence conditions and related obligations	This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	The Trust has an approved Risk Management Framework and a Board Assurance Framework which set out a process for identifying, managing and escalating risk. This is scrutinised and reviewed quarterly. The Board Assurance Framework identifies key strategic risks relating to the Trust's key priorities and longer-term strategies. Internal and External Audit reports on regulatory compliance and effectiveness of internal controls provide an additional layer of scrutiny and precaution. In the management response to the Coronavirus pandemic, the Trust operates a revised risk management process through its Gold Command structure.	**Chief Executive**
G7	Registration with the Care Quality Commission	This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled.	Certificates and reports are received from the CQC and Trust. NHSI is notified when CQC attend the Trust and advised of the outcome on receipt of a final report from CQC. NHSI is advised of the report and provided with a copy. If there is a concern highlighted by CQC at their informal feedback, the Trust will review and advise NHSI as appropriate.	**Chief Nurse / Chief Executive**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G8	Patient eligibility and selection criteria	This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.	The Trust publishes descriptions of the services it provides on the Trust's website. Directory of services supporting choose and book	**All Directors**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
G9	Application of Section 5 (Continuity of Services)	This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. Licensees are required to notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. Licensees are required to continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. Services shall cease to be Commissioner Requested Services (CRS) if: • commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS; • three years have elapsed since the 1 April 2013 or one year has elapsed since the commencement of the license, whichever is the latter; or • the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of provision has expired. Licensees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide.	NHS Standard contract and services	**Finance Director**

SECTION 2: PRICING

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
P1	Recording of information	Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by NHSI.	The Trust notes this condition. The Trust records all of its information about costs in line with current guidance and intends to comply fully with any new guidance.	**Finance Director**
P2	Provision of information	Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	The Trust notes this condition. The Trust intends to comply fully with any new requirements to submit information to NHSI. All reference cost information has been submitted to NHSI. Routine report submissions. Covid reporting as required.	**Finance Director**
P3	Assurance report on submissions to NHSI	When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	The Audit Committee receives and monitors all Internal Audit reports including specific reports on pricing. A Data Quality Working Group is in place to advise on data produced being complete, accurate and timely. Routine report submission	**Finance Director**
P4	Compliance with the national tariff	The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.	The Trust follows national guidance. NHS Standard contract and services.	**Finance Director**

P5	Constructive engagement concerning local tariff modifications	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification.	As above.	**Finance Director**

SECTION 3: CHOICE AND COMPETITION

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
C1	Patient Choice	This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust has complied with all guidance and has systems in place.	**Finance Director**
C2	Competition Oversight	This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	All licensed provider organisations will be treated as 'undertakings' under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an 'economic activity' for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act. The Board and Executive Management team has access to expert legal advice to ensure compliance with this condition. NHS Standard contract and services	**Finance Director**

SECTION 4: INTEGRATED CARE

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
IC1	Enable the provision of integrated care	The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care	Values of the Trust and the development of the Operational Plan.	**Chief Executive**

SECTION 5: CONTINUITY OF SERVICES

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
CoS1	Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.	As for condition G9 above.	**Finance Director**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
CoS 2	Restriction on the disposal of assets	This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI's consent before disposing of these assets when Monitor is concerned about the ability of the licensee to carry on as a going concern.	The Trust has prepared its accounts on a 'going concern' basis Internal Audit reports and routine report submissions	**Finance Director**
CoS 3	Standards of Corporate Governance and Financial Management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The Risk Assessment Framework will be utilised by NHSI to determine compliance *Single Oversight Framework introduced in October 2016*	The Trust has a suite of governance documents including: • An overarching corporate governance framework; • Standing Financial Instructions; and • Reservation of Powers to the Board and Delegation of Powers. Routine and regular governance and financial reports to Board meetings and Board committees confirm details of the Trust's governance and financial management and information around achieving the performance targets. The framework includes compliance with the NHS Foundation Trust Code of Governance, relevant Directors' codes of conduct and other guidance routinely issued by regulators or best practice standard-setters. Single Oversight Framework – segment 2	**Chief Executive** **Finance Director**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
CoS 4	Undertaking from the ultimate controller	This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This is best described as a 'parent/subsidiary company' arrangement. **If no such controlling arrangements exist then this condition would not apply.** Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days. Governors, Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'.	The Trust is a Public Benefit Corporation and neither operates or is governed by an Ultimate Controller arrangement so this licence condition does not apply.	**Not applicable**
CoS 5	Risk Pool Levy	This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.	The Trust currently contributes to the NHS Resolution risk pools for clinical negligence, property expenses and public liability schemes.	**Chief Executive** **Finance Director**

	Licence Condition:	Explanation:	Board Assurance:	Lead Director(s):
CoS 6	Cooperation in the event of financial stress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	System in place	**Finance Director**
CoS 7	Availability of Resources	This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	The Trust has well established services in place and currentlyprovides all services required by commissioners to a high standard. The Trust has forward plans and agreements in place with commissioners that meet this condition. The Board's Resources Committee closely monitors the continuous availability of key resources including financial and infrastructure resources, and any emerging risks surrounding the availability of these and the potential impact on the quality of commissioner requested services. Resourcing, including human resources, in the context of the pandemic situation are temporarily monitored by the Emergency Oversight Committee.	**Finance Director** **All Directors**

SECTION 6: NHS FOUNDATION TRUST CONDITIONS

	Licence Condition:	Explanation:	Board assurance:	Lead Director(s):
FT1	Information to update the register of NHS Foundation Trusts	This licence condition ensures that NHS Foundation Trusts provide required documentation to NHSI. NHS Foundation Trust Licensees are required to provide NHSI with: • a current Constitution; • the most recently published Annual Accounts and Auditor's report; • the most recently published Annual Report; and • a covering statement for submitted documents.	The Trust has a track record of compliance with this condition and all documents are routinely submitted to NHSI via the Portal and are also published on the Trust's website. The Board and the Executive Management Team have an agreed business/forward planning cycle that ensures all key documents are prepared and approved by the Board timely. The Audit Committee monitors the preparation and submission of the Trust Annual Accounts, Auditors Report and theAnnual Report. The Trust Secretary ensures that these documents aresubmitted to NHSI in a timely manner and that any amendments are communicated to NHSI within specified timeframes.	**Trust Secretary**
FT2	Payment to NHSI in respect of registration and related costs.	If NHSI moves to funding by collecting fees, they may use this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration.	NHSI will consult further before introducing such a fee. There has been no indication of an intention to apply this condition. See G3 above.	**Finance Director**
FT3	Provision of information to advisory panel.	The Act gives NHSI the ability to establish an advisory panel that will consider questions brought by governors. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.	The advisory panel has been dissolved by NHSI. No alternative arrangements have been communicated by NHSI. Governors would be advised to contact NHSI through other routine channels including complaints and whistleblowing reporting. The SID acts as a point of contact for Governors where issues cannot be resolved through the normal channel via the Trust Chair, Chief Executive Officer or Trust Secretary. The Trust has a track record of complying with such information requests and collaborates well with NHSI any matters of concern raised by Governors or Members.	**Trust Chair** **Senior Independent Director** **Trust Secretary**

FT4	NHS Foundation Trust Governance arrangements.	This condition will enable NHSI to continue oversight of governance of NHS Foundation Trusts. In summary, licensees are required to: • have systems and processes and standards of good corporate governance; • have regard for the guidance published by NHSI; • have effective Board Committee Structures • have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board; • comply with healthcare standards; • have effective financial management, control and decision making; and • maintain accurate information.	See CoS 3 above In response to the Coronavirus pandemic, the Board put in place a set of refined and supplementary governance arrangements to ensure continued effective oversight and scrutiny and the continued effectiveness of governance systems and processes during the emergency situation. A Bronze-Silver-Gold Command structure was in operation during the pandemic situation. Additional assurances are provided through regular calls with all Non-Executive Directors and regular engagement by the Trust Chair with all Governors. The refined governance arrangements remain in place throughout the pandemic situation. Routinely, the Board undertakes an annual review of: • Board and Committee effectiveness. • Strategic/Principal objectives and risks to delivery (Board Assurance Framework). • Board committee terms ofreference and performance against these. • Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers. Other forms of assurance include: • Outcome of the Well-led governance review in June/July 2019. • Managerial and professional lines of accountability and clinical leadership. • Annual Governance Statement, Annual Report and Quality Account. • Audit Committee and Quality Assurance Committee scrutiny. • Internal and External Audit reports. • Performance reports received by the Board at every meeting.	**Board of Directors** **Trust Secretary**

			• Annual appraisals and development plans. • Performance Management Framework. • Board committees. • Dashboards and patient information monitoring and experience systems. • Strategies and policies kept under regular review.	

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

York and Scarborough Teaching Hospitals NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2021/22 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	System and controls assurance are obtained via the Audit Commtttee. More complete explanations about the systems of corporate governance and internal control are set out in the Annual Governance Statement included in the Trust's Annual Report.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Revised guidance with regard to good corporate governance forms part of the board development programme as appropriate. Corporate governance processes and systems are revised to reflect the guidance where appropriate e.g. Conflicts of Interest Guidance published by NHS England.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Ongoing focus of the Board on its structures to ensure it can undertake its central role of strategic planning, risk management and performance oversight effectively.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Alan Downey	**Name**	Simon Morritt

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates | 2021/22 | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Susan Symington	**Name**	Simon Morritt
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

York and Scarborough Teaching Hospitals NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2021/22

Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

	Statement	Response	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

	Statement	Response	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22
	OR		
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond
	OR		
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Management have completed a full going concern assessment and it is recommended that the Board of Directors prepare the Group 2021/22 annual accounts on the basis of the going concern principle in having adequate resources, or access to appropriate support should this be necessary, to continue in operational existence and to continue to provide all licensed services for the foreseeable future.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Alan Downey	**Name**	Simon Morritt
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
25 May 2022
Fit and Proper Persons Review

Trust Strategic Goals

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

Recommendation

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

Purpose of the Report

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

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

Executive Summary – Key Points

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

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

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

Recommendation

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

Author: Mike Taylor, Associate Director of Corporate Governance
Director Sponsor: Alan Downey, Chair
Date: 17 May 2022

Appendix 1

CQC 2022 – Fit & Proper Person Matrix of Evidence

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

Individual	Photographic ID	Evidence can work in the UK	Qualifications	Disclosure and Barring Service	Insolvency Bankruptcy Check	Disqualified Directors Register Check
Polly McMeekin Director of Workforce & OD	Copy Passport Copy Driving Licence Santander Card Summary page	✓	CIPD Member – Chartered Fellow MA in Personnel & Development Health & Human Science Degree	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Lucy Brown Director of Comms	Copy Passport Copy Driving Licence	✓	PG Cert in Health Communications Shadow Board Certificate CIPR Diploma Psychology Degree	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Alan Downey NED	Copy Passport Water Statement Gas Statement	✓	Master of Arts Degree MBA Certificate	Copy of certificate on file	Clean – 22.12.21	Clean – 22.12.21
Jenny McAleese NED	Copy Passport Copy Driving Licence Council Tax	✓	The Institute of Chartered Accountants in England & Wales Certificate	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Lorraine Boyd NED	Copy Passport Copy Driving Licence Copy Council Tax Demand Notice	✓	Registered with the GMC	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Lynne Mellor NED	Copy Passport Copy Driving Licence Annual mortgage statement	✓	Master of Business Administration	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20

Individual	Photographic ID	Evidence can work in the UK	Qualifications	Disclosure and Barring Service	Insolvency Bankruptcy Check	Disqualified Directors Register Check
Stephen Holmberg NED	Barclaycard Statement Copy Driving Licence Copy Passport	✓	Medical Degree Membership Royal College of Physicians	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Jim Dillon NED	Copy Passport Copy Driving Licence N Power monthly statement Yorkshire Water bill	✓	BA – Business Economics with Manpower Studies CIPD	Copy of certificate on file	Clean – 11.05.20	Clean – 11.05.20
Matt Morgan HYMS NED	Copy Passport Barclays Bank Letter	✓	Batchelor of Medicine & Surgery PG Renal Medicine Philosophy Doctorate GMC Registration confirmed	Copy of certificate on file	Clean – 14.05.20	Clean – 26.05.20
Denise McConnell NED	Copy Passport Copy Driving Licence Council Tax Bill	✓	The Institute of Chartered Accountants in England & Wales Certificate	Copy of certificate on file	Clean – 05.10.21	Clean – 05.10.21
Ashley Clay Associate NED	HSBC Statement Copy Passport Eon Energy Bill	✓	Chartered Institute of Management Accountants BSc Accounting & Finance	Copy of certificate on file	Clean – 05.10.21	Clean – 05.10.21