York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 27th July 2022
Time: 9:00am – 11.45pm

Via Webex

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 27th July 2022

TIME	MEETING	ATTENDEES
9:00 – 11:45	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:30 – 2:15	Board of Directors – Private	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	Report/ Verbal	Page No	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 29 June 2022** To be agreed as an accurate record.	Chair	Report	09	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	23	
6.	**Chief Executive's Update** To receive:	Chief Executive			9.05
6.1	• Update from the Chief Executive		Report	25	
6.2	• Priorities Plan 2022-23		Report	31	

Trust Priority: Our People

Item	Subject	Lead	Report/ Verbal	Page No	Time
7.	**Nurse Staffing Report** To receive the report.	Chief Nurse	Report	61	9.25
Trust Priority: Quality and Safety					
8.	**CQC Report** To present the CQC action plan in response to the recent inspection.	Chief Nurse	Report	71	9.35
9.	**Ockenden Report Update** To receive the report to include: • Perinatal Clinical Quality Surveillance Report • Continuity of Carer Report Appendix A - G	Chief Nurse	Report	103	9.55
10.	**Infection Prevention and Control Annual Report** To receive the 2021/22 infection prevention and control annual report.	Chief Nurse	Report	111	10.05
11.	**Guardian of Safe Working Hours** To receive the Q1 2022/23 Guardian of Safe Working Hours report.	Medical Director	Report	135	10.15
12.	**Quality Assurance Committee Minutes** To receive and note the minutes of the meeting held on 21 June.	Committee Chair	Report	147	-
Trust Priority: Elective Recovery Trust Priority: Acute Flow					

Item	Subject	Lead	Report/ Verbal	Page No	Time
13.	**Operational Performance Update** To receive an update on the Trust's operational performance.	Interim Chief Operating Officer	Report	157	10.25
14.	**Healthy Bridlington Engagement**	Chair	Verbal	-	10.40
15.	**Integrated Board Report** To receive and discuss the IBR, highlighting any areas of concern not already discussed. Full Integrated Business Report	All	Report	163	11.05
	Governance				
16.	**Finance Performance Report** To receive the Trust's June Finance Position.	Finance Director	Report	177	11.10
17.	**YTHFM Final Operational Financial Plan 2022/23** To receive and approve the YTHFM financial plan for 2022/23.	Finance Director	Report	187	11.25
18.	**Resources Assurance Committee** To receive and note the minutes of the meeting held on 21 June.	Associate Director of Corporate Governance	Report	197	-
19.	**Any other business including questions from the public**	Chair	Verbal	-	11.40
19.1 19.2	• Latest Executive Committee minutes • Star Award nominations - August				

Item	Subject	Lead	Report/ Verbal	Page No	Time

20. Time and Date of next meeting

The next meeting held in public will be on 28 September 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 11.45

Minutes
Board of Directors Meeting (Public)
29 June 2022

Minutes of the Public Board of Directors meeting held on Wednesday 29 June 2022 in The Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital, commenced at 9:00am and concluded at 11:08am.

Members present:

Non-executive Directors
- Alan Downey (Chair)
- Jenny McAleese - virtual attendance
- Steve Holmberg - virtual attendance
- Lynne Mellor
- Jim Dillon - virtual attendance
- Matt Morgan
- Lorraine Boyd
- Denise McConnell

Associate Non-executive Directors
- Ashley Clay

Executive Directors
- Simon Morritt, Chief Executive
- Andrew Bertram, Deputy Chief Executive/Finance Director
- Heather McNair, Chief Nurse
- Wendy Scott, Chief Operating Officer
- Polly McMeekin, Director of Workforce & Organisational Development
- Andy Williams, Interim Chief Digital Information Officer – virtual attendance
- Jim Taylor, Medical Director

Corporate Directors
- Lucy Brown, Director of Communications

In Attendance:
- Mike Taylor, Associate Director of Corporate Governance
- Cheryl Gaynor, Corporate Governance Manager (for minutes)

Observers:
- Joe Cooper, Local Democracy Reporter

The Chair welcomed everyone to the meeting.

22/21 Apologies for absence
There were no apologies received

22/22 Declaration of Interests

There were no declarations of interest to note.

22/23 Minutes of the meeting held on 25 May 2022

With the suggested inclusion, the Board approved the minutes of the meeting held on 30 March 2022 as an accurate record of the meeting.

Minute 22/06, paragraph 5 to include "…in particular around empowering staff to make decisions that would not necessarily be standard practice."

The Board:

- **Approved the minutes of the meeting held on 25 May 2022 with the inclusion of the above.**

22/24 Matters arising from the minutes

Action log:

Action 4 (Nurse Recruitment and Retention & Coventry University) – Non-executive Director Jim Dillon confirmed that he had a meeting arranged with Professor John Latham, Vice-Chancellor and Chief Executive of the Coventry University Group.

Action 5 (Nurse Recruitment and Retention Report & nursing quality indicator dashboard) – Have restarted the work as a priority and working through well with the team being able to deliver ahead of the return and the response to the CQC report. This action now closed.

Action 6 (Final Ockenden Report & publications on website) – This action was now closed.

22/25 Patient Story

Jane Miller attended the Board meeting to share her late husband Bill's patient journey through Scarborough hospital. Jane was also supported by Lead Nurse for End of Life Care, Kathryn Sartain. Jane shared that although Bill was in reasonable health and had always been stoic as he fought health issues as a result of his days as a Royal Engineer spent on Christmas Island in the 1950s for the atomic testing. However, as covid started his general health started to deteriorate until on the Thursday 15th September, together with the family GP, it was decided he needed to be in hospital to get the correct fluids and antibiotics. Jane went on to describe Bill's story:

"Now our nightmare begun. When he left home in an ambulance with spongebag, 3 pairs pyjamas etc we (and the ambulance drivers) were unaware visiting would be stopped that very day - indeed I first found I could not visit him when I went down to take him his mobile phone. Eventually in the evening after 3 phone calls I found him on Lilac Ward and managed to speak to him. He had seen a doctor who had told him he had a leaking heart valve and chest infection - both of which we knew. He was told that a small operation at Hull would correct the valve and antibiotic treatment would sort chest infection.

At 7.00am on Saturday 17th he rang me - he didn't know where he was and seemed confused - I rang Lilac ward to be told he had been moved at midnight to Chestnut Ward. I rang him back and put his mind at rest - but concerned about the situation I then tried for 2

hours to speak to a nurse. Eventually I was informed they were treating him for pneumonia. I asked which Consultant had been appointed for his care only to be informed that he wouldn't be allocated a consultant until Monday when Dr. Humphries did his ward round - some 5 days after he was admitted.

On Sunday I rang to see how he was and expressed my concerns - and was offered a video call but that would have to be when a nurse was available to organise it. Why a nurse I wondered.

Eventually on Sunday I saw Bill via video - my shock at his condition still haunts me. He was unshaven, could hardly talk, he was slumped in his bed, still in the same shirt and clothes that left home in - what has happened in 4 days? He was later to tell me about his experience on Chestnut Ward when an elderly man asked for a bed pan, only to be told he would have to wait till the staff had time and had finished doing the medicine round. Sadly, when they eventually got to him it was too late, they drew curtains round him and the ward heard him in tears as the nurses chastised him calling him "a dirty old man who should have shown more control". Listening to that my husband decided not to drink or eat in case it happened to him.

Monday morning came and following a consultant ward round I received a telephone call from a junior doctor to inform me that my husband would be taken to Beech Ward. They had decided he needed to drain his lung and there was a shadow that needed investigation. I explained to him that my husband had served on Christmas Island - which meant nothing to him - and that he had a previous history of pneumonia.

Later that evening I spoke to a nurse who told me the lung procedure had been completed, he was fine and comfortable.

Imagine how it felt the next morning at 7.0 I phoned to see if he had had a comfortable night to be told "well Mrs Miller what do you expect your husbands dying of lung cancer". I will never forget that cold insensitive conversation, I can hear his voice today.

As soon as the surgery opened, I rang and spoke to our GP. He looked at his results and could see no indication of such a diagnosis but that there was infection, but he was fighting it. He had looked after my husband for over 20 years, understood about Christmas Island and was shocked at how the nurse had spoken.

I rang Beech Ward, asked which consultant was responsible for his care and requested an appointment to discuss my husband's care. I offered to go to York as I was told that was where he was based, I offered to pay for a private discussion if necessary (having worked in the NHS I knew that could unblock the communication block).

On Tuesday I was offered that consultation accompanied by my husband and would I attend Beech Ward to see the doctor the following day.

I took my husband's eldest son with me and when we arrived was callously told he couldn't see him, only me, so he went back to the car park.

I can only describe the Ward as looking like a war zone. Dirty laundry littered the floor, equipment was blocking entrances to the ward, and I was just left to await being put in an unused wing to await my husband. Eventually they pushed him in to me. The vision of him unshaven, his hair unclimbed, slumped on one side of the bed. He held my hand - he said get me out of this "hell hole".

A junior doctor and a nurse came to see us. Very coldly he told us that my husband had terminal lung cancer and we had only days/weeks - did he want to go to the hospice or home. My husband said, "you have no proof - I just want to go home". It was agreed that they would remove the drain, seal the lung and arrange the palliative care package which would be done in 24 hours and he would be home either Thursday or Friday.

A nurse offered us a cup of tea which we accepted. I helped him drink it - he told me that was the first warm drink he had had since being admitted. He held my hand and smiled at the thought of coming home.

They wheeled him back to his ward and as I watched him go I said to the nurse he looked so weak - she callously said if his condition deteriorated they would ring me and with that I left to go back to the car park to tell the family. I will never forget finding the back way to avoid meeting anyone, shaking, in tears and thinking what has happened to the NHS. Alone my battle had only just begun, the battle to get him home.

Lunch time on Thursday - all morning spent trying to speak to someone in authority on Beech Ward. 5 phone calls answered by the Ward Clerk - asked to ring back when the nurses had finished their coffee break. Eventually a nurse informed me that the procedure to remove the lung drain and seal the cavity had still to be done so it would by the next day - Friday. By noon Friday I had received no communication. On the phone only to be told that it would be after the weekend as they hadn't got the care package completed. Every minute, every hour they kept my husband against his wishes was taking precious time we had left to spend with him.

After talking at length to our solicitor and the Health correspondent at the Yorkshire Post and the Mail, I then rang the Chief Executive's office at York. I was put through to a "Matron", I told her about my husband his treatment, his wishes and that if his wishes were not respected I together with my lawyers and the press would see the Trust in Court later that day as I had his power if attorney which also covered his health. Within an hour my husband had been seen by a senior member of staff at Scarborough Hospital, he was being washed and shaved and prepared to be discharged. He was home in his own bed within two hours.

Why should I have had to go to these lengths - the fact that my knowledge of the system armed me with the ability to press these buttons does not make it right - Supported by the Hospice at Home team and the fantastic young team from React we were able to spend the last twelve days together. He talked about his stay, about how he felt at being treated without care, empathy or informed about anything - sadly he just had to rely on me to get him out. I can never forget his words " you wouldn't treat an animal as we were treated". A strong dignified man who had served his country, served his community, farmed for over fifty years and always believed in his local hospital and the NHS felt so badly let down in his hour of need. It was for those reasons he wanted to make the formal complaint stressing this was not about money but shining a light on the reality of being a patient in the hope his legacy would be to help others not to have the same treatment.

My husband died peacefully at home in my arms surrounded by his family, supported by dedicated carers allowing his dignity to be restored.

The story doesn't quite end there. Whoever completed the death certificate did not complete it to the Coroners satisfaction and I was told he needed a Post-mortem. Another fight to persuade him to release my husband ensued and this was only averted because

we have a caring wonderful GP who went into the hospital, got my husband's hospital records and thus the correct information were given to the Coroner.

Four months later I did get the phone call from his Consultant that I had requested. The Medical Director had suggested he should ring me - I am not proud of the way I handled that call, suffice to say I left him in no doubt that in my opinion he was not fit to hold the position of Consultant and that his department was an absolute disgrace and that his call was too little and too late.

Working with the Hospital I hope I can help to fulfil my husband's wishes to shine a light on the issues that this case raises. In summary these issues are not anything to do with resources - they are about care, communications, sensitivity, empathy and respect for the patient and their family in difficult times. That is what the complaint system should be about, and I sincerely hope I can support and help in the endeavour to re-establish the care we all hope and expect from our local Hospital."

The Chair apologised on behalf of the Board for the experience of both Jane and her late husband. The Chief Executive described that it was evident that there was a significant amount of work to do with workforce and tackling some of the behaviours that are known to exist as soon as possible and agreed to accept Jane's offer of support in re-establishing the care that was hoped and expected from the Trust.

The Chief Nurse highlighted that a gap in the Trust around public and patient involvement had previously been recognised and acting on this, the Trust had recently appointed a new Lead for Patient and Public Involvement, Hannah Gray who would primarily focused on how patients and the public can become more involved with the services that the Trust delivers. The Chief Nurse was keen to put Mrs Miller in touch with Hannah and also Kath Sartain following her new appointment and Head of Nursing for the Scarborough site to begin discussions.

Non-executive Director, Lynne Mellor had suggested that the it would be good to see this included in the work programme as part of the newly established People and Culture Board sub-committee, particularly to have sight of and understand how this was being addressed and what some of the actions were that came from the discussions.

The Board recognised that the experience highlighted some behaviours particularly in relation to decency towards patients and continuity in care that needed to be addressed and acknowledged strong awareness of what had been raised. A clear apology from the Board and agreement to work together with the family to address some of the actions was heard.

The Board:

- **noted the contents of the presentation.**
- **thanked Jane and Kathryn for attending.**
- **agreed to work with the family in addressing concerns raised.**

22/26 Chief Executive's Update

The Chief Executive presented the report to the Board and highlighted some key additions to note:

- Operational pressures – there had been an increase in covid numbers. Admissions of covid patients was beginning to rise and currently at approximately 100 patients. Whilst clearly some changes had been made to IPC guidance, the Trust was

however, reconsidering its standards around covid restrictions such as mask wearing and how the Trust may cohort covid patients

- Omicron Variant – confirmed the variant was very transmissible, this was being closely monitored and checks were being carried out if there are any additional measure that could be put into place.
- CQC – Report has been published. The Trust was submitting an action plan by the 6th July A plan had already been sent in response to the CQC section 29A findings which was received before the final report from the CQC
- Long Service Award – The Long service award event in York had taken place the previous week and also one arranged for Scarborough shortly after. The Annual Celebration of Achievement event was to commence once again later in the year and nominations had opened for various categories for those awards. It was important to have these public events and share and acknowledge the good work that people and staff do around the Trust.
- The Trust has now launched the new robotic surgical system which was based at the York site – the purchase of the robot was supported generously by York Against Cancer contribution of over £600,000
- The Integrated Care System (ICS) was to formally become a statutory body from the 1st July 2022 who will take on the responsibilities of the previous 6 Clinical Commissioning Groups to become a single primary ICS
- Notable changes to the Board membership:
    - Medical Director James Taylor to retire 30th November 2022. Recruitment was underway for a suitable replacement
    - Chief Operating Officer, Wendy Scott to take up a secondment as Director of the Humber and North Yorkshire Collaborative of Acute Providers. During the period of Wendy's secondment, Deputy Chief Operating Officer Melanie Liley will take up the role of Interim Chief Operating Officer
    - The Trust welcomes a new Chief Digital Information Officer from 30th August 2022

Non-executive Director Lorraine Boyd highlighted the uptake in covid patients and questioned whether there had also been an increase in staff absences. The Director of Workforce and Organisational Development advised that through the daily sitrep reports (situation report) the Trust had seen an increase of around 30 additional staff who were absent because they had tested positive. There was now around 130 absent at any one time due to a positive covid test. Learning from previous waves, there didn't seem to be a link between those who have it and those who were catching it, but the vaccine reduced the effects of the virus and, despite this the Trust was seeing an upturn unfortunately. Discussions were taking place in relation to a 4th booster around Autumn time for Health and Social Care staff however there was no further detail on this at this stage.

The Board:

- **noted the contents of the report.**

22/27 Nurse Staffing Report

The Chief Nurse presented the report and provided information and assurance to the Board on how the Trust had responded to provide the safest and most effective nurse staffing levels during April 2022. There were some key points of the report highlighted.

The Trust has complied with the submission of CHPPD (Care Hours Per Patient Date) and the April 2022 submission was included in the main report. Overall the average day fill rate in April for Registered Nurses/Midwives was 74%, this was a 3% improvement from March 2022 and for Non–registered Nurses it was 82%, an 8% improvement since March.

The Board noted the sickness levels of nursing staff and highlighted that Registered Nurses & Midwifery monthly sickness rate for April 22 was 7.27% (compared to 7.83% the previous month). However, it was highlighted that the new variant of covid was likely to have an impact on this in the coming months.

The Chief Nurse highlighted the international recruitment and that the Trust continued to deliver the international nurse recruitment program. The Trust had welcomed a total of 336 international nurses (IN) with a further 64 expected to arrive by December 2022. She highlighted that there were national issues with the NMC Test of Competency (ToC) exam capacity, the new ToC centres at Leeds and Northumbria had increased testing capacity however the national backlog had led to the Trust IN's using centres as far afield as Ulster in order to secure a booking. The Board were assured that the educational programme continued to work outside process whilst attempts were made to secure more timely ToC bookings. As noted in the report, IN's should complete their 4 weeks of ToC training followed by the test in week 5. Currently there were 44 IN who have completed their ToC training and were waiting for test dates who continued to work in their clinical areas as Pre Registered Nurses (Band 4).

Recruitment and nursing teams continued to strive to recruit Healthcare Assistants however, this currently reports with a 131 WTE (Whole Time Equivalent) vacancy, 93 WTE for the inpatient wards. It was hoped that by August the Trust will be fully recruited. The Chair sought assurances in terms of the new HCA's and what the Trust was offering to support them to develop in their new roles. The Chief Nurse described some of the key initiatives that have been introduced to support the HCA's through their employment and also where potential HCAs can clearly understand the expectations of the role through existing HCA's attending recruitment days and sharing their experiences.

An ambitious target had been set within the workforce team; by April 2023 to have no more than a 1% vacancy rate for Healthcare Assistants and no more than a 7.5% vacancy rate for Registered Nurses. Non-executive Matt Morgan questioned how confident the Trust was that it was going to get its nursing recruitment up to establishment. The Chief Nurse advised that the current year was unlikely, despite their being a number of new registered nurses coming, it was known that there would be approximately over 100 registered nurses short. A report was due to be presented to the Executive Committee at its meeting on the 6th July in relation to an additional 40 international nurses but there were cost implications around this. Should this international addition be successful, it would naturally support the nursing establishment however, this was provided the retention continued. By summer 2023, when there is awareness that university numbers will have increased, and a number of nursing apprenticeships beginning to come through, will knowingly contribute well to the position of establishment.

The Board:

- **noted the report.**

22/28 Resources Assurance Committee Minutes

The Board noted the minutes of the Resources Assurance Committee held on 17 May 2022 meeting.

The Board received the escalation log of the Resources Assurance Committee held on 21 June 2022. Of note in the escalation report was that the Committee wished to raise for action a discussion on the 'unfunded CIPHER service'. Currently this was a private service which would cost the Trust over a £1M per annum to offer nurses/paramedics and care

assistants to provide cohorted care for ambulance patients pending delay to ED. The Finance Director had advised the committee that Yorkshire Ambulance Service (YAS) and the ICS were in discussions to resolve. YAS had prepared funding they were seeking as part of their operational plan. The Committee requested that the Board reflect strategically on what the Trust could consider regarding releasing ambulance crews in a timely fashion, for example a similar service to CIPHER to assure patient safety and improve flow.

The Chief Executive agreed to share with the Board the outcomes of the discussions with YAS and the ICS.

The Board:

- **received and noted the report.**

22/29 Care Quality Commission (CQC) Report

The Chief Nurse presented the report which provided an updated position of communication between the Trust and the CQC, as well as action plan progress for regulatory requirements.

The Board were reminded that an unannounced inspection from the CQC was undertaken on 30 March 2022. Immediate safety actions were implemented on the day on inspection and these had been further strengthened over the days and weeks which had followed. The Trust received a Section 29A warning notice on the 3 May. The Board acknowledged that improvements must be made to be demonstrated by the end of August 2022. A full inspection was due to take place within three months of August 2022.

The final comprehensive action plan, which was currently in draft, was to be shared with the CQC by 6 July 2022. The report provided a brief overview of the key high level actions. The Board noted that the full action plan was to be included in next Board report following finalisation and sharing with external stakeholders.

The Board were assured that the actions were on track for delivery with an effective check and challenge process through an established fortnightly operational delivery group.

The Board:

- **received and noted the report.**
- **noted the Regulatory Section 29A Warning Notice which had been received**
- **noted the publication date of the final report.**
- **noted the high-level action summary within the body of the report.**

22/30 Ockenden Report Update

The Chief Nurse presented the report which provided a monthly oversight of perinatal clinical quality as per the minimum required dataset, ensuring a transparent and proactive approach to Maternity safety across the Trust. The report also described an introduction to Ockenden, Clinical Negligence Scheme, and Continuity of Carer for context and information.

The Board noted that over the course of the reporting period, there were 4 incidents graded moderate harm or above; one of which was notably a Never Event and another which met the criteria for referral to HSIB (Healthcare Safety Investigation Branch). There were 8 unit diverts (care provided on an alternative obstetric site within the Trust) in March 2022 primarily in relation to staffing and acuity which were also detailed in the report.

The Board also noted that the CNST (Clinical Negligence Scheme for Trusts) was relaunched on 6 May with new timeframes and a submission date of 5 January 2023. The Board hoped to receive monthly progress against compliance.

The Board were reminded that an Ockenden report was presented in May which provided key information around progress and risks against all Immediate Essential Actions. The decision to initiate a Maternity Transformation Board (MTB) had been agreed and membership discussions continued to take place. Non-executive Director Lorraine Boyd, who was set to Chair the MTB, expressed that the purpose of the MTB was to help with managing resources. Although the recommendations from the Ockenden visit were largely reflective of what was already known to the Trust, it was important to not become complacent with this and embedding some of the actions remained a challenge.

The Chief Nurse advised that there had been a regional assurance visit that took place on 23 June 2022. This was primarily to investigate the Trusts Ockenden submission and test out the evidence submitted. To do this they visited clinical areas to physically observe some of the actions the Trust had identified were compliant. During this visit there were discussions including with the Lead Obstetricians, Paediatricians and the Chief Nurse as maternity champions. Feedback from the day was positive but a formal report was yet to be received. A notable recommendation following the visit was that the newly appointed Director of Midwifery attends the Board to raise awareness of Ockenden at Board level. With nothing significant raised as an outcome from the visit, the Board were assured with the progress to date. It was noted that there were 15 new actions (with 92 sub points) for maternity services in addition to the 7 Immediate and Essential Actions published in December 2020 however, NHS England and Improvement had stated that they were awaiting the publication of the East Kent report (expected at the end of June but had been delayed) before instructing Trusts any further.

The Chief Nurse highlighted the service user feedback element of the report and advised that a meeting was held on 29th April 2022 with the York Commissioner and the Local Maternity System National Maternity Voices Partnership (MVP) to the York MVP required a Chair and Coast and Country required a co-Chair for further support. There had been some interviews held and was hoped that those were successful.

The Board were sighted on the Continuity of Carer where the Chief Nurse reported that following a letter from NHS England and Improvement (received on 1st April 2022), the Trust was asked to immediately consider their midwifery staffing position and make a decision about whether or not they met the safe minimum staffing requirements to continue with the provision of continuity of carer. It was recognised that the safe minimum staffing level, according to the birthrate plus report in June 2021, was not met and consequently continuity was to be paused from June 2022. Non-executive Director Matt Morgan questioned how the suspension of care was being managed and how was it impacting the mothers. The Chief Nurse assured that communication was underway with all patients affected, detailing the reasons behind the decision and plans for their ongoing care. To date there had been no negative feedback received from the patients and they had been quite understanding however, there were mothers who were yet to give birth who would now not receive their continuity therefore this may change. In terms of feedback from the midwives, the suspension had been well received.

The Board:

- **received and noted the report.**

22/31 Quality Assurance Committee Minutes

The Board noted the minutes of the Quality Assurance Committee held on 17 May 2022 meeting.

The Board received and noted the escalation log of the Quality Assurance Committee held on 21 June 2022.

22/32 Integrated Board Report

The Chief Operating Officer provided an update in relation to Elective Recovery and Patient Flow:

- The Trust was achieving zero 104 week waiters by the end of June and currently there were 13 patients who had been waiting over 104weeks. These patients had been offered at least two appointments which have been declined, the Board were assured that every effort was seeking to see these outstanding patients as quickly as possible.
- The next challenge was a focus on reducing the numbers to zero of those patients who have been waiting 78 weeks or more. Currently there were 295 (126 waiting for an inpatient procedure, 133 waiting for a day case procedure and 36 waiting for an outpatient appointment or procedure) patients who had been waiting for this length of time. There was a trajectory that continued to be monitored in order to reach the desired target.
- Operational Plan - in terms of the delivery of activity against the plan, the Board noted that the Trust had delivered in May (as the baseline compared against May 2019), more activity in relation to first outpatients and follow-ups with 101% and 105% respectively. Also 104% of day cases in comparison and in terms of advice and guidance responses the Trust was delivering 174% in comparison which was positively received.
- Ordinary Elective – This was a challenge where delivery at present was circa 77% of 2019 and were seeing on a weekly basis, a number of cases stood down as a result of ongoing workforce pressures for example there were significant unfilled vacancies in theatres. There was ongoing work around workforce and recruitment but also around Theatre utilisation and how to make sure that the sessions that are ran are maximised to ensure as many patients are seen as possible.

Emergency care pressures was an ongoing challenge. On a day by day basis there are patients who were waiting a considerable length of time to be admitted either because they require a senior review or because other discharges were required to ease patient flow and move those waiting patients on. This was felt to be a relentless challenge around how flow was managed and how this was taken forward not only locally but across the whole system around emergency care. Of particular concern to the Trust was the number of patients that were classed as 12 hour trolley breaches (patients waiting 12hours or more once deemed ready for transfer). There was some assurance that there was work progressing around models of flow and emergency care which could support some improvements.

Non-executive Director Matt Morgan questioned the flow of patients and whether the same position was because it was difficult to manage patients coming in or out of the hospital. Also, was the ability to get patients out of the building any different over the last several months. The Chief Operating Officer advised that there had been little or no improvement on delayed discharges (patients deemed as requiring ongoing support on discharge) and those numbers were constant. Some of the delayed discharge numbers for both the York and East Coast areas were described as a contributing factor to the block in flow. This

continued to be an ongoing challenge for the Trust in terms of delays and impact on capacities and flow. In support of addressing some of this, all Acute Trusts were working on a national piece of work on potentially increasing beds over the winter period. It was not yet clear whether this was physical beds or virtual, but Trusts' had been asked to bid against a national pot of funding in order to be able to increase their bed base in Q3 and Q4. Further bids being put forward were in relation to continuing with Thornton Ward in Bridlington and an opportunity to create an additional ward to be a similar model. Another bid related to potentially replicating the successes of the ward and applying this to the York site. Other bids related to 24/7 models around surgical areas and expanding the community response team. These bids had been presented through working with local partners and community providers so for the Trust this was across Humber and North Yorkshire ICS, in order to contribute to improving patient flow. The timescales were not yet clear.

The Board:

- **received and noted the report.**

22/33 Finance Report Update

Trust May Finance Position

The Finance Director presented the report and shared the detail for the May 2022 (month 2) financial position for the Trust. The Board noted that the Trust was reporting an adjusted deficit of £2.17m against a planned deficit of £1.99m at May 2022 and was £0.18m adversely adrift of plan. The Board were advised that the plan currently being used was the £11.8m deficit Board plan (approved at its April 2022 meeting) and remained subject to further Integrated Care System (ICS) and NHS England and Improvement (NHSE/I) discussion.

In relation to the delivery of the efficiency programme, plans were almost in completion meaning that Care Groups and Corporate Teams had now identified areas that they were pursuing. The corporate Efficiency Team were now returned to full engagement levels with all of the Care Groups and Corporate teams – it was going to be challenging to manage the efficiency programme which would be supported through the new Digital, Performance and Finance Assurance Committee. There were no issues raised for the attention of the Board around the efficiency programme at this stage.

The Finance Director updated the Board in terms of the four material unfunded revenue pressures, the report described confirmation of the schemes and the current position with action being taken. These had also been tracked through the Resources Assurance Committee.

The Board:

- **noted the May 2022 financial position for the Trust.**

Final 2022/23 Financial Plan

The Finance Director presented the report which described the final Group operational financial plan for 2022/23. The Board (in March) received a report of the Group's draft operational financial plan for 2022/23. The draft plan presented at that time delivered a prospective £40.2m income and expenditure deficit which was significantly out of step with NHSE/I's expectation of a balanced planned I&E position. At the Board's April meeting a revised plan showing an £11.8m deficit was presented and approved for submission to NHSE/I. This position was replicated in many ICS communities around the country. Following this submission, the national NHSE/I team released further funding to each ICS to help close the outstanding financial gaps and required resubmission of balanced plans.

In response to this the Finance Director wrote to the Board (on 1 June 2022) describing the latest iteration of the ICS and Group Financial Plan. This briefing confirmed a balanced position for the Group and for the ICS had been achieved. The Board subsequently virtually approved the submission of that plan. This plan was duly submitted to the ICS and to NHSE/I. the Finance Director confirmed the income and expenditure account (including reconciliation of the changes from the previously Board-approved £11.8m deficit), the balance sheet and the cashflow forecast.

The Finance Director stressed that the majority of the gap had been closed through additional income coming through to the organisation through the national team recognising significant pressures in the acute landscape, the CCG's making further savings and the Integrated Care Board (ICB) setting itself a controlled cost savings target to bridge the gap. The trust had submitted and await feedback from NHSE/I. This would now form the basis of internal financial performance monitoring with both the ICB and NHSE/I and it was anticipated that the Q4 report would switch to tracking progress against the revised balance plan.

The Board:

- **formally approved the Group's final financial plan for 2022/23 following virtual approval to meet the NHSE/I submission deadline**

Draft Capital Programme and Priorities for 2022/23

The Finance Director presented the report which detailed the current position in relation to the Trust's Capital Programme. The board were reminded that each Care Group, Corporate Directorate and the Group Wholly Owned Subsidiary (YTHFM) had provided their initial requirements for prioritisation, primarily for 2022/23, but also for the 2 subsequent financial years of 2023/24 and 2024/25. The original long list of schemes had now been streamed to appropriate funding sources, where they exist, leaving a number of schemes which required prioritising in line with the available funding. The Board received an update following a comprehensive prioritisation process carried out by each Care Group, Corporate Directorate and YTHFM for 2022/23 only.

The Board noted the overall Capital shortfall for 2022/23 was assessed at a minimum of (£3.5m) along with £9.2m of schemes not currently prioritised or costed. Discussions had started with the ICS to try and identify a funding source for the (£3.5m) shortfall. Internally the Trust would continue to seek alternative funding for example through further lease opportunities and reviewing Digital Essential Services plans.

Non-executive Director Denise McConnell raised the £6m non-recurrent amount and questioned whether it had been considered as yet how the Trust was going to manage with this extra in its 2023/24 year. One of the sources of pressure this year was the loss of non-recurrent the previous year and the pressure would undoubtably be taken forward. It was difficult to advise with there being no clear understanding of what the ICS position looked like for the following year however, the Finance Director assured the Board that the ICS finance team had already begun planning to identify where organisations are using non-recurrently (as it happening right across the NHS where resources were being used in this way) and identifying what that sum looked like. It was hoped that allocation details would be shred for the next two years and switch to multi year plans, it would be at this point where the position would be clearer to answer questions around managing the non-recurrent funds going forwards. The Board would be briefed as work progressed.

Non-executive Director Matt Morgan raised a question in relation to the communication around the investments and what the Trust was planning to do about getting this

information out to staff and the public. This could include a key message about this approach in how the Trust was going to look at capital development and also publicising some of the schemes and help to understand how we are investing to support the patients and public services/care. The Finance Director advised that he would be seeking to use the opportunity of Staff Briefing to brief the capital and priorities story and also the programme developments. As the programme develops and as the schemes come forward, the Communications Team were working on filtering those key messages through various staff engagements. The Director of Communications also advised that capital schemes were a priority and a core part in what the team delivers in terms of its strategy. Engaging key staff in the process of developing the capital programme, has meant that there is an existing level of investment of people's engagement. A key message from the Board was not to lose sight of those schemes that were unable to be delivered and what the implications of those would be. Wherever an opportunity would arise, these schemes should be considered.

The Board noted to receive routine updates on both progress with the programme spend and identification of alternative funding.

The Board:

- **approved the capital programme for 2022/23 and the action taken to identify and secure additional funding/CDEL cover for the programme shortfall.**

22/34 Trust Revised Governance Structure

The Associate Director of Corporate Governance presented the report which formally proposed to change the Board of Directors Assurance Committees to:

- Quality and Safety Assurance Committee
- Digital, Performance and Finance Assurance Committee
- People and Culture Assurance Committee.

The Board also noted the terms of reference and committee work plans for each of the revised committees.

The Board acknowledged that the governance structure ensured that the committee structure of the Board was properly aligned with the four priorities set as an organisation for the foreseeable future. The expectation was that the Chairs of the revised committees would take forward their agendas with each of the priorities and really drive progress and provide assurance to the Board that the Trust was delivering on its priorities.

The Board:

- **approved the revised structure and terms of reference of the committees.**

22/35 2022/23 Board Assurance Framework (BAF)

The Associate Director of Corporate Governance presented the report. The BAF had changed format as a result of a Board of Directors survey as part of an internal audit review of the 2021/22 BAF. The Board noted:

- All risks had been reviewed by the Risk Committee for Q1 2022/23
- The risk BAF format has been amended to take into account:
  - The clear delineation between the risk description, its causes and consequences of each risk materialising
  - Providing guidance on the constituent parts of the management of the BAF risks

    - Through Board and Committee report templates being amended the collation of clear specific assurances that can be added to the BAF throughout 2022/23 reporting supplemented by the Committee Chair's escalation reports
- A dashboard is reported presenting each risk's gross, net and target score with a status of those mitigating actions to achieve the target score.

Non-executive Director Lynne Mellor highlighted that PR6 needed to include digital as oversight. Lynne also raised whether the 'Amber' indicating a delay of 1-2 months and suggested that this was perhaps not in line with ordinary standard therefore asked that this be reconsidered.

There was some discrepancy around PR1 and some members of the Board were questioning whether it was right that the risk was rated as low as 16.

It was agreed that the above to points raised be discussed and agreed offline.

The Board:

- **approved the BAF subject to discussions raised to be carried out offline.**

22/36 Any Other Business

There was no other business discussed.

22/37 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 27 July 2022.

Action No.	Date of Meeting	Minute Number Reference	Title	Action (from Minute)	Executive Lead/Owner	Update / comments	Due Date	Status
4	25 May 2022	21/10	Nurse Recruitment and Retention Report	Commence discussions with Coventry University on behalf of the Board in relation to premises in York to develop courses in the city.	Non-executive Director Jim Dillon	29.06.22 Non-executive Director Jim Dillon confirmed that he had a meeting arranged with Professor John Latham, Vice-Chancellor and Chief Executive of the Coventry University Group.	Jul-22	Outstanding

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☐ Information ☒ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☒ Workforce
☒ Elective Recovery	☒ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☒ Integrated Care System

Summary of Report and Key Points to highlight:

To provide an update to the Board of Directors from the Chief Executive in relation to the Trust priorities. Key points include: Delivering our people recovery plan, international recruitment, flu and Covid-19 vaccinations, CQC update, tackling long waits for procedures, Covid-19 updates, managing delayed discharges, 100 day discharge challenge, and Humber and North Yorkshire Health and Care Partnership update.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History Board of Directors only.

Meeting	Date	Outcome/Recommendation
Board of Directors	27 July 2022	

Chief Executive's Report

1. Our People

1.1 Delivering our people recovery plan

We have identified Our People as the main priority for the year ahead as we learn to live with Covid-19. To support delivery of the actions identified in the Trust's priorities plan, and to align this with the priorities outlined in the NHS People Plan and the Trust's Workforce and Organisational Develop Strategy, we have identified six workstreams through which we will streamline and drive the actions required to deliver the plan's objectives. These are:

- Culture and engagement
- Health and wellbeing
- Retention and attraction
- Flexible working
- Equality, diversity and inclusion
- Excelling at the essentials (people policies and processes)

Each of these will have a steering group to shape the work programme and help to move it forward at pace. Each workstream will also have separate working groups to operationally deliver the work as required.

Progress will be reported to the People and Culture Committee.

1.2 International recruitment

In a bid to grow our workforce and address our staffing challenges we are continuing to expand our international recruitment programme. 336 international nurses have already joined us and we expect to welcome a further 64 by the end of the year.
In addition to this, we are also bidding for national funds to recruit 40 more international nurses. If this bid is successful, we hope to see these new recruits join us by the end of 2022.

We are also expanding this beyond the nursing workforce, including for the first time for our trust looking to recruit AHPs, specifically radiographers and occupational therapists, as well as exploring potential relationships with overseas health providers who could offer us a number of doctors who would take placements with us for a fixed period and gaining additional skills and experience whilst making a welcome contribution to our medical workforce.

1.3 Flu and Covid-19 vaccinations

We have received an update on plans for the autumn and winter Covid-19 and flu vaccination programmes.
The Government has confirmed that it has accepted the advice of the JCVI on the Covid-19 booster dose, and that additional cohorts will be offered the flu vaccine.

The autumn Covid-19 booster will be offered to the following groups:

- Residents and staff in care homes for older adults

- Frontline health and social care workers
- All adults aged 50 and over
- Persons aged 5 to 49 in a clinical risk group
- Persons aged 5 to 49 who are household contacts of people with immunosuppression
- Persons aged 16-49 who are carers

Additional cohorts have been added to the flu vaccine cohorts this year and will be offered the free NHS flu vaccine. This includes secondary school children in years 7, 8 and 9 in order of school year, and 50-64 year olds not in a clinically at-risk group, who are likely to be offered vaccination later in the year once people more vulnerable to Covid-19 and flu have been offered their vaccine.

We are awaiting further detailed operational guidance however we are planning on the assumption that boosters will be administered alongside flu vaccines. The model we plan to use is a hybrid of bookable and drop-in appointments in dedicated vaccination hubs, with additional capacity from peer vaccinators who can target areas of lower uptake.

2. Quality and Safety

2.1 Care Quality Commission (CQC) update

The CQC's report following their unannounced visit to York Hospital at the end of March 2022 was published in June.

The report highlights a number of concerns requiring immediate action, and the trust was subsequently issued with a Section 29A Warning Notice.

The CQC requires the Trust to produce an action plan in response to the report, and this was submitted to the CQC on 6 July. There is a dedicated agenda item covering the CQC action plan as part of this meeting.

We absolutely recognise the seriousness of the concerns raised by the CQC and since their visit there have been a number of actions taken to improve quality and safety across the organisation. The areas of focus for the immediate actions that were taken since the CQC visit, and for the full action plan, are nutrition and hydration, risk assessments and documentation, compliance with the Mental Capacity Act, staffing, and the development of ward improvement plans.

We expect to discuss our progress against the action plan with the CQC at our regular engagement meetings, and they will assess our progress against delivery when they revisit us to follow up on their findings.

3. Elective Recovery

3.1 Tackling long waits for procedures

We achieved our target of treating all of our patients waiting 104 weeks by the end of June. This was a tremendous effort by a large number of people, thank you to all involved. Of course the pressure will not end there, and there is a requirement from our regulators to further reduce our backlogs, with focus turning now to 78 and 52 week waits.

All trusts are assessed in terms of the risks against delivery of elective activity recovery plans, and due in large part to our 52 week wait position and the impact this will potentially

have on our ability to deliver our elective recovery plans in full, we are meeting regularly with the regional team to discuss our progress.

4. Acute Flow

4.1 Covid-19 update

As has been the case many times throughout the pandemic, the relatively optimistic position described in my last report where number of inpatients were reducing and we were able to lift some of our Covid-19 restrictions, has once again deteriorated.

Despite numbers of patients with Covid-19 falling in April and May, they have been on the increase again to the point that we have had over 150 patients with Covid-19 in beds across the trust at points during this month. In response to this, along with the growing community prevalence and associated increase in staff absence due to Covid-19, we have returned to mask wearing in virtually all areas.

This is kept under review by the Living with Covid-19 Working Group who continue to make recommendations regarding our approach to managing Covid-19.

This, alongside the challenges in discharging patients who no longer need to be in hospital and our ongoing workforce pressures, means that that we continue to have significant issues with flow on both of our acute sites.

4.2 Managing delayed discharges

We have continued to operate the Bridlington Community Unit which has been open for several months and provides care for the growing number of patients without the 'right to reside' in the Scarborough acute bed base until they can be discharged.

The unit currently has 15 beds, and we have submitted a bid for funding to secure this provision for the longer term and, if possible, to double the capacity to 30 beds. In addition we are bidding for funding to provide an equivalent facility of 15 beds for the York population, housed on the York Hospital site. We expect to learn the outcome of these bids in the coming weeks.

4.1 100 day discharge challenge

The National Health and Social Care Discharge Taskforce brings together partners from across health and social care to focus on opportunities to improve discharge. The taskforce has identified 10 best practice initiatives that demonstrably improve flow and should be implemented in every trust and system to improve discharge.

These are:
1. Identify patients needing complex discharge support early
2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems
9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation.

To support efforts to embed these practices, a national '100-day challenge' has been launched to take place throughout July, August and September. A dedicated national NHS England team is working with each regional executive discharge lead to ensure there is a focus on improving processes and performance around discharge and working across the wider system to address challenges.

This supports the discharge work that we are already doing and our local delivery plans should reflect these nationally-recognised best practice initiatives.

5. System update

5.1 Humber and North Yorkshire Health and Care Partnership update

On 1 July 2022 Integrated Care Systems (ICSs) became statutory bodies. Our ICS is Humber and North Yorkshire Health and Care Partnership. Each ICS is led by an NHS Integrated Care Board (ICB) which takes over the statutory responsibility for NHS functions and budgets previously held by CCGs.

The Humber and North Yorkshire Health and Care Partnership is a collaborative of health and care organisations striving to improve the health and wellbeing of the population as well as the quality and effectiveness of the services provided.

ICS responsibilities include:

- Developing a plan to meet the health needs of the population within their defined geography
- Developing a capital plan for the NHS Providers within their health geography
- Securing the provision of health services to meet the needs of the system population

The ICSs will also be able to delegate to place level and to provider collaboratives. There are six 'places' in our ICS, of which three relate to the population covered by our trust: York, North Yorkshire and East Riding. Arrangements for these places are being established, and leads have been appointed for North Yorkshire (Wendy Balmain) and East Riding (Simon Cox).

The collaboratives are also taking shape, with our Chief Operating Officer Wendy Scott heading up the Acute Provider Collaborative on a secondment basis. The other provider collaboratives cover primary care, mental health, community and the voluntary sector.

The ICB met for the first time on 1 July 2022 to formally approve and adopt the governance arrangements documents and policies including the constitution, standing orders, standing financial instructions, and policies, and to take ownership of the statutory responsibilities that the ICB has taken on from Clinical Commissioning Groups.

The ICB also held its first full Board meeting on 13 July which I attended in my role as Provider Partner Member of the ICB. The main substantive item of business was for the ICB to receive and endorse the Humber and North Yorkshire Health and Care Partnership People Strategy. The five year strategy has been created through engagement with partners across the ICS and identifies a number of priorities which have been aligned to national NHS People Promise, NHS People Plan and NHS People Outcomes.

Date: 27 July 2022

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Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Board Priorities 2022-23
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Lynette Smith, Deputy Director of Planning and Performance on behalf of Corporate Directors.

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☒ Workforce
☒ Elective Recovery	☒ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

In response to the feedback from the staff survey, findings from the CQC inspection at York Hospital and the operational position of the organisation, the Board has committed to taking action over the next 12 months on the four priorities to progress towards delivery of our strategy.

This document describes what we intend to do during the financial year 2022-23 to support our strategic goals and deliver on these priorities. The actions will target the following areas:

Priority	Focus Area	Measures
Our People	Culture Change Working Life (fix the basics) Recruitment Workforce Planning	• Improve our comparative position on the staff survey 'Staff Engagement and Morale' responses to above average in 2022/23 • Improve the stability index to be in the top quartile within Model Health System (retention)

		• Maintain recruitment activity at 2021/22 levels (numbers TBC) • Increase the % retention of non-medical student who train and quality with us, with an ambition to achieve 80% retention
		• By April 2023 to have no more than 1% vacancy rate for Healthcare Assistants • By April 23 to have no more than a 7.5% vacancy rate for Registered Nurses
Quality and Safety	Fundemental of Care Journey to Excellence Infection Prevention and Control	• To continue to achieve and sustain a 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months) • To eliminate all category 4 pressure ulcers where lapses in care have been identified for patients in our care • To achieve at least a 20% reduction in C-DIFF bacteraemia in 2022/23 • Increased number of CQC self-assessment rating improving to the next category from baseline assessment • Increased audit compliance with mental health risk assessments and Malnutrition Universal Screening Tool. • Evidence that all wards have undergone HPV decontamination during the 2022-23 financial year
Elective Backlogs	Maximizing additional capacity Maximizing internal capacity Outpatients Transformation	• Reduce number of 104 week RTT waits to 0 by June 2022 and maintain to March 23 • Reduced number of 78 week RTT waiting to 0 by March 23 • Stabilization of waiting list growth by March 23.
Acute Flow	Diversionary and alternative pathways of care Bed capacity and discharge	• Less than 10 % Ambulance handovers waiting >60 minute as we work towards eliminating long waits. • Improvements in time to initial assessment to ave. of 18mins overall and consistently meeting 15 mins for walk-in patients to manage undifferentiated risk • Less than 7.5% of admission wait more than 12 hours in department (from 15% of current admissions) • Proportion of patients discharged before 5pm - SAFER metric from 58.9% to 70%,

The detail of the actions, the plan summary, is provided in annex A.

Recommendation:

To note the report and consider the frequency of reporting on progress to the Board of Directors and relevant sub-Committees.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
Board of Directors	29th June	To present to public board.

1. Introduction and Background

The Board of Directors refreshed the organisational strategy, Building Better Care Together (Trust Strategy) in 2021. This sets out our strategic goals and commitment to recovery and renewal as we move beyond the initial phase of the pandemic and learn to live with COVID-19.

In response to feedback from the staff survey, findings from the recent CQC inspection at York Hospital and the operational position of the organisation, the Board has committed to taking action over the next 12 months on four priorities to progress towards delivery of our strategy
:

- Our people
- Quality and safety
- Elective recovery
- Acute flow

The Board has agreed that these are the priority areas that we must focus on to see real improvement in the next twelve months. This document describes what we intend to do during the financial year 2022-23 to support our strategic goals and deliver on these priorities. The detail of the actions, the plan summary, is provided in annex A.

2. A new chapter for York and Scarborough Teaching Hospitals NHS FT

Our organisation has experienced considerable change over recent years, with a major organisational restructure, the review of sustainable services at the East Coast and structural changes to our local system, and then the significant impact of the pandemic on our services, professional and personal lives.

Alongside many parts of the NHS, we have new challenges with higher sickness and vacancy rates than before the pandemic and our staff expressing fatigue and concern at their growing workloads[1]; at the same time as more patients need our care. The operational and staffing pressures we have faced in recent times have meant that it has not always been possible to give the standard of care we would want for all our patients, all the time[2].

As the management of COVID-19 stabilises and we move forward together, we can face this challenge and continue our commitment to delivering excellent care and being a great place to work and develop careers. We will focus our collective efforts on the areas that we know will have the greatest impact for our patients and workforce.

People are at the heart of everything we do, and so to deliver our Strategic Goal of delivering safe, effective, and high-quality patient care, we must deliver our goal of 'an engaged, healthy, diverse and resilient workforce'. The main priority for this coming year is our workforce.

3. Our priorities for 2022-23

3.1 Our People

We are committed to move towards consistently having the right number and right skill mix of people to deliver safe, high quality care for those patients who need to access our services, in our hospitals and community services.

There are four focus areas for 2022-23 to deliver our people priority and support a safe, open, and empowering working culture and environment:

- Cultural Change Initiatives.
- Working Life (fix the basics).
- Recruitment.
- Workforce planning – including staffing levels across clinical services.

The first two focus areas are designed to support the retention and development of our staff, to support morale and sense of value by the organisation. The second two focus

[1] 2021/22 *Staff survey results on the People Promise 'I am able to meet all the conflicting demands on my time at work'*
[2] CQC report 2022- CQC Reports

areas are about how we plan for and attract the people we need to deliver safe and high-quality services.

This year we will:

- Refresh our leadership approach through increased visibility, growing and developing our leaders of the future and embedding quality improvement.
- Launch our behaviours framework and review our processes for addressing experiences of bullying and harassment.
- Invest in our working environment; improving IT infrastructure, reviewing travel options to help staff get to and from work and improve the availability of hot food and drinking water across our sites and shifts.
- Refresh and relaunch our approach to recruitment, including a dedicated website for Trust recruitment, open days, and pro-active recruitment, streamlined 'on-boarding' processes and a more personalised approach to welcome new starters.
- Complete the clinical establishment review and refresh our workforce planning to enable more effective succession planning, for example recruitment in advance and enhanced support and supervision for new clinical roles.

We will measure our success by:

- Improve our comparative position on the staff survey 'Staff Engagement and Morale' responses to above average in 2022/23.
- Improve the stability index to be in the top quartile within Model Health System (retention).
- Maintain recruitment activity at 2021/22 levels.
- Increase the % retention of non-medical student who train and quality with us, with an ambition to achieve 80% retention.
- By April 2023 to have no more than 1% vacancy rate for Healthcare Assistants.
- By April 23 to have no more than a 7.5% vacancy rate for Registered Nurses.

We acknowledge that delivering a sustainable workforce for our patients' needs will take more than one year and it is a core part of our multi-year Trust strategy. We aim to have made significant improvements by March 23.

4. Priority areas to deliver safe, effective, and high-quality care

As we continue to make progress to strengthen our workforce capacity, we will take action to reduce the levels of risk to patients by focussing on the delivery of fundamental care within the Trust; and to reduce the risk of clinical deterioration as a result of delayed patient care across clinical pathways.

4.1 Quality and Safety

While the Trust mobilises the plans to recruit additional workforce and retain more staff to enable the safe staffing of all of our wards; the organisation will continue to dynamically review the bed base on each site to ensure fundamentals of care can be delivered during 2022-23. We will review our available capacity to meet safe staffing levels; this can include changes in the number or function of the bed capacity.

This year we will

- Deliver the fundamentals of care, this includes:
  - Working to ensure every patient on our inpatient wards and units has basic care and dignity needs met, including hydration, nutrition, mobilisation and washing during their inpatient or community unit stay.
  - Enabling the delivery of care by meeting safe staffing levels for inpatient wards and units, taking action to minimize nurse staffing moves through planning and timely rostering; and wherever possible keeping patients on the appropriate ward for their care.
- Progress our Journey to Excellence:
  - Refreshing our processes for identifying and mitigating risk across our clinical pathways.
  - Act and evidence improvements in response to CQC actions, including audits of mental health assessments.
- Focus on Infection Prevention and Control:
  - Working to create a safe environment for our patients and staff. This includes retuning to the programme of ward cleaning, training, and effective learning from outbreaks.

We will measure our success by:

- To continue to achieve and sustain a 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months).

- To elimate all category 4 pressure ulcers where lapses in care have been identified for patients in our care.
- To achieve at least a 20% reduction in C-DIFF bacteraemia in 2022/23.
- Increased number of CQC self-assessment rating improving to the next category from baseline assessment.
- Increased audit compliance with mental health risk assessments and Malnutrition Universal Screening Tool.
- Evidence that all wards have undergone HPV decontamination during the 2022-23 financial year.

4.2 Elective Backlogs

The demand on our elective services is unprecedented with over 42,000 pathways of care on our waiting list, around 200 patients waiting more than 62 days on a cancer fast pathway and more than 28,000 patients overdue their follow up appointment. We are part of a national multi-year elective recovery programme to address the extended waiting lists, and we will focus on reducing waiting times for those at the highest clinical risk and those waiting the longest to reduce the levels of risk of clinical deterioration.

This year we will

- Separate our elective work from acute work where possible, including opening an elective hub in York, increasing surgical operating times at Bridlington and bidding for major capital works to create additional outpatient and surgical space.
- Be more productive with the capacity we have, including implementing the GIRFT recommendations for the Trust, targeting improvements in theatre productivity and moving back towards the full surgical programme as we address theatre staffing shortages.
- Increase access to alternative capacity for our patients, including mutual aid with neighbouring Trusts and use of the independent sector.
- Review our systems and processes to ensure waiting lists are accurate and validated and ensure that patients waiting extended periods are contacted supported to keep fit for their treatments and can identify any deterioration.

We will measure our success by:

- Reduce number of 104-week RTT waits to 0 by June 2022 and maintain to March 23.
- Reduced number of 78-week RTT waiting to 0 by March 23.

- Stabilisation of waiting list growth by March 23.

4.2 Acute flow

We need to implement new ways of working across our sites to manage our bed capacity to safe staffing levels in a way that doesn't increase risk of patient deterioration due to delays in patient flow, and/or increase pressure in the Emergency Departments.

This year we will:

- Develop diversionary pathways for patients who need urgent care, but not in an acute hospital.
- Increase our capacity for same day emergency care to provide an alternative to admission for suitable patient needs.
- Develop virtual wards to manage patients in the best place for their need.
- Deliver national expectations for surgical procedures that can be done as outpatient procedures and day case as an alternative to an overnight ward admission.
- Change how we work to support earlier discharge on the day for patients due to go home and improve discharges over the weekends.

We will measure our success by:

- Less than 10 % Ambulance handovers waiting >60 minute as we work towards eliminating long waits.
- Improvements in time to initial assessment to aver of 18mins overall and consistently meeting 15 mins for walk-in patients to manage undifferentiated risk.
- Less than 7.5% of admission wait more than 12 hours in department (from 15% of current admissions).
- Proportion of patients discharged before 5pm - SAFER metric from 58.9% to 70%.

5. Working in Partnership

We are an integral member of the Humber and North Yorkshire Integrated Care System (ICS) and contribute to the delivery of the Integrated Care Board's plan. As part of the collaborative approach across the system we will both help deliver the aims of the ICS and access support from our partners.

We recognise that we cannot make the scale of improvement we aspire to without the assistance of our system partners, in NHSE/I and across the Humber and North Yorkshire Integrated Care System.

This year we will;

- Work collaboratively with Health Education England, the deanery and universities to develop our workforce.
- Respond to the CQC and work across the Integrated Care System to enhance our quality and safety.
- Work with primary care and the Yorkshire Ambulance Service on our diversionary pathways.
- Collaborate with social care and primary care to support complex discharges new pathways of care.
- Develop new alternative diagnostic and outpatient pathways with primary care and local acute providers.
- Work to deliver our part of the system activity plan, so that the system can collectively access additional resource and expertise.
- Identify named leads for the Trust to engage on work across the Collaborative of Acute Providers, Clinical Networks, and regional developments.

The Trust will continue to be an active partner in the system, to support improvements across the whole health and care system, and ensure we make the most of any investment, equipment or expertise to deliver our plans.

6. Supporting Delivery

The organisational priorities for this year are:

- Our people
- Quality and safety
- Elective recovery
- Acute flow

To ensure the delivery of the supporting action plans, the resources of the organisation will be aligned to support these priorities through 2022-23. The prioritisation of enabling work including as digital developments, data analysis, capital requirements, equipment provision, programme management and quality improvement support to deliver these priorities will be managed through the Executive Committee.

A refresh of the current work programmes will be undertaken to ensure that these are aligned to the organisational priorities and refocussed where required.

6.1 Monitoring and Reporting

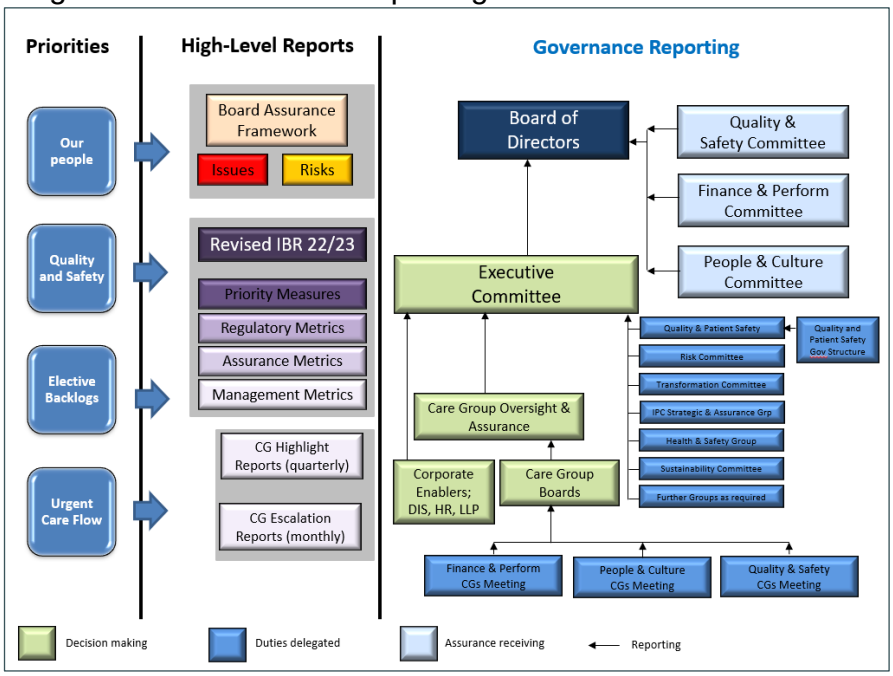
The Board of Directors will monitor the delivery of the priority actions each month, with a specific section of the Integrated Business Report for each priority.

The sub-Committees will receive detailed updates relevant to the specific priority areas:
People and Culture Committee – Our People Priority.
Quality and Safety Committee – Quality and Safety Priority.
Digital, Finance and Performance – Elective Backlogs and Acute Flow Priorities.

The Executive Committee will be responsible for the delivery of the actions on behalf of the Board of Directors.

The Executive Committee will monitor delivery of actions across the Care Groups through the Oversight and Assurance Meetings. The agendas of the meeting will be updated to reflect the four priorities for 2022-23.

Diagram of Governance Reporting:



7. Continuous Improvement across all our services

The four agreed priorities for 2022-23 are set within a context of continuous development and improvement across all our services and models of care.

There are significant developments planned in 2022-23 across the wider organisational services, which will provide a platform for organisational improvements in the years ahead. Further detail on these can be found below. These include, but are not limited to;

- Humber and North Yorkshire Integrated Care Board Plan Summary

- Maternity Transformation - programme to be launched 2022-23 to respond to the Ockenden Proposals.
- Delivery of the CQC Action Plan [link once available].
- Building Better Care High Impact Programme, including outpatients, earlier diagnosis and staging of Cancer and diagnostics reform through Community Diagnostic Centres: Building Better Care.
- Scarborough Emergency Care Development: Building for the Future.
- The Trust's Green Plan and contribution to a net zero NHS: Green Plan, Travel Plan.
- Implementing the Digital Strategy for the Trust [link once available online].
- Implementation of the Capital Programme [link once available online].
- Delivery of the Financial Plan [link once available online].
- Collaboration of laboratory medicine across the system through the Scarborough Hull York Pathology Services (SHYPS) Laboratory Medicine.
- Allied Health Professions Strategy: AHP Strategy.

Annex A: Priorities Action Plan 2022-23: Summary.

Annex A: Priorities Action Plan 2022-23: Summary

Priority: Our People	**Focus Area: Culture Change**	**Portfolio lead: Chief Executive**
Measures:	• Improve our comparative position on the staff survey 'Staff Engagement and Morale' responses to above average in 2022/23 • Reduction in external whistleblowing concerns. • Improve the stability index to be in the top quartile within Model Health System	
Monitoring Arrangements	• People and Culture Committee • Executive Committee • Workforce Working Group	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	Status
1.1 Establish the Workforce Working Group to lead on implementation of the action plan	Chief Executive	Director of Workforce and OD	July 2022	Working Group established and communicated and meetings being diarised.
1.2 Implement the Leadership Development Programme for the Trust, including Board and Executive development, reinvorgation of the shadow board and role of staff stories to inform decisions on workforce.	Director of Workforce and OD	Gail Dunning	December 2022	On track
1.3 Increased Executive Visibility across the wider organisation, including the re-introduction of face to face communication and engagement at all levels, e.g. staff brief, leadership walk-arounds and staff surgeries	Chief Executive	Corporate Directors	To commence from June 2022	Staff brief launched and programme of sessions in place
1.4 Re-establish the 'business as usual' governance structure as COVID-19 stabilises, including the step down of the Command & Control structure	Chief Operating Officer	Mike Taylor	Complete	Complete
1.5 Behavioural Framework launched and embedded in the appraisal process	Director of Workforce and OD	Gail Dunning / Jenny Flinton	June 2022	Complete and included in staff brief

1.6 Revamp exit feedback to inform retention actions and improvement actions	Director of Workforce and OD	Lydia Larcum/ Gail Dunning	March 2023	On track – revised process developed and pilot to begin.
1.7 Embed the 'Just & Learning Culture' Programme	Chief Executive	Corporate Directors	September 2022	On track – to be delivered via the Culture & Engagement workstream
1.8 Empower employees to deliver change through the roll out of the Quality Improvement Strategy (QI)	Medical Director	Caroline Johnson	November 2022	Associate Medical Director for QI. Quality Improvement working group established to drive the roll out of the strategy.
1.9 Develop the Trust's communication and engagement strategy to improve the flow of information to all staff.	Director of Communications	Emma Clement	September 2022	On track for September Board
1.10 Implement Equality Diversity &Inclusion gap analysis, and strengthen organisational capacity for Equality, Diversity, and Inclusion.	Director of Workforce and OD/ Chief Nurse	Lydia Larcum/ Tara Filby	November 2022	On track - Head of Equalities, Diversity, and Inclusion for workforce to start post in August
1.11 Relaunch reward and recognition events (Long service and Celebration of Achievement)	Director of Communications	Emma Clement	Complete	Complete

Priority: Our People	**Focus Area: Working Life (fix the basics)**	**Portfolio lead: Director of Workforce and Organisational Development**
Measures	• Improve our comparative position on the staff survey 'Staff Engagement and Morale' responses to above average in 2022/23 •	
Monitoring Arrangement	• People and Culture Committee • Executive Committee • Workforce Working Group	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by	Status
2.1 Implement wellbeing spaces at each hospital site and develop plans for wellbeing spaces across the Trust footprint to enable staff to take a break.	Director of Workforce and OD/ Finance Director	Lydia Larcum/ Mark Steed	March 2023	Work continues with Estates colleagues with space now identified at York hospital. Costs being scoped in advance of bid for funding.
2.2 Develop and implement a food and drink plan for out of hours staff and shift workers across our sites.	Finance Director	Mark Steed	November 2022	On track
2.3 Implement the Travel Plan for staff, including increasing access by bus & secure Cycle Parking at hospital sites, and options for increasing car parking.	Finance Director	Dan Braidley	November 2022	Travel plan is in place, implementation plan is in progress with partial delivery implementation.
2.4 Provide lockers for staff and develop planning options for Shower & Changing Facilities across our sites.	Director of Workforce and OD / Finance Director	Vicki Mallows / LLP representative	March 2023	Work continues to identify a solution
2.5 Develop the strategic outline business case for a new electronic patient record system to support the migration away from the in-house CPD system	Chief Digital Information Officer	Luke Stockdale	March 2023	Draft Strategic Outline Business Case in development

				for submission to support CPD.
2.6 Implementation of a new staff intranet to facilitate access to Trust policies, best practice, guidance and procedures.	Director of Communications	Emma Clement	September 2022	Dedicated capacity has been identified with expected delivery in early Autumn.
2.7 Deliver transparent and equitable local medical pay agreements.	Director of Workforce and OD	Lydia Larcum	December 2022	On track to take a proposal to the August Executive Committee and LNC subsequently

Priority: Our People	Focus Area: Recruitment	Portfolio lead: Director of Workforce and Organisational Development
Measures	• Maintain recruitment activity at 2021/22 levels • Increase the % retention of non-medical student who train and quality with us, with an ambition to achieve 80% retention. • By April 23 to have no more than 1% vacancy rate for Healthcare Assistants • By April 23 to have no more than a 7.5% vacancy rate for Registered Nurses	
Monitoring Arrangement	• People and Culture Committee • Executive Committee • Workforce Working Group	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	Status
3.1 Re-introduce recruitment Open Days	Director of Workforce and OD	Lydia Larcum	July 2022	Programme commenced with open days held in June and July
3.2 Re-establish consultant recruitment events	Medical Director	Care Group Directors	September 2022	In progress, and planned dates.
3.3 Enable recruitment in advance of anticipated vacancies aligned to approved succession plans and delivered through a reinvigorated Care Group Vacancy Control process	Finance Director	Associate Chief Operating Officers	September 2022	Work to commence to develop a consistent and agreed process.
3.4 Pay the Real Living Wage for employees	Director of Workforce and OD	Lydia Larcum	July 2022	Agreed by Corporate Directors. This has however been superseded by the pay award.
3.5 Launch the recruitment microsite by September to facilitate external messaging and easy access for potential employees	Director of Workforce and OD	Lydia Larcum	September 2022	On track – work on building content continues
3.6 Review and update recruitment packs	Director of Workforce and OD	Lydia Larcum	March 2023	On track – work continuing to develop packs.

				HYMS information to be included
3.7 Develop a personalised on-boarding approach for the Trust	Director of Workforce and OD	Will Thornton	February 2023	On track – will be taken forward by the Recruitment & Attraction workstream
3.8 Implementation of the international nurse recruitment programme, with a further 80 nurses recruited in 2022-23	Chief Nurse	Emma George	December 2022	On track
3.9 Implementation of the Trust's six developments for nursing (Trainee Nursing Associate Apprenticeship, International Nurse Recruitment, Registered Nurse Degree Apprenticeship, Healthcare Support Worker recruitment and retention plan, Preceptorship programme, return to practice course)	Chief Nurse	Emma George	December 2022	On track

Priority: Our People	Focus Area: Workforce Planning	Portfolio lead: Director of Workforce and Organisational Development
Measures	• Trust workforce plan	
Monitoring Arrangement	• People and Culture Committee • Executive Committee • Workforce Working Group	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	Status
4.1 Review all in patient area establishments across all clinical roles and present at Exec Committee to describe the gaps to ensure safe and sustained staffing levels	Director of Workforce and OD	Will Thornton/ Emma George, Vicky M-T	March 2023	On track
4.2 Increase our spend of the Apprenticeship Levy, with plans to fully spend in 2023/24	Director of Workforce and OD	Will Thornton	March 2023	On track
4.3 Explore opportunities to increase research options in job plans (all professions) as part of annual job planning	Medical Director	Will Thornton	December 2022	On track
4.4 Further development of alternative clinical roles e.g. ACPs/SCPs/PAs etc.	Director of Workforce and OD	Will Thornton	November 2022	On track
4.5 Procure activity planning software to support job planning and assessment of capacity gaps.	Director of Workforce and OD	Lydia Larcum	March 2023	On track – draw down option has been built into the Allocate contract.
4.6 Undertake and embed Safer Nursing Care Tool (SCNT) every 6 months to ensure establishments remain appropriate	Chief Nurse	Emma George	March 2023	On track
4.7 Development of a retention strategy for nursing and midwifery through collaboration and engagement	Chief Nurse	Emma George	September 2022	On track
4.8 Development of a nursing workforce dashboard for Care Groups and triangulating impact on patient quality indicators	Chief Nurse/ Andy Williams	Emma George	December 2022	On track – review of systems commenced.

Priority: Quality and Safety	**Focus Area: Fundamentals of Care**	**Portfolio lead: Chief Nurse/ Medical Director**
Measures	• To continue to achieve and sustain a 10% reduction in the average number of falls per 1000 bed days (based on the last 12 months) • To elimate all category 4 pressure ulcers where lapses in care have been identified for patients in our care • Completion of Malnutrition Universal Screening Tool (MUST) within 24 hours of admission. •	
Monitoring Arrangements	• Quality and Safety Committee • Executive Committee • Quality and Patient Safety Meeting	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	Status
5.1 Develop a triangulation risk assessment and 'heat map' of high clinical risk service areas to inform prioritisation of resources across the Trust.	Medical Director/ Chief Nurse/Chief Operating Officer	Caroline Johnson/ Tara Filby/ Lynette Smith	September 2022	Meeting in place to triangulate risks and develop the assessment.
5.2 To develop and implement digital risk assessments for falls, pressure ulcers and nutrition and the associated digital care plans.	Chief Nurse	Nik Coventry	March 2023	On track – Nursing Documentation
5.3 Develop a communications strategy to raise awareness regarding falls prevention	Chief Nurse	Tara Filby	September 2022	On track
5.4 Recruit a falls prevention lead to support ward-based education and training	Chief Nurse	Tara Filby	October 2022	On track
5.5 Ensure incident investigations for pressure ulcers and falls focus on learning and are conducted in line with national guidance	Chief Nurse	Tara Filby	March 2023	On track
5.6 Review and update the fluid balance guidelines	Chief Nurse	Tara Filby	October 2022	On track
5.7 Ensure the nutrition policy is updated in accordance with national guidance	Chief Nurse	Tara Filby	September 2022	On track
5.8 Revise and launch the food and drink strategy for patients.	Chief Nurse	Tara Filby	September 2022	On track
5.9 Undertake training needs analysis to identify staff groups that require training	Chief Nurse	Tara Filby	April 2023	On track
5.10 Develop an educational strategy for nutrition and hydration	Chief Nurse	Tara Filby	September 2022	On track – nutrition nurse recruited.
5.11 Pre-operative fluid management process and updated protocols	Chief Nurse	Lyndsay Truscott	July 2022	Complete
5.12 Implement the Trust's nutrition and hydration action plan	Chief Nurse	Tara Filby	December 2022	On track

Priority: Quality and Safety	**Focus Area: Journey to Excellence**	**Portfolio lead: Chief Nurse**		
Measures	• Increased number of self-assessment rating improving to the next category from baseline assessment • Increased audit compliance with mental health risk assessments • Reduction in external whistle blowing			
Monitoring Arrangements	• Quality Committee • Executive Committee • Building Better Care Programme Board • Quality and Regulations Meeting			
Action in 2022-23		Executive Lead	Operational/ Clinical Lead	Delivered by:	Status
6.1 Undertake a full suite of self-assessment ratings with a suite of associated evidence attached.		Chief Nurse	Shaun McKenna	September 2022	Potential slippage of deadline to October due to care groups capacity to undertake all the self-assessments
6.2 Create a schedule of peer review assessments, prioritising high risk areas first.		Chief Nurse	Shaun McKenna	August 2022	On track
6.3 Enhance the existing governance framework to include a fortnightly operational delivery group to “check & challenge” actions and associated evidence base.		Chief Nurse	Shaun McKenna	June 2022	Complete
6.4 Ensure timely closure of actions, ensuring they are revisited for assurance that actions are embedded in practice.		Chief Nurse	Shaun McKenna	August 2022	On track
6.5 Further amend the risk assessment tool based on feedback and audit findings		Chief Nurse	Shaun McKenna	July 2022	Complete
6.6 Revise the mental health risk assessment audit tool based on feedback and audit findings		Chief Nurse	Caroline Johnson	July 2022	On track
6.7 Ensure process is embedded in practice, subsequently delivering greater audit results and assurance.		Chief Nurse	Associated Chief Nurses	August 2022	In progress
6.8 Deliver a suite of training to the ED departments (suicide prevention, self-harm and mental health first aid)		Medical Director	Medical Director	December 2022	On-track

Priority: Quality and Safety	**Focus Area: Infection Prevention**	**Portfolio lead: Chief Nurse**
Measures	• Evidence that all wards have undergone HPV decontamination during the 2022-23 financial year • Reduction in the number of Staph aureus bacteraemias 2021-22 baseline • To achieve at least a 20% reduction in C-DIFF bacteraemia in 2022/23 •	
Monitoring Arrangements	• Quality Committee • Executive Committee • Quality and Patient Safety Meeting • IPC Strategic and Assurance Meeting	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	
7.1 Develop and implement a proactive HPV programme both main sites, including use of 29 (York) for decant purposes and identification of a decant space at Scarborough site.	Chief Nurse	Astrida Ndlovu/ Lucy Turner	December 2022	A comprehensive HPV program is not yet implemented, with bay by bay cleaning compete for 4 wards. Ward 29 is being used a decant space for full refurbishment of 26.
7.2 Implement the programme of multidisciplinary walk rounds to identify priority areas	Chief Nurse	Emma George	September 2022	Complete. These have started with 12 walk rounds completed since April 2022.
7.3 Embed the Post Infection Review process for outbreaks to increase learning and reduce future outbreaks.	Chief Nurse	Astrida Ndlovu/ Associate Chief Operating Officers	December 2022	Outbreaks are managed in line with guidance and actions completed within

				the framework of the outbreak control group
7.4 Ensure Care Groups embed processes for tracking the implementation of actions arising from PIRs	Chief Nurse	Astrida Ndlovu	December 2022	In progress. CGs have taken over the management of the PIR process and are embedding these within the Care Group.
7.5 Provide funding for formal training and courses to develop the workforce	Chief Nurse	Emma George	July 2022	Complete
7.6 Establish the IPC Strategic and Assurance Group (IPSAG) meeting as a replacement for TIPSG	Chief Nurse	Dr Damian Mawer	July 2022	Completed, with the first meeting held in Q1.
7.7 Embed reviews of IPC performance within Care Group quality meetings	Chief Nurse	Associate Chief Nurses/ Emma George	August 2022	In progress. IPC attendance to CG quality meetings was paused whilst the number of COVIDs increased resulting in pressure on the team. These have now resumed.

Priority: Elective Backlogs	**Focus Area: Maximising Additional Capacity**	**Portfolio lead: Chief Operating Officer**			
Measures	• Reduce number of 104 week RTT waits to 0 by June 2022 and maintain to March 23 • Reduced number of 78 week RTT waiting to 0 by March 23.				
Monitoring Arrangements	• Finance and Performance Committee • Executive Transformation Committee • Building Better Care Programme Board • Care Group Boards				
Action in 2022-23		Executive Lead	Operational/ Clinical Lead	Delivered by:	
8.1 Implement an elective hub through the national transformation funding in York to create a protected theatre and ward space for electives.		Chief Operating Officer	Liz Hill	June 2022	Hub now operational
8.2 Implement the 50 week theatre Service Level Agreement for Bridlington		Chief Operating Officer	Karen Cowley	June 2022	50 Week SLA agreed. Implementation is linked to job plan reviews and not yet commenced.
8.3 Develop the short form business case for the capital bid to secure TIF2 monies for York site and Bridlington development of Post-Anaesthetic Care recovery and outpatient procedures and develop site plans for implementation in 2023.		Chief Operating Officer	Liz Hill	August 22 – Business Case	On track for August
8.4 Agree the arrangement and access for Mutual Aid from local partners		Chief Operating Officer	Lynette Smith	March 23 (ongoing)	Mutual Aid in place for Urology. An ICS Mutual aid programme has commenced to coordinate across trusts
8.5 Embed a consistent approach to capturing and reporting harms due to elective backlogs		Medical Director	Caroline Johnson	September 2022	On track
8.6 Extend capacity at the York Community Stadium to support outpatients and procedures.		Chief Operating Officer	Neil Wilson	December 2022	On track

Priority: Elective Backlogs	**Focus Area: Maximising Internal Capacity**	**Portfolio lead: Chief Operating Officer**		
Measures	• Reduce number of 104 week RTT waits to 0 by June 2022 and maintain to March 23 • Reduced number of 78 week RTT waiting to 0 by March 23. • RTT Total Waiting List stabilise growth to no more than 45,000 •			
Monitoring Arrangements	• Finance and Performance Committee • Executive Transformation Committee • Building Better Care Programme Board • GIRFT Assurance Board • Care Group Boards			
Action in 2022-23		Executive Lead	Operational/ Clinical Lead	Delivered by:
9.1 Assess the Getting It Right First Time (GIRFT) impact for surgical specialities (BADS) and procedures per list to increase productivity (GIRFT action plan), including day case as default and 'Golden Patient' SOP		Chief Operating Officer	Liz Hill/ Jenny Hey	March 23
9.2 Reinstate WLI working for York, Scarborough, and Bridlington		Chief Operating Officer	Liz Hill	Complete
9.3 Implement insourcing at York site for Q1-3.		Chief Operating Officer	Liz Hill/ Michelle Adeniji	June – Dec 2022
9.4 Pilot and evaluate prehabilitation for patients due to undergo complex surgery (York pilot).		Chief Operating Officer	Liz Hill/ Amber Lee	Impact evaluation December 2022

Analysis complete and shared with Executive in June. Working groups in place and reviewing data and action plans for delivery.
WLI available, however availability of theatre staff remains a challenge
Insourcing in place
First cohort of patients have completed their trial. Results will be analysed as patient receive their surgery.

9.5 Provide an electronic platform for patients to access guidance on keeping 'fit for surgery'.	Chief Operating Officer	Liz Hill	September 2022	My Planned Care Platform pages live with guidance on keeping fit for surgery. Review of options for patient specific information underway.
9.6 Implement the Outpatients Transformation Programme (Building Better Care) to increase 1st Outpatient capacity through productivity (room booker) and revised clinical pathways for Follow Up appointments (Patient Initiated Follow Up)	Chief Operating Officer	Dr Mark Quinn Karen Cowley	March 2023	Room booking software delayed and now in testing. Roll out of guidance and support for PIFU underway.
9.7 Complete full validation of the RTT waiting list, including review of position against national best practice	Chief Operating Officer	Lynette Smith	July 2022	Complete for the TWL.
9.8 Review the patient pathway processes to identify improved efficiency and target patient 'do not attends and cancellations.	Director of Workforce and OD	Jim Fishburn/ Annette Wardman	March 2023	As-is workshops and analysis of the current pathways for outpatients underway and efficiency opportunities identified. Further work to develop the to-be proposals for the Trust.
9.9 Implement a 'back to basics' training and development package for operational and administrative teams on RTT rules and operational tasks	Chief Operating Officer	ACOO	September 2022	The ICS Director of Elective Recovery is looking to secure a standardise support package across local providers.

Priority: Acute Flow	**Focus Area: Diversionary and alternative pathways of care**	**Portfolio lead: Chief Operating Officer**
Measures	• Less than 10 % Ambulance handovers waiting >60 minute • Improvements in time to initial assessment to ave of 18mins • Less than 7.5% of admissions wait more than 12 hours in department •	
Monitoring Arrangements	• Finance and Performance Committee • Executive Transformation Committee • Building Better Care Programme Board • Care Group Boards	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	
10.1 Complete the ED build at York to provide additional clinical space for the urgent and emergency pathways.	Chief Operating Officer	Jamie Todd / Dr M Harkness	March 2023	On track
10.2 Implement a revised clinical model for emergency care pathways by September at York Hospital.	Medical Director	Jamie Todd / Dr M Harkness	September 2022	Emergency Assessment pathways implemented in July.
10.3 Increase direct admission from ambulance to assessment units by extending the range of clinical criteria for paediatrics, gynaecology and medicine.	Medical Director/ Chief Operating Officer	Jamie Todd / Dr M Harkness York David Thomas/ Dr G Robins SGH	March 2023	On track – Improvement plans in place in both Care Groups
10.4 Work collaboratively with YAS, urgent care and out of hospital services to develop and consistently access diversionary pathways.	Chief Operating Officer	Programme Lead Urgent Care	December 2023	Ambulance Handover Plan in place. Additional capacity from mid-August to support delivery.
10.5 Work with system partners to deliver the Urgent Care service review and recommendations for urgent care services that effectively divert patients to the most appropriate care.	Chief Operating Officer	Programme Lead Urgent Care	March 2023	On track – additional capacity from mid-August to support delivery

10.6 Extend the range of clinical criteria and operating hours for the Emergency Assessment Units from 6 hours to 12 hours at weekends, and review the opening times during week days.	Chief Operating Officer/ Medical Director	Jamie Todd / Dr M Harkness York David Thomas/ Dr G Robins SGH	March 2023	On track – funding review and business case in development.
10.7 Extend the range of specialities working through a Surgical Assessment Unit e.g. orthopaedics and gynaecology	Chief Operating Officer	Karen Cowley/ Caroline Alexander	March 2023	On track
10.8 Explore opportunity to 'ring-fence' assessment beds for predicable admissions (e.g. fracture), based on patterns of admission.	Chief Operating Officer/ Medical Director	Jamie Todd / Dr M Harkness York David Thomas/ Dr G Robins SGH	September 2022	On track- implemented on stroke ward at York Hospital.

Priority: Acute Flow	**Focus Area: Bed Capacity and Discharge**	**Portfolio lead: Chief Operating Officer**
Measures	• Proportion of patients discharged before 5pm - SAFER metric from 58.9% to 70%, • Reduction in delayed discharges on inpatient wards •	
Monitoring Arrangements	• Finance and Performance Committee • Executive Transformation Committee • Building Better Care Programme Board • Care Group Boards	

Action in 2022-23	Executive Lead	Operational/ Clinical Lead	Delivered by:	
11.1 Complete a baseline of the current position and agree priority areas of focus for seven day clinical standards	Medical Director	Caroline Johnson	September 2022	On track – questionnaires returned and analysis underway.
11.2 Review medical work rosters aligned to the pattern of demand, including assessment	Medical Director	Caroline Johnson	March 2023	Demand analysis commissioned
11.3 Work to ensure speciality senior decision makers are see the patients wherever the patients are located to support early clinical decision making.	Medical Director	Caroline Johnson	March 2023	Work to be scoped.
11.4 Bid for additional bed capacity monies to support delayed patients in alternatives to acute ward care	Chief Operating Officer	Jenny Hey	July 2022	Bid submitted and awaiting outcome from the national and regional teams
11.5 Implement clinical models to enable criteria led discharge and expected discharge date as part of the admissions process (post take or first board round).	Medical Director	Caroline Johnson	March 2023	Discharge report submitted to Executive Committee with agreed recommendations. Work plan in development.
11.6 Review the audit of OPEL actions and respond to the recommendations	Chief Operating Officer	Patient Flow Managers	September 2022	Review completed and planned date in August to update processes

				and documentation.
11.7 Complete the bed modelling review, and associated business case to reorganise the ward configuration to best meet current and forecasted demand	Chief Operating Officer	Jenny Hey	September 2022	Bed modelling paper completed and presented to Executive. Care Group implementation ongoing. Business case developing is pending the results of the bid for bed monies.
11.8 Implement the virtual ward approach, increasing capacity in line with funded plans to facilitate discharge and prevent admission.	Chief Operating Officer	Steve Reed	March 2023	Virtual Ward milestones identified; Project Manager appointed. Business cases currently under development. Implementation plan awaiting feedback on the bed capacity bid.
11.9 Deliver BADS targets to increase the number of procedures that can be delivered as Day Case as an alternative to overnight admission	Chief Operating Officer	Liz Hill/ Amanda Vipond	March 2023	On track – BADS working group in place and driving delivery.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors
27 July 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 May 2022. This will include the requirement to submit the safer staffing metrics using Care Hours per Patient Day (CHPPD).

/ Executive Summary

- The quality committee 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.
- Acknowledge the ongoing work in regard to retention, the recent improvement in HCA retention figures
- Undertaking of the Safer Nursing Care Tool in June 2022 to assist and strengthen the establishment reviews.
- Ongoing response to the CQC inspection in regard to nurse staffing levels

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 May 2022 submission is attached in Appendix 1. The table (1) below details the overview of each care group for May 2022.

Table 1

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	76%	77%	20%	-	90%	97%	7%	-
CG2	85%	94%	14%	-	94%	99%	16%	-
CG3	80%	85%	-	-	88%	104%	-	-
CG4	58%	84%	-	-	100%	79%	-	-
CG5	67%	74%	-	-	78%	85%	-	-
CG6	-	-	-	-	-	-	-	-
Total	77%	83%	24%	-	89%	98%	12%	-

The average day fill rate in May for Registered Nurses/Midwives was 77, this is a 6% improvement from March 2022 and for Non – Registered Nurses, 89%, which indicates a 15% improvement since March which is a positive picture.

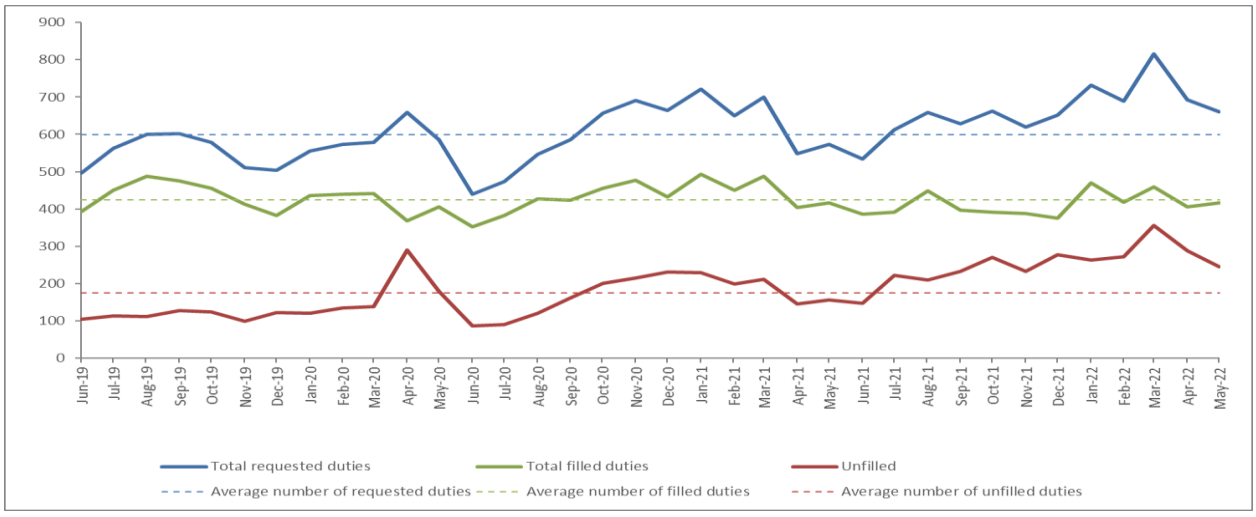
There are 13 inpatient Wards below the 80% average RN day fill rate, an improvement from May 2022, There is 1 ward below 80% RN fill rate for nights which shows an improvement of 7 wards since March 2022. CCU in York the RN is regularly deployed to support the cardiology ward and the Cardiac Outreach Nurse supports CCU.

This is the most improved CHPPD and will be shown in table form from next month to demonstrate this improvement month on month.

Temporary Staffing

The Temporary Staffing Team continues to co-ordinate high levels of demand with agency HCA usage is the highest since March 2020. Work continues with our Framework compliant agencies to maximise their fill rates with the aim to reduce the level of Thornbury requests.

Table 2



The table above (2) shows the peaks in demand for temporary nurse staffing, the amount filled and unfilled shifts. 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 3). In May 2022, 40% of all shift requests were unfilled.

Table 3

	Requested			Agency Filled			% of requested duties	Bank Filled			% of requested duties	Total % of duties filled	Unfilled			% Unfilled
	HCA	RN	Total	HCA	RN	Total		HCA	RN	Total			HCA	RN	Total	
Trust	6200	6130	12330	126	1374	1500	12%	3501	2421	5922	48%	60%	2573	2335	4908	40%
York	3964	4266	8230	126	993	1119	14%	2063	1669	3732	45%	59%	1775	1604	3379	41%
Scarborough	2236	1864	4100	0	381	381	9%	1438	752	2190	53%	63%	798	731	1529	37%

Workforce deployment and escalation

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 and the basic fundamentals of care are not being met.
- 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 Escalation '<u>Adult Inpatients Wards,</u>** detailing the process, this has been trialled and is now embedded across both sites. There is now an ability to identify where wards require additional support through a RAG rated system and the impact of this on the fundamental basic cares for patients and where support can be deployed on a daily basis from other areas, volunteers and staff who have offered time to support wards.

A review of all ward establishments is underway and will be completed in July 2022. Care Group teams have reviewed the previous establishments and there is now a final process of checking and confirming. This will be presented to the executive committee in July 2022, due to the immense changes during the pandemic and the complexities of these changes to ward establishment this has been a complex process. 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.

Safer Nursing Care Audit

A trust wide daily data collection of the Safer Nursing Care Tool (SNCT) commenced 6 June 2022 and a dedicated Matron supported this across all inpatient wards, leading the project to ensure it was 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. Both EDs are undertaking the audit next with a view to include paediatrics later in the year. The evidence will be used to support the annual establishment review process moving forward 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.

Nurse Vacancies

Table 4 Nurse Vacancy Levels Trust wide May 2022

Nurse Midwifery and Care Staff – Staffing Data - April 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	2,309.62	129.62	1,136.25	2,077.97	152.11	992.21	13.03	0.00	5.64	11.20	0.00	17.73	233.48	-22.49	131.95	10.11%	-17.35%	11.61%

Table 4 details the April 2022, vacancy position for the Trust and for York, Scarborough and Bridlington sites 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%. In April 2022 the following RN and HCA posts were recruited.

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. Where wards are deemed as red there is a visible check of the ward and an assurance that basic patient needs are being met and where there isn't additional support is deployed and escalation to the ACN or HON of the day.

The prevalence of pressure ulcers still continues to show an upward trend in the ward areas where there are sustained staffing pressures; as a result, intentional grounding of patients has not been undertaken regularly according the patients needs. The assessment and implementation of care is provided by the Registered Nurse.

There is a sustained increase in the IPUs, staff are deployed to protect the acute site and this is having an impact on the quality of care delivery. 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 quality indicator dashboard and whilst there is a dashboard available, additional information is required and this is on going. Due to demand and reduced resource in the DIS team and the ability to utilise data

from tendable along with the launch of the clinical documentation project , there is currently 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. 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 twice daily staffing check-in meeting, which includes a Matron from each Care Group and is chaired by one of the Associate Chief Nurses or Head of Nursing. 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.

2.4 **Development work**

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, considering new roles.

Progress continues on the Trusts' 6 developments for nursing, listed below.

- Trainee Nursing Associate Apprenticeship (tNA)
- International Registered Nurse Recruitment
- Registered Nurse Degree Apprenticeships
- HCSW recruitment to achieve 1% vacancy and a 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

Following from the retention timeout day in November 2021, there was another session led by the Assistant Chief Nurse to update and refresh improvement plans. The regional retention lead was invited from NHSEI and as part of the retention project six work streams have been developed. 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
- Pastoral care for HCAs
- Training and preceptorship

- Celebrating success and communication , including the development of a nursing council and HCA forum
-

Each workstream has a lead and this will report into the nursing retention steering group that will be established in August 2022

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 351 international nurses (IN) with a further 47 expected to arrive by December 2022. The latest cohort has arrived in the UK on 20 June and has commenced their 4 weeks of ToC training.

National issues with the NMC Test of Competency (ToC) exam capacity continue to create a difficult training environment and unfortunately the situation does not appear to have improved despite additional capacity being provided by new testing centres in Leeds and at Northumbria University. All testing centres are currently unable to provide a 'block booking' for cohorts and centres are reporting being fully booked for several weeks or months. We will continue to encourage INs to find individual bookings as far as possible.

We continue to escalate our concerns directly to the NMC and to identify IN's who have been in the UK for over 12 weeks without taking their test- a core standard for their visa requirements.

IN should complete their 4 weeks of ToC training followed by the test in week 5. Currently there are 33 IN who have completed their ToC training and are waiting for test dates who continue to work in their clinical areas as Pre Registered Nurses (Band 4).

Additional funding has been released through NHSE&I to support recruiting additional IN's to have arrived in the UK by December 2022. There will be a request for 40 additional INs to the organisation meaning that we will have recruited 120 INs this year.

The Trust has started to support the first cohort of NHSE&I International Midwives (IM) through use of the training facility at York University Science Park with 1 International Midwife in training. It is expected that an additional 3 cohorts of IM will use the Trust training venue over the year.

Health Care Assistant Recruitment

The recruitment and nursing teams continue to strive to recruit HCAs but currently sit with 55.52 WTE for the inpatient wards. There is some caution with this due to the ongoing establishment reviews and the consequent increase in HCA posts as a result and the accuracy of the current establishments. The opening of additional capacity has consequently increased vacancies.

It is projected that we require 200 HCAs in the next year and need to consider new ways to attract HCAs. 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 HCA 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 HCAs into a career in healthcare. The employment of 4 WTE pastoral workers allocated to Care Groups 1-3 has had a positive impact also on the well-being of our HCAs. We have seen an improvement in our HCA turnover rates this month for the first time (Table 6).

Table 6

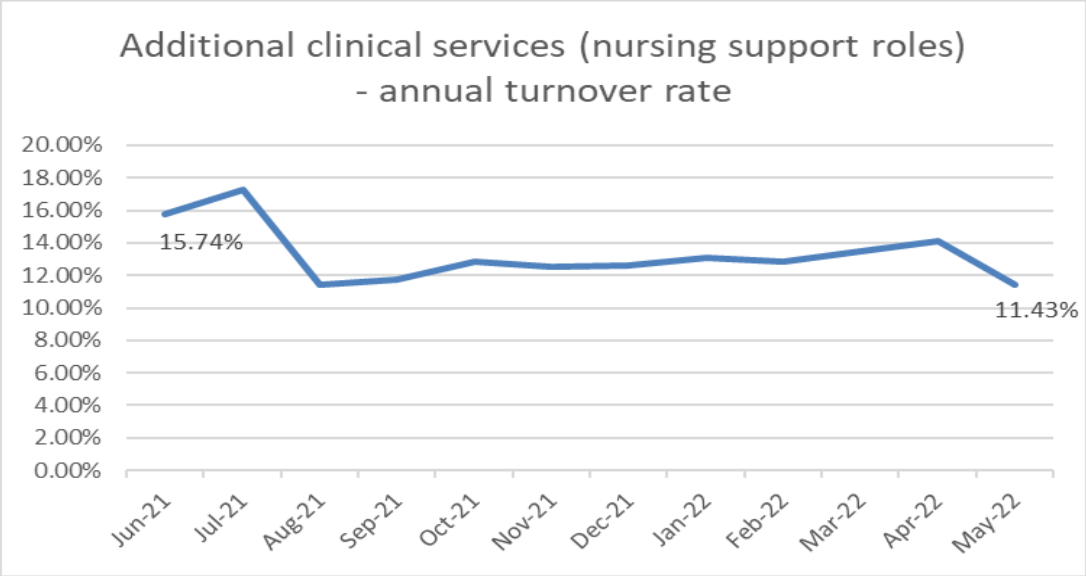


Table 6 indicates an improvement in the turnover rate from April 2022 which is a positive message for the organisation.

Following a number of successful HCA recruitment campaigns and the introduction of further pastoral support across the organisation we are able to see a positive vacancy position for August 2022.

Table 7 Indicating current vacancy and forecast

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Mar-23
Establishment	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07	1242.07
In post	1172.15	1186.55	1214.95	1243.35	1257.75	1272.15	1286.55	1300.95	1315.35	1329.75	1344.15	1358.55
Projected leavers		10.6	10.6	10.6	10.6	10.6	10.6	10.6	10.6	10.6	10.6	10.6
Projected New Starters		25	39	39	25	25	25	25	25	25	25	25
Vacancies	-69.92	-55.52	-27.12	1.28	15.68	30.08	44.48	58.88	73.28	87.68	102.08	116.48

The Trust has also appointed three Band 4 Pastoral Roles for HCAs who started in post this May 2022, this role is proving to be a success and a HCA forum has been established. There has been further funding for another Band 4 and a request to NHSEI for a further two across sites.

A HCA Recruitment and Retention Group (HCARRG) 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 a continued 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. York University are proposing to run the RNDA programme from September 2023 and are in early conversations with the Trust for this to start.

The tender for the apprenticeship programmes is due for renewal and has been completed ,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 and the adverts will go out Monday 13 June.

An apprenticeship schedule has been developed for 2022- 2025:

Proposed activity:

Dates	Programme numbers & duration	SGH places	York places	Training Provider
Sep-22	20 direct entry (3 yr) **RNDA**	7	13	CUS
	10 AP top up (2 yr) **RNDA**	3	7	CUS
Jan-23	35 Nursing Associate (2 yr)	10	25	CUS & University of York
Sep-23	20 direct entry (3 yr) **RNDA**	7	13	CUS & University of York
	10 AP top up (2 yr) **RNDA**	3	7	CUS
Jan-24	30 NA top up (18 months) **RNDA**	10	20	CUS & University of York
	30 Nursing Associate (2 yr)	10	25	CUS & University of York
Sep-24	20 direct entry (3 yr) **RNDA**	7	13	CUS & University of York
	10 AP top up (2 yr) **RNDA**	3	7	CUS
Jan-25	30 NA top up (18 months) **RNDA**	10	20	CUS & University of York
	30 Nursing Associate (2 yr)	10	20	CUS & University of York

This will be available on Staff Room as an Apprenticeship recruitment schedule, so that all employees will know when the cohorts will be taking place, entry criteria, dates for applications to be submitted and interview dates.

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

We have five staff members who are undertaking the RTP course, two who were already in post and three who we have recruited to the Trust. There are another three learners who have requested a placement and we are currently looking at where we can offer them employment for when they finish.

Professional Nurse Advocate (PNA)

Restorative supervision sessions are ongoing, focusing on NQN's and International Nurses. We are just waiting for more training dates and have a list of people who would like to attend. Four of the PNA team will be attending the inaugural regional conference next week. The PNA forum will be launching a campaign to recruit more PNAs in September with a full communication plan and advertsing the importance of this role in the retention of 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

Nursing workforce remains a challenging landscape, the outcome and impact of the pandemic has identified an increase in our attrition rates for Registered and Non Registered nurses has increased, but we are seeing an improvement in the turnover rate for HCAs. As a result it is recognised that a retention strategy is required to include various work streams. Care Groups need relevant and appropriate data that is available for them to articulate their requirements. How we care for our workforce is paramount, with pastoral care being central to the work undertaken such as new roles and the PNAs. Making York and Scarborough NHS Foundation Trust the place where nurses want to work needs to be our aspiration. Establishment reviews will ensure we have the right workforce to care for our patients and to ensure staff feel a sense of satisfaction in the care they are providing.

3. Detailed Recommendation

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

Author: Emma George, Assistant Chief Nurse

Director Sponsor: Heather McNair, Chief Nurse

Date: June 2022

Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	CQC Report
Director Sponsor:	Heather McNair – Chief Nurse
Author:	Shaun McKenna – Head of Compliance & Clinical Effectiveness/Caroline Johnson – Deput Director of Quality Governance and Patient Safety

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	**Board Assurance Framework**
☐ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

- Scarborough Hospital Emergency Department have recruited a new clinical director for the department, who holds a PEM qualification. Following appropriate job planning, this will meet the requirements following the January 2020 inspection report.
- The Trust continues to have Section 31 conditions associated with registration due to the lack of consistent audit results for mental health risk assessments.
- The CQC action plan following inspection in March 2022 has been submitted within the required timescales (6th July 2022). (Appendix A).

Recommendation:

1. Acknowledge the outstanding Section 31 Conditions and 29A Warning Notices.
2. Recognise the progress which is being made with the recruitment of a PEM consultant at Scarborough Hospital Emergency Department.
3. Acknowledge the CQC action plan submission (Appendix A).

Report History

Meeting	Date	Outcome/Recommendation
Quality and Patient Safety	• 13.7.22	
Quality Assurance Committee	• 19.7.22	

CQC Report – July 2022

1. Introduction and Background

The purpose of this report is to provide an updated position of communication between the Trust and the Care Quality Commission (CQC), as well as action plan progress for regulatory requirements, and any other relevant updates.

2. Enforcement Action

2.1. Overview

Section 29A Warning Notice	Section 31 Conditions of Registration
1. Scarborough Hospital Emergency Department – Vacant PEM consultant post. (Jan 2020) 2. York Hospital Medicine – Assessment & management of patients' nutrition & hydration needs. *(May 2022)* 3. York Hospital Medicine – Recording of patients risk assessment and subsequent management of those risks. *(May 2022)* 4. York Hospital Medicine – Adherence to the Mental Capacity Act. *(May 2022)*	1. York Hospital Emergency Department – Mental Health Risk Assessments. (Jan 2020) 2. Scarborough Hospital Emergency Department – Mental Health Risk Assessments. (Jan 2020)

3. Regulatory Action Plan Update *(January 2020 Inspection)*

3.1. Outstanding Actions

PEM Consultant

The recruitment of a Paediatric Emergency Medicine Consultant for Scarborough Hospital has been overdue since November 2020. The successful applicant for Clinical Director of Scarborough Emergency Department already has a PEM qualification, which will meet the criteria to close this action. Care Group 2 is working on the associated job planning to make a meaningful impact with the role. The candidate is expected to commence in post in late autumn 2022.

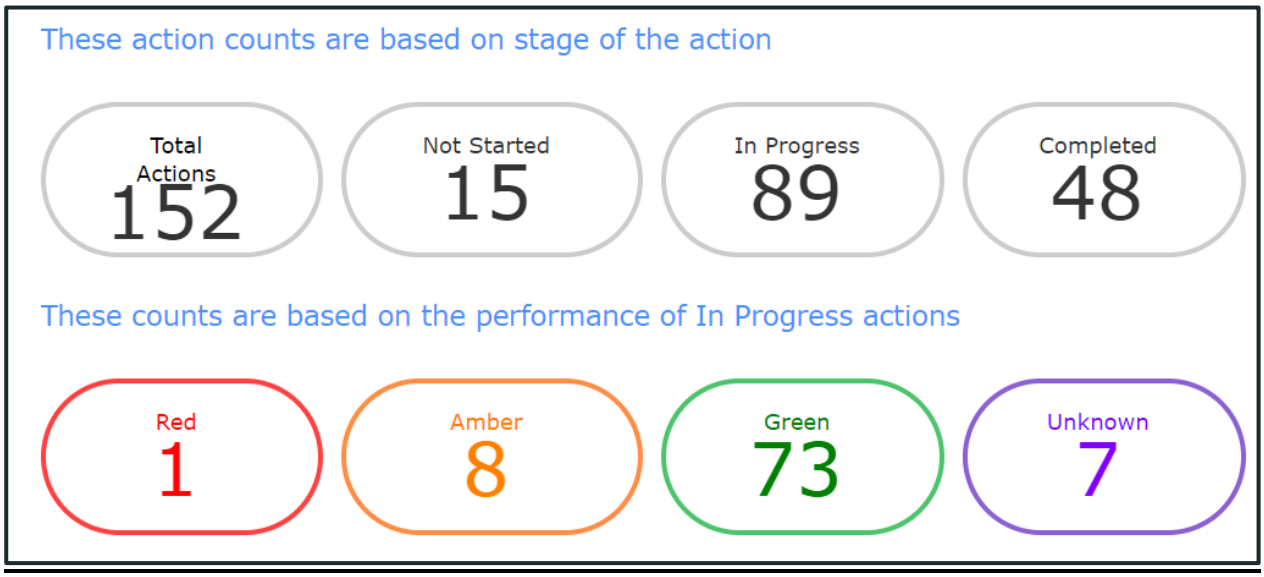
2.1. Ongoing Risk

Both of the Trust emergency departments have a Section 31 condition associated with mental health risk management. The Trust is not in a position to request for these conditions to be removed due to inconsistent audit results which suggests the process is not consistently embedded in practice. Training is continuing to take place with the ED teams to improve their mental health knowledge. Concerns have also been raised by the teams regarding the audit tool and as a result this will be amended and digitalised by the end of July 2022.

4. Regulatory Action Plan Update *(March 2022 Inspection)*

4.1. Outstanding Actions

Appendix A provides a high level summary of action plan performance utilising the InPhase Quality Oversight platform. The infographic below displays the progress of the action plan delivery. (Submitted to CQC on 6th July 2022). It is not anticipated that we will receive feedback on the plan before our next CQC engagement meeting when we will be required to provide a progress update regarding the delivery of the plan.



There are currently no overdue actions for delivery. The red RAG rated action relates to the delivery of fluid management training for patients with heart failure. The status is red due to sickness absence within the team which would deliver the training. The Matron and Ward Manager are working on a plan to address this action being delivered within the required timescales.

4.2. Ongoing Risk

48 actions have been completed to date; a deadline for evidence upload has been given to all action owners for review through relevant governance processes. Ward 26 improvement plan is showing as complete; further review of this plan is required to measure the outcomes associated with the completion. Following this, further actions may be added to ensure that a robust plan with measurable outcomes is delivered. Measurable outcomes for all recommendations are required to ensure effective progression can be monitored and demonstrated.

5. CQC Insight Report

5.1. Overview (CQC National Comparison)

The release of the CQC Insight report (Appendix C) scheduled for the end of May 2022 was delayed nationally. This was received in late June 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	Number of Indicators – May 2022
Much Worse	5	6	8	7	9	10
Worse	25	23	24	27	25	23
About the Same	174	175	179	167	175	179
Better	7	5	5	6	2	4
Much Better	2	3	2	2	2	1

5.2. CQC Insight Summary

- **Whistleblowing Alerts**

No further whistleblowing concerns have been raised following the last report.

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

The data used for this metric demonstrates a decrease in performance from 71.2% in April 2021 to 47.7% in April 2022, compared to the national average of 59% 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 demonstrates a decrease in performance from 4 breaches in April 2021 to 750 in April 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 demonstrates a decrease in performance from 80.7% in April 2021 to 70.8% in April 2022, compared to the national average of 69.1% and the overall aim of 95%.

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

The Head of Children’s Nursing has established the Trust is expected to participate in this audit and as such has registered to provide the data. This should show as compliant when the first audit report is published (up to 12 months)

- **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 fractured neck of femur improvement group are

aware of the information and their improvement plan is designed to address the factors impacting on this, for example reducing the between diagnosis and theatre.

- **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.

6. Journey to Excellence Self-Assessments

6.1. Overview

Self-assessments have commenced across all care groups utilising the InPhase system with an extended timescale of August 2022. A summary report will be presented in September 2022.

7. Summary

The CQC action plan was submitted on time on 6 July 2022 and the CQC require an update on the delivery of the plan at their next engagement meeting 2 August 2022. Delivery of the plan is on track with the exception of one action related to training in fluid management for patients with heart failure, which is delayed due to sickness but recovery plans are in train.

The action plan delivery is monitored through a two weekly Quality and Regulations Operational Delivery Group and formally through the Quality and Patient Safety Group and Quality Assurance Committee. Any risks to delivery will be quickly identified an immediately escalated should they occur.

8. Next steps

The Board are asked to note the update contained in this report.

Date: 8th July 2022

York and Scarborough Teaching Hospitals
NHS Foundation Trust

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6 July 2022

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Rachel Beynon
Inspector
Rachel.Beynon@CQC.org.uk

Reference: INS2-12828219831

Dear Rachel
Please find attached the Trusts action plan following the York Hospital Medicine inspection from 30th-31st March 2022. This follows the initial action plans and updates which were submitted. The attached action plan provides a high level summary of progress with the agreed actions, behind each action is a more in depth summary of required action and the ability to upload evidence into a central repository. As previously communicated the Trust has commissioned software to digitalise our action plan, whilst also giving us the opportunity to undertake self-assessments against the CQC domains and Key Lines of Enquiry. We would love the opportunity to demonstrate the system to you in the near future and discuss the impact it will have on our quality oversight within the Trust. The benefits of a digital CQC action plan include visibility and accessibility for all staff; anyone with a log in is able to see content on the platform which promotes openness and transparency.

Since the unannounced inspection took place, a number of actions have been completed to improve quality & safety across the organisation. As you can imagine, whilst actions are linked to a singular recommendation, the outcomes affect numerous recommendations. A summary of progress is provided below.

Nutrition & Hydration – A robust review of the nutrition and hydration policy, including fluid balance guidelines has been undertaken. In addition, specialist nurses for nutrition & hydration have commenced in post on each of the acute sites. Their main function is to provide visible support to all ward areas in relation to nutrition & hydration, focussing on those with complex needs such as PEG requirements. The increased visibility of specialist nurses in nutrition & hydration should increase knowledge and education for staff whilst also ensuring a safety net for patients with complex nutrition & hydration needs. Several projects have been initiated in the last week, utilising quality improvement methodology, which will have an impact for patients on key wards. The learning from the improvement projects will be shared following a full PDSA cycle.

Risk Assessments & Documentation – The Integrated Nursing Assessment document, created to identify individual patient care requirements, was consistently not being completed as noted in audits. The reasons for non-completion were multifactorial however one of the major contributing factors was due to the document being too large and time-consuming. As a result, an “at-a-glance” two sided document was created to replace the pre-existing document. This has resulted in staff being able to identify patient care needs at a glance, consistently across the hospital. Feedback from teams to date indicate the document is much more user friendly and has a better impact on service provision. Key posts including falls and tissue viability senior nurses are in the process of being recruited to. As well as providing visible clinical leadership to wards, their function will include promoting appropriate documentation and record keeping. By the end of July 2022, the initial roll out of the digital nursing risk assessments will be undertaken, significantly reducing the nursing hours required to undertake and record assessments.

Mental Capacity Act – A rolling programme of audit activity has been planned across the Trust, taking a support approach to promote rectification of identified issues in the moment. To enhance this and ensure the workforce is available to take a proactive supportive approach, mental capacity advisor posts have been established and recruited to with the first post due to commence in August 2022. A digital solution to the spot check audits is currently underway having been commissioned by the organisation.

Staffing – Following an initial reduction in COVID patients, the bed base was reduced by 5 beds on Ward 28 and Ward 29 was completely closed. This enabled staff to be dispersed into other ward areas to increase substantive staffing numbers. Twice daily staffing meetings now take place on weekdays using a RAG rated system for fundamental standards of care delivery. Whilst in the short term we haven’t yet been able to substantially increase the workforce numbers, we have better oversight of daily staffing levels and the subsequent impacts for patients and staff. This information enables informed decisions to be made to mitigate risk as much as possible such as the use of staff volunteers to offer support within their scope of practice. A nationally accredited tool has been used over the course of June to assess the required nursing establishments for each ward area; this is to be used to create a full nurse establishment report and request for associated funding.

Ward Improvement Plans – Each ward has been empowered to develop their own improvement plans pertinent to issues they have identified within their areas. This has leadership and oversight from senior managers within the Care Group Triumvirates. By taking this approach we are hoping to demonstrate a ground up approach to improvement with a ward to board approach of governance / improvement. A fortnightly meeting to discuss and debate improvement ideas and progress has been established within the Care Group.

There are numerous key actions still ongoing and yet to be started, as displayed within the attached action plan. The action plan will continue to be developed as new and innovative ideas are created through a quality improvement approach. Next steps include a review of all completed actions to ensure a robust evidence base is stored on the system with a stringent check and challenge process at the Quality & Regulations Group. Measures of success and outcomes are to be agreed for each recommendation, with an aim to have this completed and articulated in the next monthly submission. Communication is paramount so over the next few weeks we will continue to focus on an effective communication strategy to sustain the improvement momentum with our staff.

We hope that this summary along with the attached action plan provides you with a balanced view of where we are as an organisation and where we are aiming to be on our improvement journey; acknowledging there is much work still to do. Evidence will be reviewed within the engagement meetings as recently discussed and agreed. In the meantime if you do require any evidence for closed actions or further detail about a specific action, please do not hesitate to contact me.

Yours sincerely

Heather McNair
Chief Nurse

Inspection Name

York Medicine March 2022

Recommendation

Ward 36 CQC Improvement Plan

Add Recommendation

Stage

All 3 selected

Series

Active | Performance | Comments

Owner

All 23 selected

Start Date

to

Due Date

to

Completion Date (Est)

to

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Recommendation 1 - S29A Nutrition & Hydration	Design and implement an annual audit calendar	Tara Filby	Active												
			Performance	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Develop an educational piece for safety spotlight.	Tara Filby	Active												
			Performance	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Develop an educational strategy for nutrition and hydration	Tara Filby	Active												
			Performance	●	●	★	★	–	–						
	Ensure nutrition policy is updated in accordance with national guidelines	Tara Filby	Active												
			Performance	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Information Awareness Poster	Tara Filby	Active												
			Performance												
	Nutrition Nurses - Implementation	Tara Filby	Active												
			Performance												
	Quality Improvement PDSA - Complan Milkshake Rounds Wd25	Tara Filby	Active												
			Performance												
	Quality Improvement PDSA - Hydration Stations Wd32 & Wd34	Tara Filby	Active												
			Performance												
	Review and update the fluid balance guidelines	Tara Filby	Active												
			Performance												
	Review the e-learning packages to ensure it meets the needs of front-line staff	Tara Filby	Active												
			Performance												
	Revise food and drink strategy	Tara Filby	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Undertake training needs analysis to identify staff groups requiring training	Tara Filby	Active												
			Performance												
	Use of red trays Trust wide to visually highlight a patient requiring support for feeding	Tara Filby	Active												
			Performance												
	Visiting Policy Scoping Exercise - Promote Family & Carers to Attend to Support Care Delivery	Tara Filby	Active												
			Performance												
Recommendation 2 - S29A Risk Assessments	Bed Rails - Education & Communication Roll Out	Alison Bielby	Active												
			Performance												
	Create and Roll-out "Care Needs at a Glance" Document	Nik Coventry	Active												
			Performance												
	Falls Specialist Lead - Recruitment & Implementation	Tara Filby	Active												
			Performance												
	Immediate Audit of Inpatient Fundamental Standards of Care & Risk Assessment on Inspected Wards	Emma George	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Purpose T Education - International Nurses	Tara Filby	Active												
			Performanc												
	Review Bumpers & Crashmat Provision	Alison Bielby	Active												
			Performanc												
	Risk Assessment Education - Clinical Educators	Tara Filby	Active												
			Performanc												
	Specialist Staff Deployment to Address Gaps in Risk Assessments from Inspected Ward Audit	Emma George	Active												
			Performanc												
	Specialist Staff Deployment to Address Gaps in Risk Assessments from Trust-Wide Audit	Emma George	Active												
			Performanc												
	Trust-Wide Audit of Inpatient Fundamental Standards of Care & Risk Assessments	Emma George	Active												
			Performanc												
	TVN Workforce Review, Request for Additional Resource and Subsequent Recruitment	Tara Filby	Active												
			Performanc												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Recommendation 3 - S29A Mental Capacity Act	Bitesize Training - Inspected Wards	Nicola Cowley	Active												
			Performance												
	Corporate Baseline Audit of MCA compliance	Nicola Cowley	Active												
			Performance												
	Immediate Audit & Support - Inspected Wards	Nicola Cowley	Active												
			Performance												
	MCA Audit Programme Development	Nicola Cowley	Active												
			Performance												
	Safeguarding Team - Ward Based Drop-In	Nicola Cowley	Active												
			Performance												
	Safeguarding Workforce Review	Tara Filby	Active												
			Performance												
	'Train the Trainer' for Clinical Educators	Nicola Cowley	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Recommendation 4 - Must Do: Mental Capacity Act	Improvement Plan following Mental Capacity Act Improvement Group	Nicola Cowley	Active												
			Performance												
	MCA Advisors - Recruitment & Implementation	Nicola Cowley	Active												
			Performance												
	Mental Capacity Act - Improvement Group	Nicola Cowley	Active												
			Performance												
▪ Recommendation 5 - Must Do: Risk Assessments ▪ Recommendation 6 - Must Do: Record Keeping	Release 1 - Digital Nursing Risk Assessments & Care Plans	Nik Coventry	Active												
			Performance												
	Release 2 - Determine the next next risk assessments / documents to be included in release 2 & 3	Nik Coventry	Active												
			Performance												
Recommendation 6 - Must Do: Record Keeping	Information Governance - Review Storage and Location of Medical Records on Wards	Shaun McKenna	Active												
			Performance												
	Information Governance - Scope Requirements for Medical Records on Wards	Shaun McKenna	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Recommendation 7 - Must Do: Safe Staffing	Acuity & Dependency Review - Ward 28	Emma George	Active												
			Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Consider extending PSO provision as part of establishment reviews	Emma George	Active												
			Performance	★	★	★	–	–							
	Explore Military Support / Joint Working	Emma George	Active												
			Performance		★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Nurse ED Staffing Establishment Review - SNCT Review	Emma George	Active												
			Performance				–	–							
	Nurse Inpatient Staffing Establishment Review - SNCT Review	Emma George	Active												
			Performance			★	–	–							
	Nurse Staffing Escalation SOP	Emma George	Active												
			Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Nurse Staffing Establishment Review - Initial	Emma George	Active												
			Performance	●	●	●	–								

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Nursing Workforce Recruitment Open Day	Emma George	Active												
			Performance			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Retention Working Group Development	Emma George	Active												
			Performance		●	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Review Resource Requirements to Onboard Available Volunteers	Tara Filby	Active												
			Performance	▲	▲	★	–								
	Rolling Nurse Recruitment Advert	Emma George	Active												
			Performance	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Safecare Project Launch	Sarah Freer	Active												
			Performance				–	–							
	Staff Volunteer & Surge Coordinator	Tara Filby	Active												
			Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Staffing Volunteer Escalation List	Emma George	Active												
			Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Task Prioritisation Process	Donna Jack	Active												
			Performance												
	Weekday Daily Nurse Staffing Huddles	Emma George	Active												
			Performance												
	Widen the scope and locations of available military support	Emma George	Active												
			Performance												
Recommendation 8 - Should Do: Training & Development	Corporate Training Group - Development	Will Thornton	Active												
			Performance												
Recommendation 9 - Overarching Trust Actions	Closure of a Ward following Reduction in COVID19 Inpatients	Heather McNair	Active												
			Performance												
	Develop a Plan for Communicating Progress and Updates to all Staff	Shaun McKenna	Active												
			Performance												
	Develop an "You Said, Together We Did" to Share Progress and Updates	Shaun McKenna	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Fortnightly Ward Leaders Meeting	Caroline Dunn	Active												
			Performance												
	Freedom to Speak Up - Create a Mechanism for "Anonymous" Internal Whistleblowing	Shaun McKenna	Active												
			Performance												
	Implement "Huddle up for Safety" Coaching Project	Caroline Johnson	Active												
			Performance												
	Improve the datix response to staffing incidents	Caroline Dunn	Active												
			Performance												
	Simplify paper documentation process	Nik Coventry	Active												
			Performance												
Ward 25 CQC Improvement Plan	Analyse Tendable Themes	Louise Seed	Active												
			Performance												
	Dementia Care Improvement	Louise Seed	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Ensure all probationary reviews are conducted as per policy and escalate any concerns to HR	Jenni Lee	Active												
			Performanc												
	Ensure that a senior nurse (Band 6 or 7) is on duty on each shift where possible	Louise Seed	Active												
			Performanc												
	Falls training for all staff (refresher)	Louise Seed	Active												
			Performanc												
	Implement structure ward safety brief	Louise Seed	Active												
			Performanc												
	Implement ward routine	Louise Seed	Active												
			Performanc												
	Limit Nursing Documentation to one week for bed notes	Louise Seed	Active												
			Performanc												
	Mental Capacity Act, Safeguarding and Deprivation of Liberty (MCA and DOLs) Improvement	Louise Seed	Active												
			Performanc												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Nutrition training for all staff (refresher)	Louise Seed	Active												
			Performanc	★	★	★	–	–	–						
	Perform weekly nursing risk assessment audit	Louise Seed	Active												
			Performanc	★	★	★	–	–							
	Plan to introduce volunteers to support with nutrition and hydration on the ward	Louise Seed	Active												
			Performanc	★	★	★	–	–							
	Pressure ulcer prevention training for all staff (refresher)	Louise Seed	Active												
			Performanc	★	★	★	–	–							
	Reduce Ward Clutter	Louise Seed	Active												
			Performanc	★	★	★	–	–	–						
	Re-establish discharge checklist	Louise Seed	Active												
			Performanc			★	–	–	–						
	Review link nurses on Ward 35 and re-assign roles where gaps are visible	Louise Seed	Active												
			Performanc	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Share and discuss performance, behaviours and conduct document	Louise Seed	Active												
			Performanc	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Ward 26 CQC Improvement Plan	Clinical Educators to provide bite size teaching sessions around completing documentation	Katy Maskell	Active												
			Performance	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Daily audit of Standards of Care to be completed daily for 10 days (Monday - Friday only)	Katy Maskell	Active												
			Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Regular audit of patient records through Tendable weekly and monthly audits	Katy Maskell	Active												
			Performance	?	?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Share Trust wide CQC communication bulletins with ward staff	Katy Maskell	Active												
			Performance	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Walkabouts on ward	Katy Maskell	Active												
			Performance	★	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ward Sister to review and refine documentation system	Katy Maskell	Active												
			Performance	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ward to return to full Head & Neck/Gynae speciality as soon as Covid-19 capacity allows.	Liz Hill	Active												
			Performance	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Ward 28 CQC Improvement Plan	Change in ward culture and leadership	Daniel Palmer	Active												
			Performanc	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Embed nurse in charge role of a daily walk round - updating patients with next steps	Rowena Coleman	Active												
			Performanc	★	★	★	–	–	–						
	Ensure all staff are aware of the requirement for a L/S BP on admission.	Rowena Coleman	Active												
			Performanc			★	–	–	–						
	Ensure all staff are up to date on training with dementia with regular spot checks of knowledge	Rowena Coleman	Active												
			Performanc			★	–	–							
	Ensure as a bare minimum every patient has an actual weight once per week on a Sunday.	Rowena Coleman	Active												
			Performanc			★	–	–	–						
	Ensure Isolation room signs are being filled in or updated correctly	Rowena Coleman	Active												
			Performanc	★	★	★	–								
	Implementation of a ward safety brief	Rowena Coleman	Active												
			Performanc		★	★	–	–							

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Introduce monthly ward meetings	Rowena Coleman	Active												
			Performance												
	Leadership shift change to embed new systems and process on the ward	Rowena Coleman	Active												
			Performance												
	Monthly MCA and DOL's Training audit	Rowena Coleman	Active												
			Performance												
	Peer Support for new Ward Manager	Rowena Coleman	Active												
			Performance												
	Reduction in ward clutter	Rowena Coleman	Active												
			Performance												
	Re-establish a daily ward routine	Rowena Coleman	Active												
			Performance												
	Re-establish Discharge Checklist	Rowena Coleman	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Reintroduction Care plan Update Days where each day of the week corresponds to a specific assessment	Rowena Coleman	Active												
			Performance												
	Resetting standards on fluid balance recording	Rowena Coleman	Active												
			Performance												
	Review and reduce the nursing documentation at the end of beds.	Rowena Coleman	Active												
			Performance												
	Review Link nurses on ward	Rowena Coleman	Active												
			Performance												
	Review required staffing establishment	Daniel Palmer	Active												
			Performance												
	Senior team to ensure NIC badge is worn during a shift to always identify who is in charge	Rowena Coleman	Active												
			Performance												
	Streamline nursing documentation	Julie Allan	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Ward 32 CQC Improvement Plan	Fluid management in heart failure training	Juliet King	Active												
			Performance	▲	▲	▲	–								
	Holding to account / change in ward culture	Alice Hunter	Active												
			Performance	★	★	★	–								
	Mentorship and Peer support	Alice Hunter	Active												
			Performance	★	★	★	–	–							
	Nutrition training for all staff (refresher)	Juliet King	Active												
			Performance	★	★	★	–	–	–						
	Reduce Nursing Documentation at the end of the bed	Juliet King	Active												
			Performance	★	★	★	–								
	Reduce ward clutter	Juliet King	Active												
			Performance	★	★	★	–	–							
	Re-establish ward routine	Juliet King	Active												
			Performance	★	★	★	–	–							

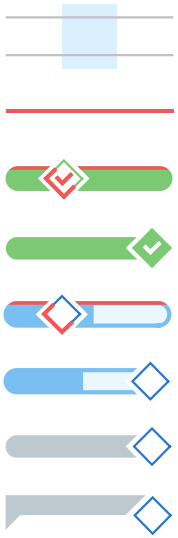
Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Reintroduce Safety Brief	Juliet King	Active												
			Performance												
	Reintroduction Care plan Update Days	Juliet King	Active												
			Performance												
	Review Link nurses on Ward 32	Juliet King	Active												
			Performance												
	Training needs analysis	Juliet King	Active												
			Performance												
	Training re fluid management for HCA's	Juliet King	Active												
			Performance												
	Trial jug lid scheme	Juliet King	Active												
			Performance												
	Ward visible leadership	Juliet King	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Work with clinical educators to design bespoke training plan based on training needs analysis	Juliet King	Active												
			Performance	★	★	★	–	–	–						
Ward 34 CQC Improvement Plan	Carry out training based on analysis.	Rebecca Howells	Active												
			Performance	★	★	★	–								
	Complete Training needs analysis on all staff	Rebecca Howells	Active												
			Performance	★	★	★	–								
	Ensure Ward is Clutter Free	Rebecca Howells	Active												
			Performance	★	★	★	–	–							
	Holding to account / change in ward culture	Rebecca Howells	Active												
			Performance	★	★	★	–								
	Re-establish Day / Night routine	Rebecca Howells	Active												
			Performance	★	★	★	–	–	–	–	–	–	–	–	–
	Reintroduce Safety Brief	Rebecca Howells	Active												
			Performance	★	★	★	–	–	–	–	–	–	–	–	–

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Reintroduction Care plan Update Days	Rebecca Howells	Active												
			Performance												
	Review link nurses on ward 34 and build upon those staff add to link nurses	Rebecca Howells	Active												
			Performance												
	Storage Nursing Documentation Reduction	Rebecca Howells	Active												
			Performance												
	Trial jug lid scheme	Rebecca Howells	Active												
			Performance												
	Ward visible leadership	Rebecca Howells	Active												
			Performance												
Ward 36 CQC Improvement Plan	Conduct training needs analysis on all staff	Claire Walker	Active												
			Performance												
	Holding to account / change in ward culture:	Claire Walker	Active												
			Performance												

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Implementation of a structured and standardised ward safety brief across Care Group 1	Claire Walker	Active												
			Performance	★	★	★	–	–	–	–	–	–	–	–	–
	Nutrition training for all staff (refresher)	Claire Walker	Active												
			Performance	★	★	★	–								
	Reduce ward clutter	Claire Walker	Active												
			Performance	★	★	★	–	–							
	Reduction of nursing documentation in the end of the bed notes.	Claire Walker	Active												
			Performance	★	★	★	–								
	Re-establish Day / Night ward routine	Claire Walker	Active												
			Performance	★	★	★	–	–							
	Re-establish discharge checklist	Claire Walker	Active												
			Performance	★	★	★	–	–							
	Reintroduction Care plan Update Days	Claire Walker	Active												
			Performance	★	★	★	–								

Recommendation	Action	Owner		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
	Re-setting standards on fluid balance recording	Claire Walker	Active												
			Performance	★	★	★	–	–							
	Review link nurses on ward 36 and build upon those staff add to link nurses.	Claire Walker	Active												
			Performance	★	★	★	–								
	SIP Test training and competence	Claire Walker	Active												
			Performance	★	★	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	To carry out training based on analysis.	Rebecca Howells	Active												
			Performance	★	★	★	–	–	–						
	Trial jug lid scheme	Claire Walker	Active												
			Performance	★	★	★	–								
	Ward visible leadership	Claire Walker	Active												
			Performance	★	★	★	–								
	Weekly Audit developed to be undertaken on a Wednesday	Claire Walker	Active												
			Performance	★	★	★	–								



Current period

Past the forecast end date

Completed late

Completed on time

In progress and not on track (estimated to complete after the due dat

In progress and on track (estimated to complete on or before the due

Not started

A parent action which has sub-tasks

Board of Directors
July 2022 (May 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

The CQC have requested monthly assurance around Tendable and MEWS compliance on ward G2. This assurance will also include updates to action planning around an HSIB case from 2021

There were 5 incidents graded moderate harm or above, 3 of which were deemed Trust Serious Incidents.

There were no incidents reported to HSIB in May 2022. Two completed reports have been received.

There were 2 unit diverts in May, which are detailed in the report, mainly around staffing and acuity. A divert means that care was provided on the alternate obstetric site within the Trust.

CNST was relaunched on 6 May with new timeframes and a submission date of 5 January 2023. Progress against compliance will be reported monthly. The revised version emphasises the joint responsibility of the HoM and CD in progressing the CNST standards and they will jointly be expected to present to Board later in the year.

The Ockenden Assurance Visit took place on 23 May and initial feedback is positive and cites openness and honesty of position, a good quality evidence submission and awareness of gaps with plans to address them.

Concerns remain in relation to the Scarborough site being able to evidence multi-disciplinary handovers and ward rounds and with medical training compliance.

Recommendation
Receive & discuss the report and appendices

Author: Michala Little, Deputy Head of Midwifery
Director Sponsor: Heather McNair, Chief Nurse
Date: 30 June 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 was paused in December 2021. An updated scheme with revised timescales was released by NHS Resolution on 5 May 2022. The submission date is now January 2023. This document has been circulated within the Care Group and fortnightly meetings recommenced.

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.
The final part of the Ockenden Report was published 30 March 2022 with a further 92 safety recommendations. The Trust is awaiting National steer around action planning but it is expected that the publication of the East Kent report, expected later this year, will guide these plans. Focus is to remain on the existing Ockenden action planning.

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.

During the reporting period, the CQC requested Clinical Governance meeting minutes along with Tendable and MEWS reports assurance documents from ward G2 and consequently now require monthly assurance. The MEWS action plan is presented via Clinical Governance monthly – issues have been experienced in embedding the alteration of standard MEWS timeframes on the system for every woman in maternity. There is now a daily Matron check of ward G2 to ensure compliance and a rise to over 90% compliance over the next few months is expected as this process is embedded. The Care Group is working with the corporate Tendable team to ensure Tendable is appropriate for maternity settings, work around this paused while we waited for the corporate lead to be re-allocated. Action planning against issues raised will be updated via this report.

The CQC's second request was updated action planning following an HSIB investigation of a baby who died during a shoulder dystocia delivery in 2021. Action planning included the audit of information given to women around the risk of shoulder dystocia and updates to the guidance and this too will be provided to the CQC monthly and detailed in this report.

1.2 Moderate Harm & Serious Incidents (Appendix B)

Over the course of the reporting period there have been five moderate harm incidents reported, one was around an unbooked non-English speaking lady who arrived in labour and obtained bloods were not marked as urgent which led to a delay in treatment for the baby as mother was Hepatitis B positive, a second was around failure to obtain a cord sample following a neonatal death. The three others have been deemed Serious Incidents and will be managed according to Trust SI Policy; one was a retained vaginal swab (tampon) following a forceps delivery, another was around the identification of MRSA at a cannula site and the subsequent delay in treatment and the third was an antenatal stillbirth. The detail for these can be found in Appendix B.

No theme is evidenced within the Moderate harm incidents reported in this period, however there is a theme identified when combined with those incidents previously reported. In April, there was a retained swab reported, and in May there has been a retained tampon reported. Both of these are SIs and are currently under investigation.

1.3 Healthcare Safety Investigation Branch Reports (Appendix C)

There were no incidents reported to HSIB in May 2022. Two completed reports have been received and are detailed in Appendix C. Both relate to term intrauterine deaths, the completion of action plans for both is underway.

1.4 Perinatal Mortality Review Tool (Appendix D)

Two cases were notified to MBRRACE and it is anticipated that the review and draft report will be completed within 4 months. The learning and outcomes will be highlighted in this report upon completion of the reviews. There was one PMRT report completed during the reporting period for an intrapartum stillbirth, the detail of which can be found in Appendix D.

There are 5 PMRTs in progress and these will be completed within timeframe and reported via this monthly report.

CNST compliance relies upon the reporting and completion of PMRT within the timeframe: perinatal deaths need to be reported to MBRRACE within 7 working days, the report commenced within 2 months, in draft by 4 months and completed within 6 months. This is currently being achieved by the Trust. All parents are aware that a review of their baby's death has taken place and that their perspectives and questions/concerns have been sought as part of the review.

Issues can be raised from the completion of the PMRT that did not affect the outcome and these, with actions, are detailed in Appendix D.

1.5 Unit diverts and closures

York diverted to neighbouring units including Scarborough Hospital on 2 occasions in May. On both occasions, insufficient staffing had a consequential effect on acuity and therefore justified the diversion. On the second occasion, the Antenatal and Postnatal wards were merged to facilitate staffing and this impacted bed capacity, which necessitated the diversion. There were no diversions required from the Scarborough site.

There were five subsequent NICE Red flags reported. Two of these relate to delay in time critical Caesarean Section, two to the delay in artificial rupture of membranes (ARM as part of the induction of labour process) and a final incident where the labour ward coordinator was unable to be supernumerary. All red flags are managed through the Datix system.

1.6 Training Compliance (Appendix A)

Training figures will be provided as two separate metrics going forwards, in line with the separate reporting period requirements of Ockenden and CNST. Projections indicate that we will reach 90% compliance required for CNST, however this remains reliant on practitioners accessing training when booked on. There are processes in place to support monitoring and compliance and a monthly training meeting assesses projections and action plans wherever necessary.

Figures for SBL v2 training appear low on the CNST table because the training takes place as part of Ockenden face to face training sessions and is available online as a 'mop up' for any sessions not attended in person.

Work is ongoing to add in the compliance of all Paediatric colleagues regarding newborn life support (NLS) training and the figures will be updated for next month's paper.

Medical staffing compliance with training remains challenging, particularly on the Scarborough site and has been escalated to the Clinical Director for action. Some staff had not attended training they were booked on to.

1.7 Safe Staffing

Maternity Staffing

The vacancy rates for midwives, is 4.59% at Scarborough site (2.75 wte not including mat leaves) and 12.9% on the York site (14.1 wte not including mat leave). Due to 2.0wte midwives withdrawing their post acceptance, 22.6wte midwives have been recruited to commence in post over the next few months – many of which are newly qualified midwives. If all of these midwives take up posts, as leavers information currently stands, we will be slightly over-recruited; however, we do anticipate further attrition. It is worth noting that if we were to appear over-recruited, the Trust would need to factor in that our establishment is still overall 2.0 wte short of the birthrate plus safe staffing recommendations. Confirmation that Board have accepted baseline establishment of midwifery staffing as per Birthrate plus is required to be minuted. Any staffing above this baseline would mean we could reinitiate Continuity of Carer, which is still the national direction.

As well as the 4 already successfully interviewed, a further 11 International recruits have been shortlisted for interview in June, updates will be reported in next month's paper. Both newly appointed 'Recruitment and Retention' Midwives will commence in post over the next month which will strengthen induction, wellbeing and ongoing support for maternity staff.

The Care Group are implementing a revised leadership structure, which includes the introduction of a B8d Director of Midwifery (interim), B8c Associate Director of Midwifery (the successful candidate will commence in post from Sept 2022), B8b Lead Matron/Deputy Head of Midwifery to support Intrapartum Care, patient experience and specialist midwife portfolios and two B8a Matron posts to support Inpatient and Outpatient areas. Going out to advert shortly will be a B8a Midwife for 'Better Births' who will support the enaction of the principles of Better Births including

Continuity of Carer and personalised care plans, fixed term for a year. The newly appointed B8a Quality and Governance Lead has commenced in post and this completes the additional support to strengthen the Quality and Governance Team.

Please see **Appendix G** for an overview of medical staffing during the reporting period.

1.8 Service User Feedback

Interviews were held for a York MVP Chair in June and unfortunately were not successful in recruiting, plans are awaited for re-advertisement of the role; the CCG have increased the time given to two days a month from one. Coast and Country need a co-Chair or further support. Collaborative working with the MVP remains the biggest risk in terms of CNST and Ockenden compliance.

The patient experience action plan is now in place. Progress will be shared with the Trust patient Experience Steering group.

At the time of writing this report April and May Friends and Family Test reports are not available.

1.9 Staff Survey

The workforce lead and senior triumvirate need to meet to discuss the staff survey results and action plans – this is anticipated during the next reporting period. Listening events, cross-site are in place through July as an open forum for staff to raise issues or concerns with the senior leadership team.

1.10 The Maternity Incentive Scheme - CNST (Appendix F)

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 was paused November 2021 in light of the current staffing pressures on maternity services and details of progress since its relaunch in May are detailed in this report.

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 to table the Ockenden final report at Trust Board in May 2022 was undertaken.
NHSEI have stated that they will await the publication of the East Kent report, expected later in the year, before instructing Trusts further. Trusts are asked to continue focusing on the seven initial IEA's.
The Regional Team attended the Trust on 23 June 2022 to undertake an Ockenden Assurance visit, following the submission of all requested evidence earlier this month. The team met with Board level representatives, the Non-Executive Director, the senior leadership team and undertook walk-arounds of the maternity unit on the York site to talk to staff. Led by the Head of Midwifery, the Trust's position against the 7 IEAs was provided and preliminary feedback from the

day was positive, citing an open and honest discussion, good understanding of 'gaps' and high quality submission of evidence. A detailed report is expected in the next two weeks.

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. It is recognised that the safe minimum staffing level, according to the birthrate plus report in June 2021, is not met and therefore continuity has been paused from June 20 2022.

1.13 Safety Champions Feedback

The Board level safety champion walkaround in June raised staff concerns in relation to the changes in leadership being experienced in care group 5 and a request for the new structure to be circulated. It is hoped the listening events that are planned will support staff in feeling reassured by the changes.

Changes to the leadership structure have been circulated via email and appointments into posts are announced once confirmed.

The care group recognise that work needs to be done around ensuring exit interviews are undertaken to try to further understand how midwives and senior leaders can be retained.

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

- Receive & discuss the report and appendices

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Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Infection Prevention and Control (IPC) Annual Report
Director Sponsor:	Heather McNair, Chief Nurse (Director of Infection Prevention & Control)
Author:	Emma George, Assistant Chief Nurse Dr Damian Mawer, Deputy Director IPC/Infection Control Doctor/Microbiologist Astrida Ndhlovu, IPC Lead Nurse

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☐ Information ☒ A Regulatory Requirement ☒

Trust Priorities	Board Assurance Framework
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

This report summarises surveillance information on *Clostridium difficile*-associated diarrhoea, Methicillin-resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia, bacteraemia due to the three Gram Negative Blood Stream Infection (GNBSI) which are part of the national surveillance; *E.coli, Pseudomonas aeruginosa* and *Klebsiella* for 1st April 2021 to 31st March 2022. The report also highlights antimicrobial stewardship, SARS COV2 (COVID-19) and important incidents and outbreaks for the same period. Finally, this report presents the IPC annual plan for 2022/23.

Key points to highlight to the Board:

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

2. The *Clostridium difficile*-associated diarrhoea objective for 2020/21 was set at 133. The trust finished the year with one case above the trajectory (=134 cases). There

were 3 outbreaks of *C.difficile* on the Scarborough site and 1on the York site in 2021/22.

3. The trust requested a review of the *C.difficile* position within the trust following an increase in the incidence. The trust continues to see cases of *C.difficile* ribotype 001 at Scarborough hospital that was implicated in the outbreak in 2019. This signifies an on-going *C.difficile* transmission possibly from the environment.

4. MRSA bacteraemia target is that of zero tolerance. There was 1 Trust-assigned case for the 2021/22 financial year.

5. There was no official MSSA bacteraemia target for 2021/22. There were 77 Trust-apportioned MSSA bacteraemia cases in the current financial year.

6. Reducing gram negative blood stream infections (GNBSI) is a national priority with the stated aim of a 50% reduction in avoidable bacteraemia by 2024/2025. There were 694 cases of the three GNBSI organisms, 259 of which were classed as trust-apportioned.

7. The COVID-19 pandemic has been on-going since 2019 and has resulted in a number of outbreaks of both staff and patients. Patients with COVID-19 who had a stay on ICU have been reported through the national SARI portal.

8. A review of the IPC team has resulted in recruitment to a band 4 post at Scarborough and a band 5 developmental post at York.

9. The overall average of compliance with the 5 moments for hand hygiene across the organisation is 99% according to the data submitted by clinical staff.

10. Cleaning standards have been monitored on all of the trust hospital sites over 2021/22 with the majority of cleaning scores above the amber Key Performing Indicators (KPI).

Recommendation:
The Board is asked to note the report and support the actions being taken to maintain high standards of care.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
Quality & Safety Assurance Committee	19 July 2022	Noted the report with no escalations to the Board for consideration.

1. Introduction and Background

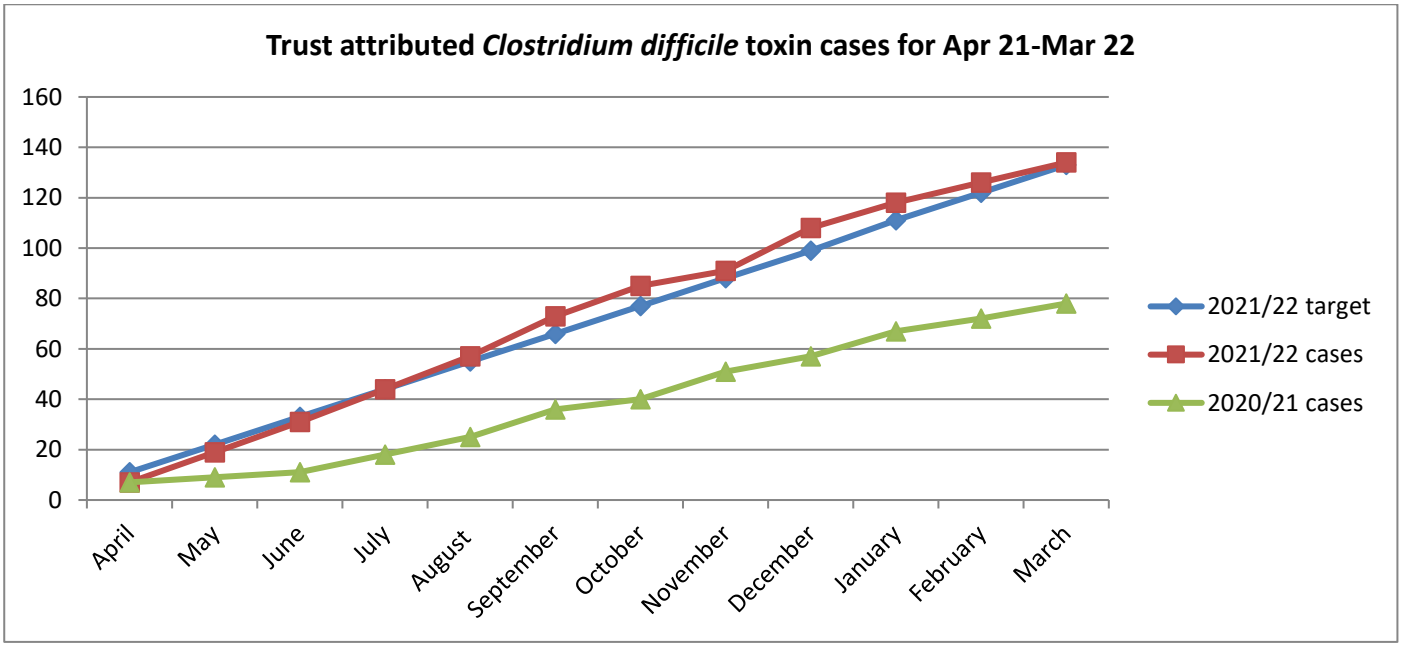
This annual report summarises information on healthcare-associated infections (HCAI) for the period 1st April 2021 to 31st March 2022. It includes information on Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and *Clostridium difficile*-associated diarrheoa including a summary of other important organisms. The report also highlights environmental cleaning and staff training in relation to HCAI management. Any outbreaks and adverse incidents that occurred from 1st April 2021 to 31 March 2022 are summarised in this report.

2. Surveillance data

2.1 C.difficile

Prior trust exposure

The total figure for *C. difficile* cases from April 2021 to March 2022 was 209. In 2020/2021 there were 158 cases so there has been a 32.28% increase in total cases this year compared to last year.



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

The annual objective for 2021/22 was set at 133 cases community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 134 trust-apportioned cases; COHA=65; HOHA=69. So the target has been exceeded.

The Trust requested NHSE/I for an external review of the Trust's *Clostridium difficile* position. Site visits and a review of processes, policies and the IPC governance structures were carried out on 7th and 8th October and 2nd November 2021in Scarborough and York respectively. NHSE/I also reviewed the roles and functions of the *C.difficile* control group including the action plan produced by that group. A formal report of the visits to both sites was received in January 2022.

From the NHSE/I recommendations, the following have been implemented:

The *C. difficile* meeting structure has been reviewed to ensure productivity and meaningful outputs from the meetings (see appendix 1). There will be an internal cross-site *C. difficile* improvement group which will review each site's position of *C. difficile* and actions to be completed within the improvement plan. This meeting will be held monthly. The *C. difficile* Improvement Group actions and escalations paper will go to TIPSG where external partners will be invited.

Trajectories for HCAI's for individual care groups have now been set and monitored.

The Cleaning Standards Group met in November 2021 and agreed to start undertaking joint environmental walk-rounds with the IPC team, Facilities, Estates and senior clinical staff to agree on the improvement plan and actions required to sustain an environment that is suitable for patient care. These walk-rounds will take place fortnightly and will include 5 random areas and any areas of concern each month across the 2 main sites; and including Bridlington and community sites. More work to improve cleanliness is on-going.

The *C. difficile* improvement plan has been re-written with smaller actions grouped in broader headlines to facilitate follow up of completed and outstanding actions to be agreed at the Improvement Group and provide assurance at TIPSG.

There has been a recruitment drive within the Facilities department as the number of domestic vacancies was a concern.

Following concerns regarding the cleanliness of shared equipment such as commodes, questions on the Tendable auditing app were revised in February 2022 to include specific items to look for in the audit for cleanliness; and included questions for matrons to review actions against HCAIs within the clinical area.

The Review of Backlog Maintenance group involving LLP and the IPC team is looking at options to locate a modular ward on the Scarborough site to use as a decant space to facilitate refurbishment and HPV of wards. York site is exploring options from another project to get elective activity transferred to Ramsey.
Chestnut refurbishment work was stared in 2021/22 and remains on-going. Two bays have been completed so far.

A meeting was held with Care Groups on 10/2/2022 and included discussion around IPC responsibilities for Care Groups as follows:

- Maintain oversight of the Care Group's IPC performance (in relation to HCAI)
- Review PIR findings and actions at Quality Committee meetings
- Seek assurance that actions arising from PIR have been completed
- Identify common themes/trends amongst the causes of HCAI identified through PIRs and other investigations
- Support IPC and colleagues within the Care Group to develop and implement actions/interventions to address common themes/trends
- Support the Care Group to develop an IPC strategy, with input from the IPC team

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

The *C. difficile* Post Infection Review (PIR) process was reviewed in 2021/22 and shared with Care Groups but needs embedding into care group practice to ensure that meaningful learning takes place.

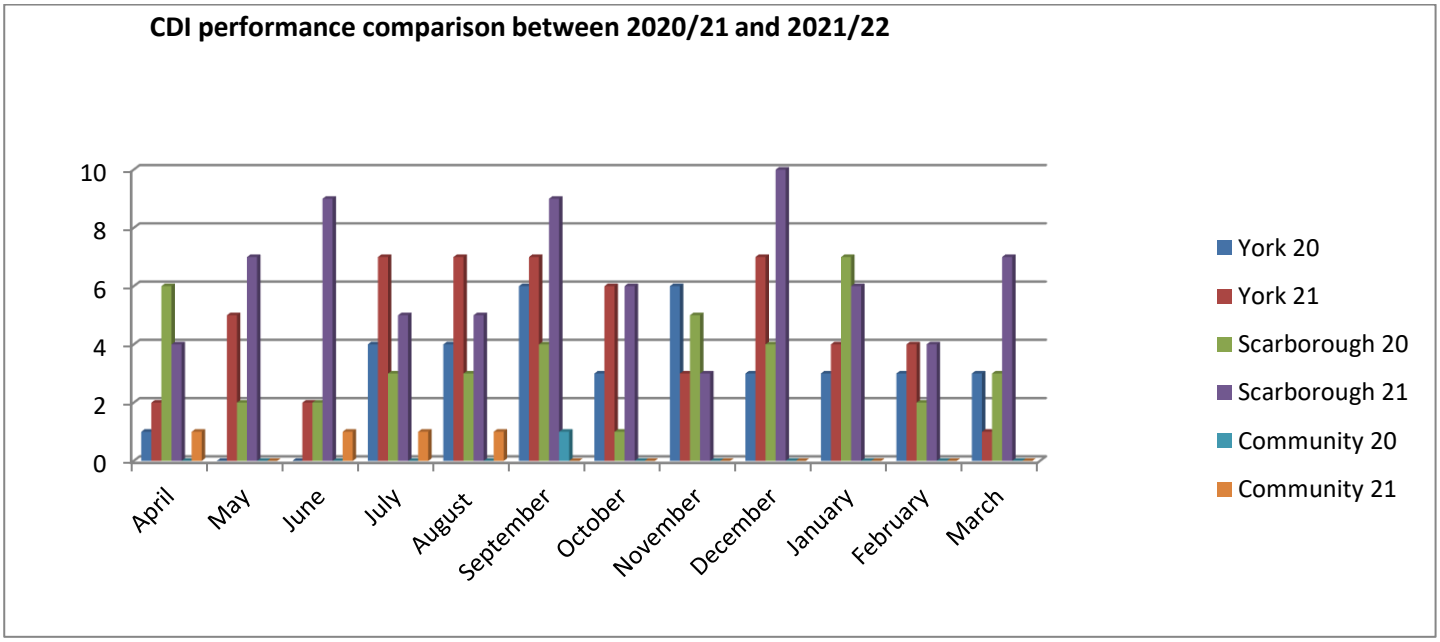
As a result of delays in embedding this process into care groups, there was a backlog of PIRs for 2021/22 of around 50%. Due to the lost value of learning from the outstanding PIRs the DIPC and the CCG agreed to not undertake PIR meetings for the *C. difficile* cases in the 2021 calendar year. Care Groups were subsequently advised to only undertaken PIRs on cases with stool sample dates from 1/1/22 onwards.

C.difficile **Outbreaks/Clusters**

There were 2 clusters of *C.difficile* on Chestnut ward in 2021/22. The first one involved 2 patients within a period of a week that had the same ribotype (001) in June/July 2021. The second cluster involved 4 patients in September 2021. The index patient was unable to be isolate and subsequently 3 other patients tested positive within the bay and had the same ribotype (014). The second cluster was investigated as an outbreak and resulted in recommendations to refurbish the ward.

Two cases of *C.difficile* that occurred in January 2022 were retrospectively identified in March 2022 as being on Beech ward with the same ribotype (001). This demonstrates possible on-going transmission of ribotype 001 within the environment.

Two cases of *C.difficile* were identified on Cherry ward in March 2022, with the same ribotype (369). A Period of Increased Incidence audit was conducted and issues with actions escalated to the Care Group. A PIR meeting to discuss these cases took place and highlighted concerns with antimicrobial prescribing, delayed sampling, delayed isolation and inability to take appropriate sample prior to antibiotic prescribing.



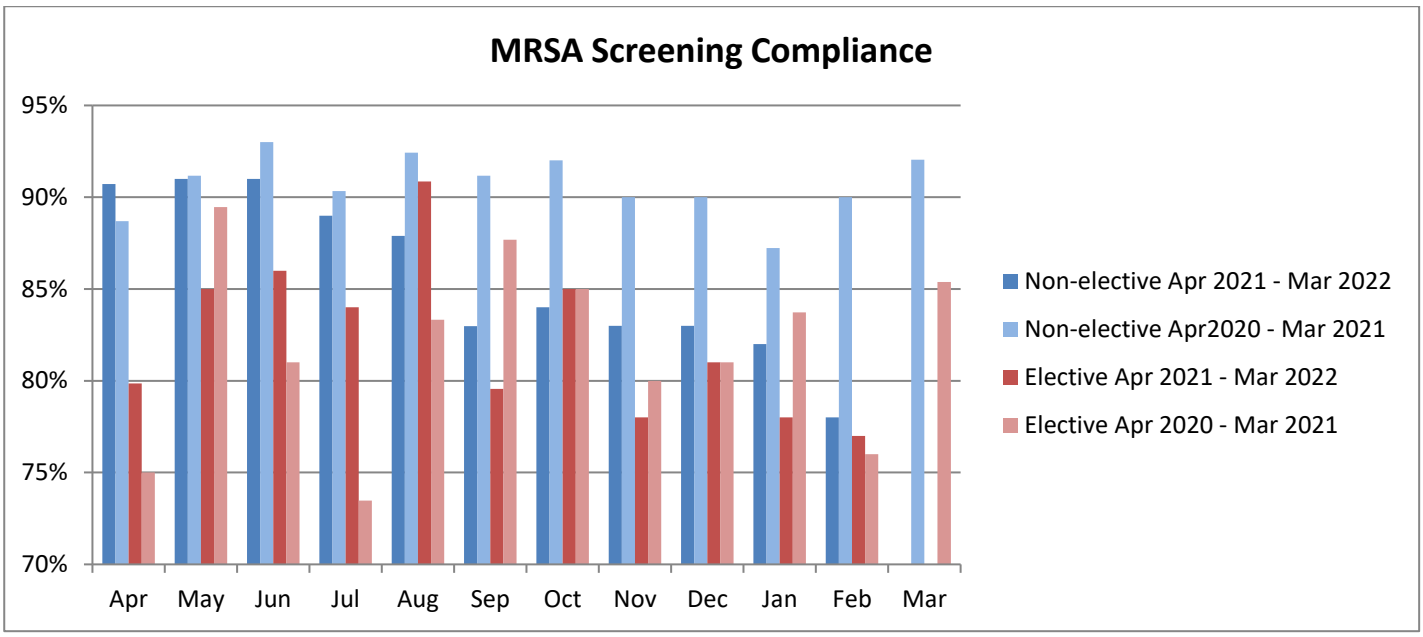
Graph 2. CDI performance comparison between 2020/21 and 2021/22

2.2 MRSA bacteraemia

The Trust approach to MRSA bacteraemia is one of 'zero tolerance'. There was 1 case of Trust-assigned MRSA bacteraemia in August 2021 and 4 community cases in 2021/22. In comparison there was 1 community case of MRSA bacteraemia in 2020/21 and 0 Trust-assigned cases.

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

The Trust-assigned case in August 2021 was found to be a contaminant during the investigations. This implies practice issues with ANTT.



Graph 4. MRSA screening compliance for Elective and non-elective April 2021-March 2022

Central to the control of MRSA is the identification of both elective and acute admissions of patients who are colonized with the organism. This is achieved through screening. Positive patients are isolated and offered decolonization treatment. MRSA screening compliance for non-elective patients remained around 82%, therefore there remains room for improvement. The average compliance for non-elective screening is around 86%. Elective screening has consistently been lower for the 12 months of 2020/21 compared to 2019/20; with an average of 82% screening compliance to the end of February 2021. Data for March 2021 was unavailable from the Information Team.

The MRSA screening compliance for parents in Special Care Baby Unit (SCBU) is on average 78% for 2021/22.

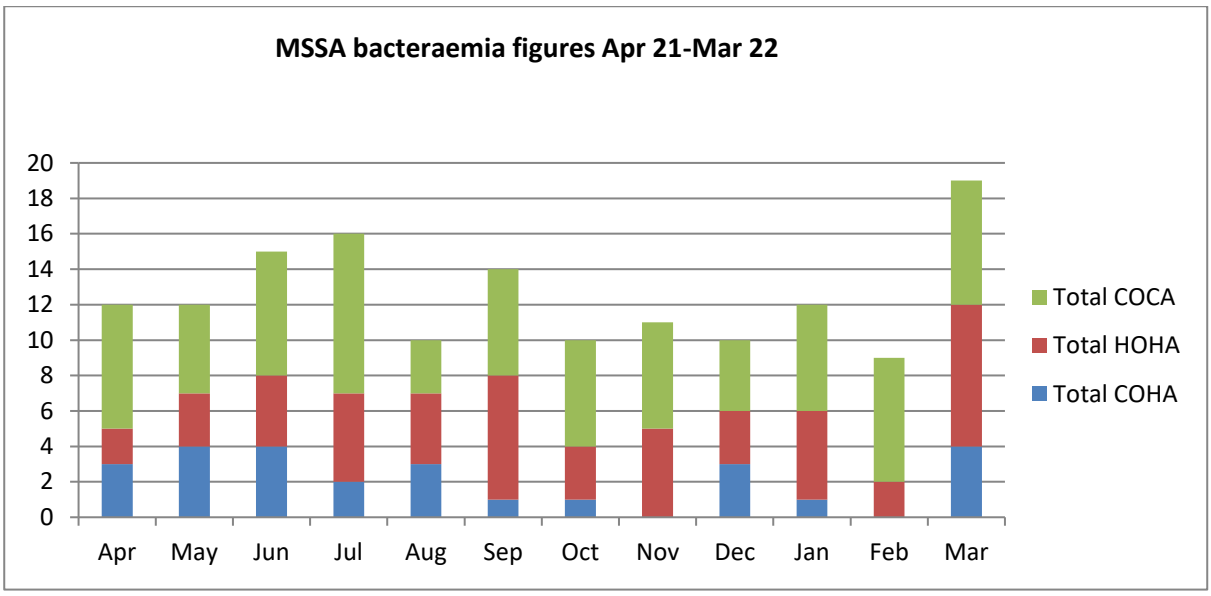
More work is needed to improve the overall MRSA screening compliance.

2.3 MSSA bacteraemia

Between April 2021 and March 2022 there were 150 cases of MSSA bacteraemia. 77 of these cases were classed as Trust-apportioned. This is an increase of 22.2% from 2020/21.

Whilst there is no external target for MSSA bacteraemia, the trust set an internal target of 30 of trust-apportioned cases for 2019/20. This target was only for HOHA cases and not COHAs.

The 2021/22 annual work plan included an ambition to revive the MSSA bacteraemia reduction group which had existed in previous years; and that had proved instrumental in reducing the incidence of MSSA bacteraemia. However, this was not achieved due to other competing pressures of managing the COVID-19 pandemic.



Graph 5. MSSA bacteraemia cases April 2021-March 2022

The trust continues to sustain Aseptic Non-Touch Technique (ANTT) practical training for all relevant staff groups to ensure appropriate management of invasive devices.

ANTT practical and theory courses were removed from staff required learning along with the essential skills subjects in 2020. This was identified as a risk to the organization. A paper outlining the risks of removing ANTT from the core mandatory subjects was submitted for consideration to Executive Board and approval was granted in October 2021 to re-instate ANTT as a required learning.

Whist this is being embedded into practice again, the compliance in practical ANTT remains low at 56% average for 2021/22.

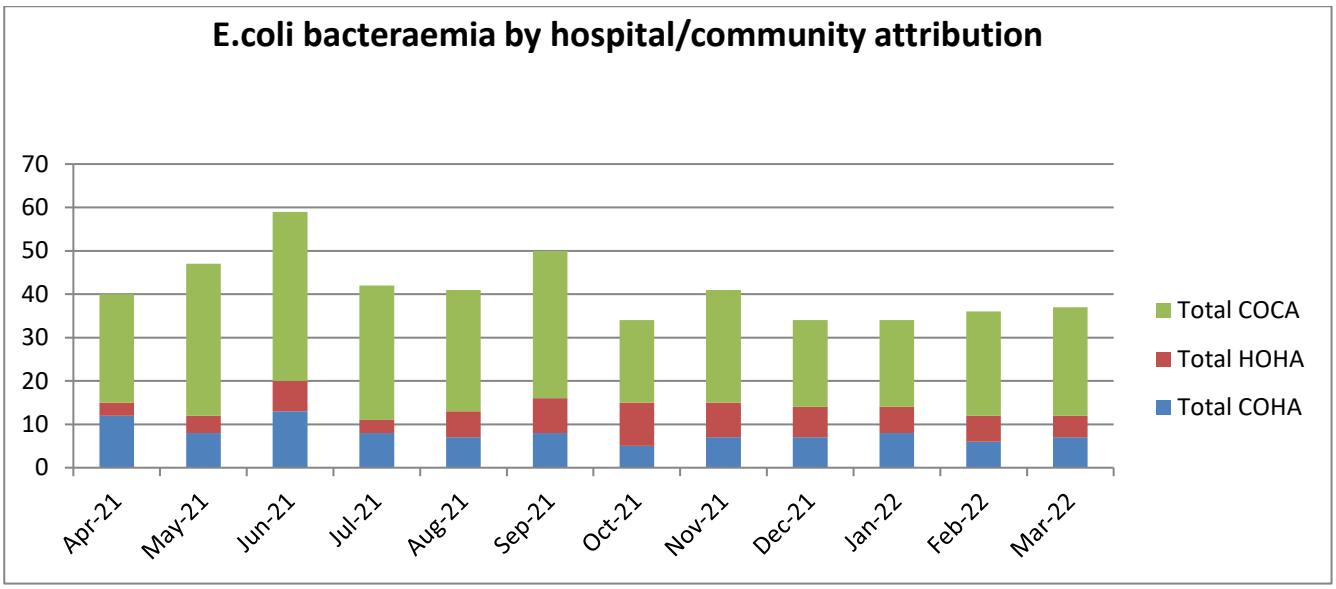
Work to explore how the trust can improve vascular line management has begun with the newly formed "Invasive Line Service Improvement Group" which is being led by the Patient Safety team with input from the IPC team. The first of these meetings was on 30th September 2021. The multidisciplinary group focusses on discussing the processes of line insertion, on-going care, policies, documentation, training and removal of lines.

2.4 Gram Negative Blood Stream Infections (GNBSI)

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

In 2021/22, 259/694 (37%) GNBSI cases were classed as trust-apportioned (E.coli 169; *Klebsiella 60*; *Pseudomonas aeruginosa 30*). In 2020/2021 234/690 (34%) were classed as trust-apportioned (*E.coli* 158; *klebsiella* 56; *Pseudomonas aeruginosa* 20). This represents an increase in the rate of trust-apportioned GNBSI for 2021/22 compared to 2020/21.

The 2022/23 annual plan includes initiatives to reduce GNBSI including line management, oral care, hydration and catheter management; that were unable to be achieved during 2021/22 because of staffing issues within the IPC team combined with pressures from managing the COVID-19 pandemic.



Graph 9. *E.Coli* by attribution bacteraemia April 2021-March 2022

2.5 COVID-19

On 11th March 2020, the World Health Organization declared COVID-19 a global pandemic. The pace of COVID-19 has been unprecedented and has stressed our healthcare system. The pandemic was driven by the high infectivity of the SARS-CoV-2 virus, infectivity pre-symptom onset, and an initial lack of understanding of the virus transmission routes.

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

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

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

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

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

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

3. Outbreaks and incidents/updates

3.1 Outbreaks

3.1.1 COVID-19 outbreaks and updates

2021/22 saw a number of outbreaks both in clinical areas amongst patients and staff and in non-clinical areas amongst staff.

The rising incidence of COVID-19 with the emergence of the Omicron variant coupled with relaxation of COVID-19 rules in the community that the government made in February 2022, resulted in increased outbreaks and pressure with patient placement and flow within the organisation.

The main themes that were identified in patient outbreaks were:

- Difficulties in managing patients who wandered on the wards
- Patients incubating the virus (testing negative on admission then subsequently testing positive a few days later) whilst in a bay with other patients
- Staff attending work with mild symptoms which they were not associating to COVID-19
- Reduced compliance with patient testing

The main theme from staff outbreaks in non-clinical areas was social gatherings outside the organisation. To ease pressure from the IPC team of managing staff outbreaks particularly of this nature, an SOP was developed to support and aide staff to manage staff outbreaks locally and review mitigations within local workplaces. The IPC team was fully involved with staff outbreaks that had any patient involvement.

In response to the patient outbreak themes, ward 37 which is a ward where patients with Dementia are managed was deemed a high risk ward for transmission of COVID-19 with the trust agreeing to consider this ward as a low threshold for outbreaks, whereby even if only one case was identified the ward would be closed.

Enhanced testing of patients was introduced to the organisation above and beyond the national recommendation of testing on admission and then on day 3 and day 5. Patients were tested on admission and for 5 days following admission, then twice weekly thereafter until discharge. COVID-19 contacts were tested daily until the end of their isolation period.

In March 2022 the trust in consultation with NHSE/I took the decision to make some changes to how COVID-19 was managed within the organization to align with some changes made in the community. The decision to make the change was also in response to the pressures that were being experienced in the organization that were in part associated with the changes that had been made in the community; and impacting on patient safety such as long waits in ED.

The focus of the changes was on protecting patients who were at high risk of severe disease from COVID-19. Three SOPs were developed to this effect:

1. IPC guideline
2. Staff testing and management of COVID-19 cases and contacts
3. Patient SOP for triaging, testing, placement and managing COVID-19 cases and contacts

The main changes to the SOPs were reduced testing for patients. Patients who were not at high risk of severe disease from COVID-19 were only to be tested if they became symptomatic or if they were being discharged to a care home. Only High Risk for COVID (HRC) patients remained on the regular testing regimen described above.

Asymptomatic staff testing was stopped with approval from Gold Command unless if staff worked regularly with HRC patients. This was contrary to national guidance released in April 2022 which

recommended for asymptomatic staff testing to continue for purposes of protecting other staff and patients.

These changes are reviewed weekly at the Silver Command meeting to highlight any impacts on the service.

The Board Assurance Framework (BAF) is reviewed quarterly and as and when required if an update to the document is produced from NHSE/I. The latest version (1.8) was updated in February 2022 and was presented at TIPSG in March 2022. The main gaps in assurance included inadequate ventilation in clinical areas that achieves the recommended air changes per hour, limited isolation capacity for all infectious conditions and the challenge to maintain segregation of COVID and non-COVID patients in York ED due to the current building project to expand the department. To mitigate the risks of increased footfall in ED, a Risk Assessment document has been produced and presented to Board.

3.1.2 *C. difficile* outbreaks and updates

In 2021/22 four outbreaks of *C.difficile* were identified across the organisation. In July/August 2021 two patients with ribotype 026 were identified on ward 11. A Period of Increased Incidence (PII) audit and follow on meeting highlighted issues with the environment and some practice isues which were shared with the clinical teams.

In September 2021 a *C.difficile* outbreak involving 4 patients with ribotype 014 was identified on Chestnut ward. This outbreak led to closure of the ward, decant and HPV; and also recommendations to refurbish the ward bay by bay. This work is still underway. This outbreak also prompted the trust to request an external review from NHSE/I.

In January 2022 two patients with ribotype 001 were retrospectively identified a few months later on Beech ward. These cases may have been missed due to pressures on the IPC team and short staffing resource in the team. There is an appetite within the annual plan to purchase ICNET which is a computer software that is able to identify cases such as these much more easily and remove any human errors.

In March 2022 two cases of *C.difficile* with ribotype 369 were identified on Cherry ward, a PII audit highlighted cleaning issues and a worn environment. Post Infection Reviews (PIRs) for these patients revealed inappropriate antibiotic prescribing, delayed sampling, delayed isolation, multiple patient movements across the organization and inability to take appropriate samples prior to antibiotic prescribing. All these issues were cascades to appropriate individuals**.**

Despite several attempts it has not be possible to sustain a proactive ward decant programme at either main hospital site over the past few years. This process is crucial, as it allows terminal cleaning, the deployment of HPV and refurbishment of the ward. These interventions contribute to the removal of *C. difficile* spores and makes future cleaning of the environment more effective. Without this work *C.difficile* reservoirs in the environment cannot be effectively eradicated, creating an on-going risk of transmission, including of the 001 ribotype in Scarborough.

3.2 Incidents

There were a total of 5 patients with Aspergillus identified in ICU at York since August 2021. Two patients possibly had COVID-19 associated pulmonary aspergillosis (CAPA). Three had aspergillus isolated in respiratory samples that was not thought to be causing clinical disease.

Meetings to investigate this incident were held in August 2021 and in November 2021 to review the building risk assessments of the capital projects that were taking place outside of ICU. The meetings also looked at processes for management and maintenance of the air ducts. It was identified that the air ducts had not been cleaned for a significant period of time due to inability to access ICU.

IPC and Estates walk rounds of ICU were undertaken which revealed building fabric issues including damaged ceiling tiles, damage to walls, damaged and misplaced vent tiles and the lobby door to the POD which was not well aligned. It is possible that there could have been ingress of contaminated air through potential gaps in the fabric of the building.

The Estates department has planned to address the ventilation and building fabric issues identified above with the main scope of the work would including:

- Ductwork cleaning
- Ceiling and building fabric repairs
- Ensuring system/room integratory maintaining a positive clean air pressure
- Reviewing and addressing/minimising any impact of the ICU/ED construction works
- Reviewing and addressing any impact of the staff room including the opening of windows

The new ICU POD which is an extension to the main ICU was completed in March 2022 to facilitate more capacity for critical care patients and enable these works to take place. However the opening of the POD was delayed due to water testes which were unsatisfactory. Later it was also discovered that the call bell system was faulty and the POD could not be used by patients.

While the work remains outstanding, this matter will continue to be escalated.

Another case of Aspergillus was identified in ICU at Scarborough in February 2022. There is an acknowledged risk of poor ventilation in the Scarborough ICU. An IPC walk round in the wake of this case also revealed some damage to the fabric of the building which was reported to the Estates department. External works were completed in March 2022.

In March 2022 a patient with pulmonary TB was placed in an open bay for a few days. An incident meeting was held and identified 6 patients as contacts. Information letters were sent to the 6 patients.

Two patients with Pseudomonas aeruginosa bacteraemia were identified in ICU at York in March 2022. The two patients had the same antibiogram which raised concern for water safety. Assurance was gained from the Estates department that water testing was completed for ICU in January 2022 and all results were satisfactory. Water testing was repeated in the areas where the two patients were cared for and the results came back clear. Staff on ICU were reminded of the importance of appropriate use of hand wash basins to avoid water contamination; and to continue using hand sanitizer following washing of hands with soap and water.

4. Antimicrobial Stewardship

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

- Review of audits and their recommendations
- Review of progress with EPMA to support stewardship
- Review of progress with UTI and CAP CQUINs and reduction in antimicrobial consumption and campaigns to improve stewardship such as ARK.
- Identifying lesson learned and information to share with medical, nursing and pharmacy staff.
- Take active role in C. Difficile PIR process and share learning
- Secure additional pharmacist support to maximise patients on OPAT
- Analyses the antimicrobial dashboard and work with ICS partners to review usage patterns and take steps to reduce resistance
- Identifies items to escalate to the Medicines Management Group.

During 2021/22 various audits and action plans have been carried out and developed around antimicrobial prescribing for pneumonia in patients diagnosed with Covid 19.

5. Risks

The lack of decant spaces on both of the acute sites to facilitate proactive refurbishment of clinical areas and the ability to undertake terminal cleans and HPV across the organization is an identified risk for *C. difficile* reservoirs and on-going transmission from the environment.

Proactive refurbishment of wards has not taken place in a long time. Run down, worn environments are not easy to clean and can be a good habitat for microorganisms. The 001 *C. difficile* Ribotype in Scarborough is evidence of environmental reservoirs and impacts on patient safety from the outbreak that occurred in Scarborough.

ANTT practical and theory compliance is low and may be a contributing factor for blood stream infections. The low compliance may be due to the transition of staff getting back on the course after a period of being removed from the list of mandatory training in 2020.

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

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

From 2017 to 2019 the Trust had a task and finish group focusing on reducing Staphylococcus aureus bacteraemia (both MSSA and MRSA). The group was multidisciplinary and used QI methodology to identify and address the root causes of the bacteraemia. Outputs included the introduction of non-ported cannulas. During the group's existence there was a notable reduction in the rate of Staphylococcus aureus bacteraemia. Unfortunately the group folded due to the departure of clinical personnel and insufficient resource within the IPC team to meet the shortfall. As a result other interventions, such as the introduction of cannulation kits, have not been achieved.

The IPC team is under-resourced based on information gained from the NHSE/I reviewers in November 2021, who advised that there should be one IPN for every 70-100 beds. Basing on 70 beds per IPN due to the demands on the team as a result of the pandemic, data obtained from the information team of approximately 1000 beds in the trust, 14 WTE IPNs are required to effectively run the IPC service. There are currently 6.6 WTE IPNs including 1 Lead Nurse. Out of the 6.6 IPNs, 3 WTE are new to the team and still gaining experience. This is a concern for both staff wellbeing and patient safety.

Initiatives to reduce Healthcare Associated Infections that were outlined in the 2021/22 IPC annual plan were challenging to achieve due to other competing priorities such as managing the COVID-19 pandemic which consumed all the available IPC resource in the past few months. Some of these initiatives will be prioritised in the 2022/23 annual plan.

Ventilation is critical to the management of respiratory viruses and more than ever now for COVID-19. This was one of the main areas highlighted as a concern during the pandemic; and an area which will require the organization to focus on going forward.

Air handling units were fitted in some of the side rooms and bays on COVID-19 wards to improve ventilation. However, most non-COVID wards had no specialist ventilation. Windows could be opened during periods of good weather but in winter this was challenging.

Scarborough ICU ventilation remains non-complaint and a risk.

There is a significant and material risk of outbreaks of infection resulting from insufficient isolation facilities throughout inpatients areas and ED. It is not currently possible to isolate all appropriate patients. To assist with prioritisation for side rooms, an update to the Transmission Based Precautions document was made in 2021/22.

The lack of High Consequences Infectious Diseases (HCID) rooms at both major sites of the trust means that the management of patients with high consequence diseases becomes unsafe for staff and other patients. Avian Influenza which is classed as a HCID was flagged as a concern around our region in 2021/22. Efforts to put in place HCID facilities that are as safe as possible were undertaken for both Emergency Departments. However, these fall below the required standard and remain a risk and a concern. Capital building projects for EDs at both sites include bespoke HCID rooms.

Inappropriate and prolonged use of antibiotics, particularly broad spectrum agents, has been identified in post-infection reviews as a factor contributing to a significant number of Clostridium difficile cases. This is a trust-wide risk but there are particular concerns at Scarborough hospital due to the higher incidence of *C. difficile*. The trust has multidisciplinary antimicrobial stewardship team working to support improved prescribing.

The lack of effective surveillance systems in the IPC team is also a risk. This is required as stated inNICE PH 36/QS 3, that states there should be evidence of fit-for-purpose IT systems to support surveillance activity. This includes evidence of validation processes that ensure data accuracy and resources that can analyse and interpret surveillance data in meaningful ways. IT options being investigated include ICNet, or CPD solution.

Sluice hoppers present a risk of contamination from body fluids and transmission of infection. Costings for the hoppers were sought in 2019/20 and a risk assessment was produced in 2020/21 to progress with the work of removing hoppers from clinical areas. This work did not take place in 2021/22.

6. Successes for 2020/21

Recruitment within the IPC team has taken place in the past months resulting in the appointment of a band 4 on the Scarborough site, and a band 5 IPN developmental post on the York site. Efforts to recruit to the band 7 post following departure of a band 8 in Scarborough failed twice in March and April 2022. Funding for a 1 year CPD Clinical Educator for IPC was provided but recruitment to this post also failed twice (no applicants). Other ways of utilising this money are being explored to be able to cascade IPC training to staff.

Despite the pressures experienced with managing the COVID pandemic, the 2020/21 IPC annual plan was achieved with only 4 items not actioned. These included having an IPC time away with the ODIL team, making updates to the CPE guidance, writing a business case to procure ICNet and looking to change decolonisation treatment for MRSA. All these apart from the change to the decolonisation treatment for MRSA will be taken forward and actioned in 2022/23. The change of MRSA decolonization treatment to Octenisan from Chlorhexidine will not be carried forward as there is no compelling evidence for the change.

7. IPC annual plan 2022/23 (appendix 2)

The 2022/23 annual plan will focus priorities around ensuring that the process for post infection reviews is embedded into practice for Care Groups. This will be done through the datix system where all cases that are hospital acquired will be logged.

The annual plan will also prioritise ensuring that the IPC governance structure is embedded in Care Groups through the introduction of the IPC Strategic and Assurance (IPCSAG) meeting which will replace TIPSG. IPCSAG will enable IPC performance feedback from Care Groups.

Ward decontamination and refurbishment will be considered through multidisciplinary walk rounds which will identify priority areas for proactive HPV program at both main sites.

Expanding and developing the IPC team through recruitment, provision of funding for formal training and offering opportunities to attend courses and conferences will be achieved through the appraisal process.

Reduction in HCAIs such as *C.difficile* and blood stream infections will be prioritised through proactive audit and surveillance, thematic analysis, PIRs and projects aimed at reducing HCAIs.

8. Environmental cleaning and decontamination

The trust continues to monitor monthly cleaning scores through the Cleanliness Monitoring Group and any concerns escalated to the Cleaning Standards Group (CSG) and to TIPSG.

The CSG is overseeing the implementation of the new National Standards of Healthcare Cleanliness 2021 which stipulate cleaning responsibilities, itemise elements that require cleaning and the frequency of cleaning, categorises the functional risk areas and also offer star ratings for departments. This work is on truck and updates are escalated to TIPSG.

Recent outbreaks highlighted gaps in cleaning due to domestic staff shortages. This is a risk to the organization which was also highlighted in the NHSE/I report. In February 2022 assurance of appointments to domestic vacancies was gained. There was an improvement with reports of cleaning gaps in outbreak meetings conducted in April 2022.

Date	York	Scarborough	Bridlington	Selby
Apr-21	97.69%	97.54%	98.90%	98.24%
May-21	97.32%	97.28%	97.81%	96.79%
Jun-21	97.78%	97.75%	99.12%	97.09%
Jul-21	97.57%	98.04%	98.75%	99.17%
Aug-21	97.42%	97.91%	99.13%	99.03%
Sep-21	96.77%	97.90%	98.57%	98.74%
Oct-21	97.18%	97.15%	98.05%	99.72%
Nov-21	97.19%	97.09%	99.43%	97.78%
Dec-21	96.60%	97.35%	99.18%	97.35%
Jan-22	97.20%	96.91%	99.16%	98.94%
Feb-22	95.89%	97.49%	99.03%	99.62%
Mar-22	96.97%	96.81%	98.81%	99.66%

Table 5. Cleaning scores for very high risk areas April 2021 to March 2022

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

9. Water Safety

There was a high Total Viable Count (TVC) found in the water outlets at the Community Stadium in York in May 2021. Initial assessment identified that the water outlets were not being used sufficiently because there were not enough people utilizing the building. It was also suspected that the varying water temperature controls seemed to be contributing to the microbiological growths in the water. A recommendation to test for Legionella was made with mitigations put in place to reduce contamination from the water.

Water sampling is still being carried out at the Community Stadium and is showing no Legionella.The LLP and the Trust's health and safety department is now working with the council to resolve some systemic issues.
.

The IPC team completed the Pseudomonas risk assessments of all augmented care areas across the Trust in September 2021. The risk assessments form part of the Water Safety Strategy for the organization.

In July 2021, the IPC team commenced an annual audit of the hand hygiene facilities. Findings of this audit revealed corroded plug holes and extensive lime scale on taps. Some taps are not elbow operated.

A walk round of the ICU at York to investigate the cases of Aspergillus also found extensive lime scale on taps. This is a risk to patients as lime scale provides a good breeding ground for bacteria.

Overall findings of the hand hygiene facilities audits were highlighted to the Strategic Water Safety Group in October 2021 and escalation of concerns made to TIPSG.

10. Staff training

IPC mandatory training trust-wide average compliance is 92% for level 1 and 87% for level 2. The low IPC mandatory training compliance is highlighted to senior nurses meetings.

The IPC level 1 face to face training presentation has been updated to align with current COVID-19 guidance. This has been submitted to Work Based Learning team in readiness for the new fiscal year.

A hand hygiene training organised by the IPC team was delivered by a company representative from Purell via Microsoft Teams on 5th May 2021. A total 48 staff were trained across the trust. A second hand hygiene training session took place in June 2021 with a total attendance of 49 staff.

Commode cleaning training using Sporicidal products took place at Scarborough in late September 2021 and at York in November 2021 provided by Gamma Healthcare in response to the increasing incidence of *C.difficile* across the trust. A total of 57 staff received the training at Scarborough and a further 49 staff members were trained at York. Further training continued in December 2021 for community in-patient units including Bridlington hospital. At Easingwold Renal Unit, St Monica's, Selby Inpatient Unit- 12 staff were trained.

Other planned staff training programs based on the IPC annual plan for 2021/22 were challenging to achieve due to priorities being given to managing COVID-19 across the trust, short staffing in clinical areas and staffing challenges within the IPC team.

In April 2021the IPC staff in York received a one day in-house Water Safety training delivered by the Health and Safety team. This training meets the requirement of Health and Safety Executive (HSE) for any person responsible for water safety in a healthcare setting. Another training session is planned for the Scarborough IPC staff.

The overall average compliance with the 5 moments for hand hygiene across the organisation is 99% according to the data submitted by clinical staff. Peer hand hygiene audits targeting 5 random

areas per month were undertaken in 2021/22 by the IPC team; with an average compliance of 91% in order to gain assurance of the data being submitted by clinical staff.

11. Next Steps

- Continue to integrate the IPC team into care groups to improve engagement with clinical teams and improve outcomes for reducing HCAIs; in particular *C.difficile* and blood stream infections.
- Incorporate cleaning competencies in the IPC training program with a focus on commode and bed cleaning as part of a wider *C.difficile* reduction strategy.
- Gain assurance of the hand hygiene audit scores presented by clinical teams through comparable peer hand hygiene audits by the IPC team.
- Complete actions within the 2022/23 annual plan.
- To embed into practice the amalgamated post infection reviews (PIRs) into the DATIX system to enable local learning within care groups from PIR outcomes.
- Develop training packages that facilitate IPC training for staff within clinical areas to enhance good practice.
- Participate in the planning and implementation of the decant and proactive HPV program.
- Working with the tissue viability team to relaunch annual mattress audits.
- Audit invasive device management with a focus of reducing HCAI bacteraemia related to invasive devices.

12. Detailed Recommendation

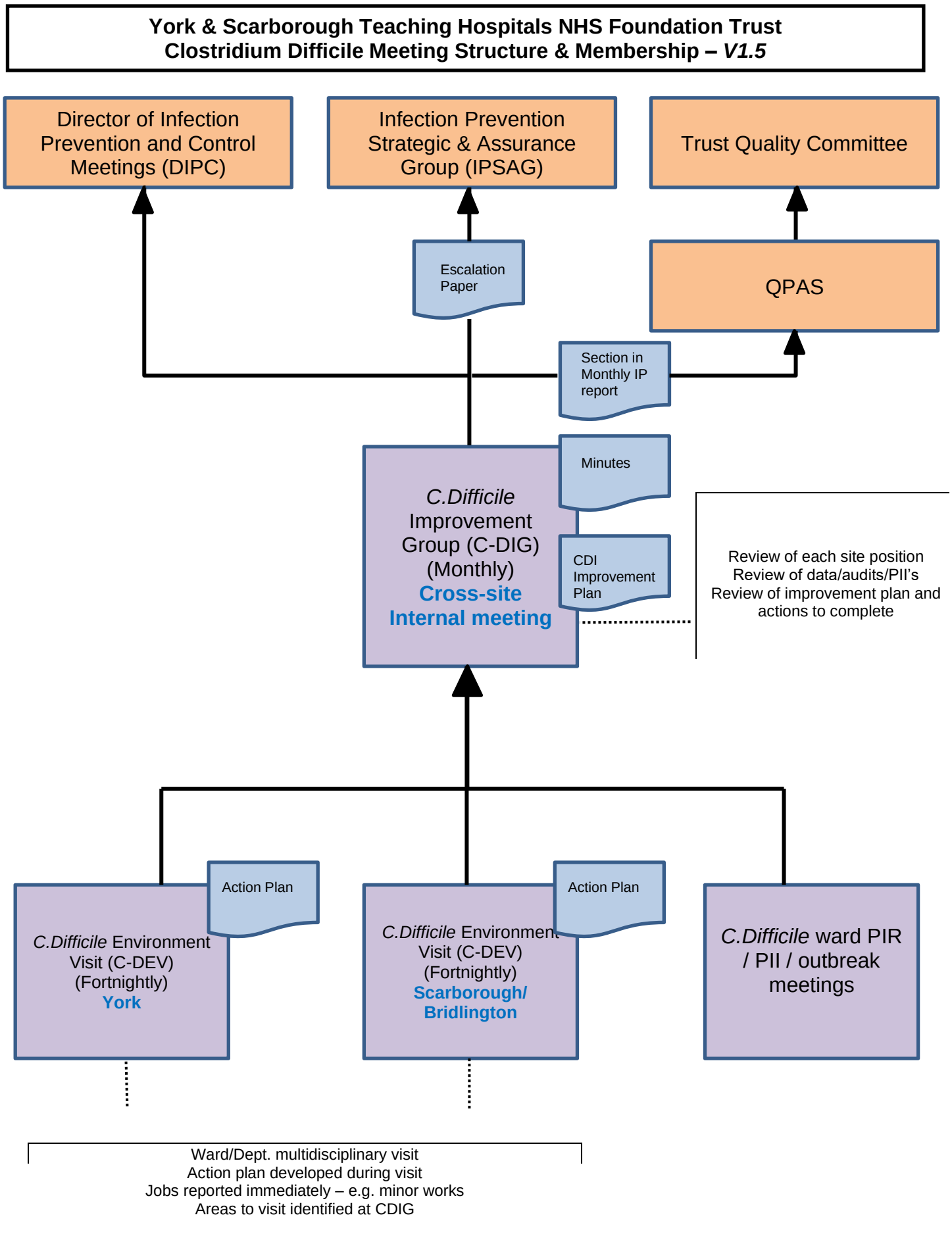
The Board is asked to note the trust position of HCAIs; and to gain assurance from the actions within the *C.difficile* action plan.

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

The IPC mandatory training compliance for medical and dental staff is low. The Board is asked to support measures to improve mandatory training including the funding of locum bank staff to ensure that the trust is assured of good clinical practice.

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

Appendix 1. *Clostridium difficile* meting structure



Proposed membership for 2 main groups (C-DIG & C-DEV):

Clostridium Difficile Improvement Group (C-DIG) – Monthly cross site internal meeting

Role	Comments	Cross site role	York	SGH
Director of Infection Prevention and Control	Chair	Y		
ICD/Deputy Director of Infection Prevention and Control (DDIPC)	Deputy chair	Y		
Assistant/Deputy Chief Nurse for IPC	Deputy chair	Y		
Lead Nurse for IPC		Y		
Clinical director CG 1	Or nominated consultant		Y	
Clinical director CG 2	Or nominated consultant			Y
Clinical director CG 3	Or nominated consultant	Y		
Clinical director CG 4	Or nominated consultant	Y		
Microbiologist	If DDIPC unavailable	Y		
Head of Nursing CG 1	Or nominated deputy		Y	
Head of Nursing CG 2	Or nominated deputy			Y
Head of Nursing CG 3	Or nominated deputy	Y		
Head of Nursing CG 4	Or nominated deputy	Y		
Lead antimicrobial pharmacist		Y		
Assistant Head / Deputy Director of Estates	Or nominated deputy		Y	Y
Assistant Head / Deputy Director of Facilities	Or nominated deputy		Y	Y
Patient Flow representation x2	Or nominated deputy		Y	Y
Operations management representation CG1			Y	
Operations management representation CG2				Y

Operations management representation CG3		Y		
Patient Safety Team representation		Y		
AHP senior manager		Y		
IPN SGH representation x1				Y
IPN YDH representation x1			Y	
IP Admin support		Y		

Clostridium Difficile Environment Visit (C-DEV) - Fortnightly visit to a clinical area (1 on each site). Requires 2 separate meeting invites

Role	**Comments**	**Cross site role**	**York**	**SGH**
IPN			Y	Y
Matron for ward/dept.			Y	Y
Ward Manager or nominated deputy			Y	Y
Facilities representation x 1			Y	Y
Estates representation x 1			Y	Y

Appendix 2. IPC Annual plan 2022/23

Objective	Action	Update	Key Stakeholders	When	RAG Rating
1.	**IPC Systems and processes**				
Development of IPC Team	Work with the Trust ODIL team to implement a team development programme. Development of QI and change management skills for IPNs.	Sessions planned for May 2022	Assistant Chief Nurse-IPC IPC Lead Nurse	Q1	
	Review the IPN specialist skills training and identify staff to attend regional/national training sessions linking to CPD availability.	Provide funding for formal IPC qualifications for those who don't yet have one. Offer opportunities for on-going informal training as and when courses/ sessions become available. Picked up via appraisal process.	Assistant Chief Nurse-IPC IPC Lead Nurse	Q1-4	
	Review the IPC team to ensure that staffing is sufficient to meet demand. Complete the induction processes based on the IPS Competency Framework for band 5	Recruited to a band 4 in SGH and a band 5 developmental post in York Band 7 and Band 8C posts not recruited to (To review this) Not been able to recruit to band 8C (To review this)	Assistant Chief Nurse-IPC IPC Lead Nurse	Q1	
	Embed Care Group IPN link strategy .	Meeting with IPC and CGs held in Q3 of 2021/22 to agree CG involvment in IPC with suggestion of IPC champions within CGs	Assistant Chief Nurse Deputy DIPC IPC Lead Nurse	Q1-2	
Staff training (Trust-wide)	Care Group IPN links to work with Care Group teams to identify any specific learning from CGs. IPNs to link together to share and cascade learning particularly from PIR and outbreak processes. Staff IPC practice to return to pre-pandemic practices that are based on risk assessment.	All IPNs allocated to CGs in 2021/22. Organise study days with external and internal speakers to share good practice that is evidence based. Engage company reps to support with training and education. Update the stat/mand training and any other IPC training packages.	Care Group Leadership teams including ACNs and Matrons Estaes and Facilities IPC Team	Q1-4	

PIR Process	Complete handover of PIR ownership to Care Groups for C.diffile HOHA and COHA cases. Implementation of the PIR process for COHA to match HOHA process. Establish PIRs for MSSA to match the C.difficile PIRs.	PIR Datix dashboard to be developed. CG PIR to go to OAM. Meeting held between IPC and CGs (excluding CG3) on 10th February 2022 to discuss take over of the PIR process from IPC to CGs. The Datix template requires to be revised. Joint environmental walk-rounds with IPC, CGs, Estates and Facilities and CG managers to be embedded.	Deputy DIPC IPC Lead Nurse Assiatant Chief Nurse-IPC Patient Safety Team Care Group Leadership teams , including ACNs, Matrons and CG Facilitators	Q1 - C.diff. Q2-3 - MSSA
IPC governance structure	Embed the new IPC governance structure New Infection Precention and Control Strategic and Assureance Group (IPSAG) to replace TIPCSG from June 2022 Develop engagement with LLP and Capital Planning within IPC governance framework	New terms of reference for the new IPSAG with defined membership developed - to be sent out to relevant stakeholders First IPSAG June 2022.	Deputy DDIPC IPC Lead Nurse Assistant Chief Nurse-IPC	Q1
IPC Community cover	Increase IPC in-reach to the community sites to ensure IPC delivery and support is matched to the acute trust	Duty allocation to include community cover once to twice a week Explore a part time band 6 for commnuty cover to maintin	IPC Lead Nurse Assistant Chief Nurse-IPC	Q1-2 dependent on staffing
Up to date and easy to navigate websites	Update internet and intranet pages	Review of the intranet IPC page is required	IPC Team	Q2

Improve IT systems to share, monitor and report on IPC information	Dependent on Telepath implementation and compatibility with CPD	Introduction of new lab system (WinPath) anticipated early 2023. Confirmation received it is compatible with ICNet. Follow up with ICNET to establish costings and contract requirements in preparation for a business case.	Deputy DIPC IPT	Q3-4	
2.	**Improving the environment**				
CDI Reduction Plan	Monthly meetings and progress tracking for CDI reduction.	CDI meeting structres revised to include monthly cross-site CDI meetings, and forthnighly walk rounds to assess the environment. Monthly C.diff Improvement Group meetings to re commence in May 2022 with new membership and ToR. To report to IPSAG and in to Care Group Quality Meetings.	Deputy DIPC IPC Lead Nurse Care Group Leadership teams including ACNs and Matrons Estaes and Facilities	Q1	
CDI work plan	On-going updates to the trust CDI workn plan. Develop a CDI focussed educational event. Improve awareness across the Foundation Trust of cases and performance. Robust proactive HPV programmes.	Take a proactive approach of CDI reduction strategy: Timely PIRs to learn from themes - within CGs and across the Trust Decant, refurbishment and HPV program (?led by the CSG) Training and education around CDI Actively address other themes/trends identified from PIRs	IPC Lead Nurse Care Group Leadership teams Estaes and Facilities	Q1-4	
Ensure that cleaning standards are reviewed strategically across the Foundation Trust.	Embed the performance and activities of the Cleaning Standards Group (CSG)	Review membership of the CSG Embes the multidisciplinary walk rounds	Assistant Chief Nurse-IPC IPC Lead Nurse	Q1	
3.	**Reducing antimicrobial prescribing**				
Improving antimicrobial stewardship across the organisation	Conduct and embed weekly antimicrobial ward rounds CDI ward rounds to involve real time liaison with the clinicians.	Input required from the Pharmacisit	Deputy DIPC Microbiologists Pharmacists		
4.	**Information for people who use our service**				

Visitors and service users are aware of IP guidance, and there is a mechanism to communicate changing advice to the public	Continue to review visitor and patient information leaflets	TV in YDH main entrance to have refreshed information. Review and update relevant information leaflets. Update IPC section of Trust's external website.	IPC Team	Q1-3	
5.	**Identification of people with infection**				
CPE screening of at risk patients	Introduce new CPE guideline	Carried forward from 2021/22	Deputy DIPC IPT Microbiology	Q2	
Identification of individuals at high risk of carrying infectious organisms	Development of electronic admission documentation	A draft of the IPC admission proforma has been developed but not adopted as an electronic document yet Embed the IPC care plans within clinical practice		Follows Trust implementation (Q3)	
6.	**Staff engagement and Care Group Assurance**				
Develop a comprehensive and robust assurance system for IPC, that is regularly reviewed, and which enables performance issues and risks to be addressed	Embed IPC performance reviews in to CG quality committee meetings and flow to TIPSG and Trust Quality & Safety meeting.	Implemented as part of the new OAM process via the Chief Nurse (DIPC)	Chief Nurse (DIPC)	Q1-3	
7.	**Reducing Healthcare Acquired Infections**				
Gram Negative Blood Stream Infections	Complete project to introduce gentamicin prophylaxis before high-risk catheter changes Review E.coli bacteraemias to identify themes and trends.	Work with CG1 to complete project for Gentamicin prophylaxis Conduct a thematic analysis for GNBSIs Conduct a PP catheter audit Drive intitiatives to promote hydration	Deputy DIPC CG1 IPC Team	Q2-3	

Methicilin Sensitive Staphylococcus aureus (MSSA)	Re-establish Staph aurues bacteraemia reduction group Review MSSA bacteraemias to update themes and trends in causes. Embed PIR process for thse bacteraemias. Develop and implement actions to address common themes /trends Promote ANTT theory and practical training through Care Group links	Work with CGs to re-establish the Staph Aureus reduction group Conduct a thematic analysis for MSSA bacteraemia. Embed PIRs for MSSA (and MRSA) bacteraemias.	Deputy DIPC IPC Lead Nurse Care Group Leads	Q2-3	

Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Guardian of Safe Working Hours 2022-2023 Q1 report
Director Sponsor:	James Taylor, Medical Director
Author:	Dr Ruwani Rupesinghe, Guardian of Safer Working

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ A Regulatory Requirement ☒

Trust Priorities	Board Assurance Framework
☒ Our People	☐ Quality Standards
☒ Quality and Safety	☒ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☐ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

1. In 2019 the Department of Health and Social Care provided £30,000 to the Trust as part of a national programme to improve rest facilities for junior doctors. Previous reports have detailed how this money was spent. It has subsequently come to light that £15,000 is still available. Details in section 2.1.1 of the report.

2. Insufficient staffing is frequently cited within reports as a reason for missed breaks and overtime. Over 1,000 bank shifts went unfilled in Q1. The impact of inadequate staffing levels on patent safety and junior doctor wellbeing is clearly demonstrated in section 2.1.3.

3. Junior doctors must be an integral part of the Boards strategic goal to support an engaged, healthy, diverse and resilient workforce and combat widespread shortfalls in the workforce. It is easy to overlook trainees due to the constant flow of individuals through departments and the organisation itself. We must recognise that their experience of working for the organisation, though brief, will have a direct bearing on uptake of locum shifts and recruitment of Trust Grade/Locally Employed Doctors (often doctors taking a break from training) and Consultants.

Report Exempt from Public Disclosure
No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History (Where the paper has previously been reported to date, if applicable)		
Meeting	**Date**	**Outcome/Recommendation**
N/A	N/A	N/A

Board report
Guardian of Safe Working Hours 2022-2023 Q1 report

1. Introduction and Background

This is the 2022/2023 Q1 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The quarterly report is for 1 April 2022 to 30 June 2022 and summarises key findings from the Junior Doctor Forum (JDF) and Exception Reporting.

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

The GoSWH holds the position of Chair of the JDF. Regular meetings are held in a hybrid fashion (WebEx and physical meeting rooms) to enhance accessibility. The Forum has core representation from Medical Staffing, Medical Deployment, Medical Education, Care Group management, Local Negotiating Committee and British Medical Association. It gives junior doctors a platform to bring forward ideas, get advice and highlight important issues pertaining to their experience of working in the organisation. Key updates from each core representative are also provided as part of the collaborative effort.

2. Current position / issues

2.1 Exception reporting and Guardian fines

2.1.1 Summary of Guardian funds for quarter 1

There were six Guardian fines in this quarter. Prior to this the last Guardian fine was levied in March 2021.

In April 2022, a doctor working on the Paediatric roster in Scarborough hospital submitted six exception reports. These reports identified that on 4 separate occasions the doctor worked shifts 13.25hrs in length (maximum length allowed is 13hours). Due to the sequential shifts it meant on 2 occasions they did not achieve the minimum 11 hours rest between shifts causing further fineable breaches. As the trainee reported these incidents several days later it was not possible to provide immediate Time Off In Lieu (TOIL).

The total Guardian fine for these joint breaches was £118.86. This was split as per the TCS as follows: £44.56 to the trainee and £74.31 to the Guardian.

This takes Guardian funds related to contractual breaches to £670.31 although £500 of that has been ring fenced for use towards the York Doctors Mess.

The national funding provided to "enhance junior doctor rest facilities" was thought to have been spent in full (£30k) as detailed in previous board reports to refurbish the Doctors Mess in York and Scarborough. This has been proved not to be the case. The details of this are as follows:

In Scarborough the mess is co-located with on call rooms. The entire area required development so £15k was merged with funding from the Trust Charity to enable all the work to be done at the same time.

In York, a process was established for Estates to access their portion of funds (£15k) which was held within the medical education budget. Unfortunately, the works were delayed due to COVID. A bid was successfully submitted by the York Mess Committee for money linked to the Captain Sir Tom Moore fund. Consequently, instead of invoicing the medical education budget code up to £15k ***all*** of the work was charged to the Charity. This decision was not conveyed to the Guardian or Medical Education Manager.

The finance department has agreed to reimburse the £15k national funding for use by the junior doctor body. It will be held in the Guardian of Safe Working Hours cost centre. This will allow it to be managed in the same way we do Guardian fines – tracked and reported to the Junior Doctor Forum and Board. Although held within the same cost centre it will be monitored and managed independently of Guardian fines. The reimbursed money must be spent before 31 March 2023.

The current available balance in cost centre 113003 is therefore £15,170.31.

2.1.2 Exception reporting trends

A complete breakdown according to Care Group and department is detailed in Appendix 1 (Table 1). It is worth noting that **the specialty recorded reflects the doctor's primary base but not necessarily where they worked the shift in question**. This is usually the case in reports related to out-of-hours shifts.

The majority (54%) of reports were received from Care Group 3 this quarter. The 3 reports attributed to anaesthetics all relate to shifts covering surgery or COVID wards. The quantity of reports relating to the surgical roster in York has been highlighted previously; changes were implemented in April 2022 with further improvements in staffing levels planned for August. A recommendation has been made to the directorate for the recognised shortfall in weekend staffing to be addressed using locum doctors until August.

The fines levied against Care Group 5 all relate to handover in Paediatrics. The junior doctors recognised that handover consistently finished after their rostered shift time. They proactively sought approval for the roster to be brought in line with practice. In doing so it became apparent that, though short, the extra time led to a breach in shift duration and rest time between shifts. The department responded swiftly and no further reports have been received.
"The team have been really supportive. The consultants held meetings and have actioned a solution to ensure we leave on time every day. In fact I have left on time every day for the past few weeks now so I'm very happy with the changes they've made!", this glowing feedback demonstrates the collaborative, solution based approach taken by the department has had instant impact.

Foundation Year doctors continue to submit the largest volume of exception reports (Appendix 1, Table 2). The system has been in place for approximately 5 years now which suggests that the low reporting from higher grades is based on more than simply unfamiliarity and lack of engagement with exception reporting in general.

The majority of reports (40 / 93%) related to Hours and Rest issues, mainly claims for additional hours worked and missed rest breaks. Appendix 1 (Table 3) shows a summary of all the reports by type. Only one can be selected when submitting a report.

The contract stipulates that exception reports should be actioned within 7 days of submission. The reporting tool does not allow a report to be 'closed' until the outcome has been accepted by the reporting doctor. Junior doctors rarely, if ever, complete this task and most are eventually closed by the Guardian team. This extra step within the software system skewed the data. To bring it back in line with the contractual definition, and historical reports, Appendix 1 (Table 4) contains information on the time between submission of an exception report and completion of the 'initial review' by the Supervisor, Guardian or Director of Medical Education. The proportion of reports addressed within 7 days has plummeted in recent months. It may reflect the exceptional pressures seen in acute and unplanned care but will be monitored. Further action may need to be taken in conjunction with the Director of Medical Education to assist supervisors in meeting this obligation.

2.1.3 Safety concerns

Junior doctors are consistently advised to use DATIX for safety related matters. However, when submitting an exception report it is possible to check an "immediate safety concern" box. It is not a replacement for employing Trust escalation protocols. They should be submitted within 24 hrs to highlight an "immediate and substantive risk to the safety of patients or the doctor making the report".

Only one report was submitted with an "immediate safety concern" that met the contractual definition (a second report has ISC status removed as it did not meet the definition):

> *"Whilst holding the COVID SHO bleep last night, I was given the both FY1 bleeps to cover. [ ] Last night was extremely unsafe as I have moved from the COVID wards to the other wards to review sick patients nonstop throughout the night. BMA states that we are not expected carry those bleeps or double the work due to unexpected rota gaps, and it lies with the employer to arrange cover for these gaps. For the rest of the week, there is a rota gap for COVID Reg, Acute Night SHO and FY1."*

The report clearly identified upcoming risks from shifts with even more rostering gaps. This was escalated as a priority to the rostering and operational team who were able to provide assurance that the matter was in hand. Occasionally reports contain information that suggests an ongoing risk to patients or staff despite not being submitted as an "immediate safety concern". Any reports with potentially serious, time critical information are escalated with more urgency to the relevant supervisor and manager.

Excerpts are included below:

> *"I was the only junior doctor all day [ ], having more than 40 patients under my care. 3 patients were acutely unwell with NEWS more than 7. There was 16 discharges and many other jobs, bloods, reviews, prescriptions etc. I only had about 5-10min to eat lunch at about 3pm. No other breaks. I had to stay 1.5h after work [ ].*
>
> *Nurses [ ] were bleeping me frequently to remind me to do the discharge letters. This was adding to my stress levels as I had no way of completing 16 discharge letters in a timely manner on my own. This has slowed the bed movement on those wards and I feel that staffing [ ] was very inadequate and unsafe."*

"Since 8am I not had a single break until 4pm when I had 5 min to eat my lunch and had a drink of water on the run.[ ] I was very tired after intense shift the day before (had to stay extra time and again no breaks and acutely unwell patients).

Discharges were delayed because I was busy reviewing the unwell patients and not having time to do any of the ward jobs including discharge letters. I think this had a direct impact on the bed flow [ ].

The shift overall impacted severely on my wellbeing and made me feel very stressed and burnt out. I was worried about the thought of coming back to work the next morning for another 12.5 hours shift with no breaks, minimal senior support and unwell patients."

2.2 Junior Doctors' Forum

Forum meetings are now a hybrid with a meeting room booked in York and Scarborough together with access via WebEx. Invitees are encouraged to join remotely whenever possible and social distancing rules followed in the meeting rooms.

This initially led to a modest improvement in attendance by junior doctors but has not been sustained. Regular representation from the Junior Doctor BMA representative and JDF Vice-Chair ensure their voice is heard.

2.2.1 Junior Doctor Awards

The finale was hosted in the education centres across York and Scarborough. Finalists and their nominators were invited. Catering and trophies were sponsored by Charitable Funds. A compilation of all the nominations is available on the Forum webpage on Staff Room.
This year's winners are:

- Team player – Dr Stuart Place
- Rising star – Dr Mohamed Ismail
- Compassionate care – Dr Sennia Ahmed and Dr Phillip Forrester
- Outstanding contribution to QI/research/education – Dr Ruth Barker
- Educational/clinical supervisor – Dr Elizabeth Baker
- Unsung hero – Dr Mohamad Kajouj

2.3 Summary of rota gaps and locum/agency usage

2.3.1 Junior doctor vacancies

At the end of June 2022, the Medical and Dental vacancy rate for the entire Trust was 9.5%, up slightly from 8.1% in May 2022.

More detailed data on medical and dental staffing vacancies is no longer produced although the headline statistics continue to be reported separately within the monthly workforce performance report. The medical staffing team is working on a new system to accurately track vacancy data and this will be included in the Guardian report once finalised.

The number of training posts allocated to the organisation is relatively static. However, due to challenges with recruitment in the region and nationally there are often unfilled training numbers. These 'gaps' are shared across the deanery. Departments can employ doctors

on a fixed-term contract until a trainee is next allocated. However, the funding in these situations is complex and departments may not be able to do so. It is recognised that the number of training posts allocated to the Trust is insufficient to meet service requirement. Trust Grade/Locally Employed Doctor (LED) posts are a critical element of bridging the gap but are also subject to pressures with recruitment. With increasing numbers leaving the profession or choosing to work overseas recruitment is not guaranteed. Taking into account these challenges and the fact trainees rotate between Trusts at different times of the year vacancy rates are fluid.

2.3.2 Locum and bank bookings

Locum/bank shifts are processed through the Patchwork App which enables doctors to book bank shifts and track their work and payments anytime and anywhere. The information in Appendix 2 (Tables 5 and 6) is presented according to categories defined within the App.

50,278 hours of locum work was requested via Patchwork in Q1. Excluding shifts that are clearly identified as being for non-junior doctor grades (marked with asterisk in Apendix 2, Table 6) this reduces to 45,928 hours of which 10,781 went unfilled. This correlates to 1,156 shifts.

The Trust has signed a contract with Medacs for agency cover. The change in provider occurred in Q1. At the time of writing similar data for agency shifts from them is awaited.

Date: 14 July 2022

Appendix 1: Exception reporting data

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
CG1			
Cardiology	4	4	0
Diabetes and Endocrinology	1	1	0
Gastroenterology	2	2	0
Renal	1	1	0
General practice	1	1	0
CG2:			
Diabetes and endocrinology	2	2	2
Elderly/rehab medicine	2	2	0
CG3			
Anaesthetics	3	3	0
General surgery	12	9	3
Colorectal surgery	3	3	0
Upper GI surgery	5	5	0
CG4	0	0	0
CG5			
Paediatrics	6	6	0
CG6			
Ophthalmology	1	1	0
Total	**43**	**40**	**3**

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous quarter**	Proportion of reports previous quarter	No. exceptions raised **this quarter**	Proportion of reports this quarter
F1	34	68%	40	93%
F2	10	20%	2	5%
CT1-2 / ST1-2	6	12%	0	0%
IMT3/ ST3+	0	0%	1	2%
Total	**50**	**100%**	**43**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions in **previous quarter**	Proportion of reports previous quarter	No. exceptions raised **this quarter**	Proportion of reports this quarter
Late finish	32	64%	34	79%
Missed breaks	7	14%	1	2%
Late finish and missed breaks	7	14%	4	9%
Late finish and missed breaks & unable to attend scheduled teaching	1	2%	0	0%
Inadequate clinical exposure	0	0%	1	2%
Inadequate supervision	2	4%	2	5%

Table 3: Exception reports by type				
Inadequate supervision & late finish	0	05	1	2%
Unable to attend scheduled teaching & late finish	1	2%	0	0%
Total	**50**	**100%**	**43**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	9	1	27	3
FY2	0	0	2	0
CT1-2/ST1-2	0	0	0	0
IMT3/ST3+	0	0	1	0
Total	**9**	**1**	**30**	**3**

Appendix 2: Locum booking (bank) data

Table 5: Locum bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine SGH	106	99	1,123	1,045
Acute Medicine YH	437	262	4,092	2,333
Cardiology YH	8	8	70	70
Elderly Frailty Unit RAFA ED YH	3	0	30	0
Elderly Medicine SGH	55	51	523	476
Elderly Medicine YH	249	200	2,109	1681
Emergency Department SGH	616	503	6,203	5,121
Emergency Department YH	1,048	792	8,661	6,637
ENT YH	42	42	596	596
General Medicine SGH	617	489	5,425	4,338
General Medicine YH	816	513	7,431	4,483
General Surgery SGH	73	57	850	679
General Surgery YH Consultants	2	2	20	20
General Surgery YH Juniors	72	72	652	656
Home First Unit (HFU) SGH	243	205	2,769	2,328
Maxillo Facial YH	34	34	525	525
Obstetrics & Gynaecology SGH	86	68	881	730
Obstetrics & Gynaecology YH	69	58	628	528
Oncology YH	39	23	281	168
Ophthalmology YH	51	51	593	593
Paediatrics SGH	131	121	1,379	1,279
Paediatrics YH	158	130	1,470	1,219
Radiology YH	15	15	43	43
Respiratory YH	10	10	90	90
Theatres, Anaesthetics and Critical Care SGH Consultants	71	67	1,223	1,157
Theatres, Anaesthetics and Critical Care	42	42	377	380

Table 5: Locum bookings (bank) by department				
SGH Juniors				
Theatres, Anaesthetics and Critical Care YH Consultants	12	12	75	74
Theatres, Anaesthetics and Critical Care YH Juniors	59	51	631	528
Trauma & Orthopaedics SGH	30	29	479	455
Trauma & Orthopaedics YH	64	63	691	682
Urology YH	2	2	15	15
Cellular Pathology (SHYPS Network)	5	5	10	10
Community In Patient Units	12	4	91	32
Urology SGH	1	1	10	10
Haematology YH	22	22	192	192
Gastroenterology SGH	3	0	30	0
Total	**5,303**	**4,103**	**50,278**	**39,185**

Table 6: Locum bookings (bank) by shift grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
ACP*	1	0	12	0
Anaesthetic ICU different base cover	32	32	551	551
Anaesthetic Juniors & SAS	92	86	912	837
Anaesthetics General different base 24 hr on-call gap	6	6	130	130
Anaesthetics General different base Mon-Fri on-call gap	12	12	188	188
Anaesthetics General same base 24 hr on-call gap	9	9	168	168
Anaesthetics General same base Mon-Fri on-call gap	14	10	206	140
Anaesthetics ST3+/Specialty Doctor/SAS	13	11	168	143
Consultant*	441	407	3,164	2,947
Consultant WE/Bank Holiday/Discharge*	82	73	844	761
CT/GPStR/ST1-2	2,497	1,981	23,210	18,506
FY1	199	120	1,761	1,072
FY2	513	205	4,945	2,008
On-call consultant*	28	28	330	330
On-call ST1+/SD	26	26	313	313
ST3+	794	703	8,291	7,350
ST4+	514	365	4,643	3,323
T&O ST3+/Specialty Doctor/SAS	30	29	438	414
Total	**5,303**	**4,103**	**50,278**	**39,185**

Table 7: Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	103	70	970	664
Bank Holiday	131	114	1,426	1,238
Bed Pressure	8	7	66	59
Clinical Coder	6	6	35	35
Compassionate Leave	5	4	33	22
COVID-19 (Additional demand)	51	48	418	401
COVID-19 (Staff sickness/isolation cover)	99	71	1,063	750
Extra Clinic	9	9	58	58
Extra Weekend Support	6	5	57	51
Maternity Leave	44	44	527	527
On-call cover	110	107	1,380	1,353
Paternity Leave	1	1	24	24
Service Requirement	1,398	1,073	12,125	9,476
Sick Leave	182	116	1,811	1,129
Sickness - Long Term	21	17	222	179
Sickness - Short Term	38	19	340	165
Special Leave	6	4	61	39
Vacancy	2,988	2,315	28,953	22,440
Winter Pressure	97	73	702	566
Total	**5,303**	**4,103**	**50,278**	**39,185**

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Minutes

Quality Assurance Committee
21 June 2022

/ Members in Attendance: Stephen Holmberg (SH) (Chair), Lorraine Boyd (LB), Lynette Smith (LS), Heather McNair (HM), James Taylor (JT), Jenny McAleese (JM), Mike Taylor (MT), Caroline Johnson (CJ), Shaun McKenna (SM), Ed Smith (ES)

/ Attendees: Sue Glendenning (SG), Michala Little (ML), Melanie Liley (ML2)

/ 1. Apologies for Absence: Donald Richardson (DR), Sara-Collier-Hield (SCH – ML deputising), Wendy Scott (WS – ML2 deputising), Liam Wilson (LW)

/ 2. Declaration of Interests

There were no declarations of interest.

/ 3. Minutes of the meeting held on 17 May 2022

The minutes of the last meeting held on 17 May 2022 were agreed as a true and accurate record.

/ 4. Matters arising from the minutes

Action 167 – SH agreed to extend this as conversations have not yet taken place.

Action 180 – JT gave an update and said that the system has suggested mandated FIT testing (to which the Trust agrees) but that this was not included in GP contracts. Negotiations are underway to agreement GP payment to deliver this priority but there is not a confirmed date for delivery.

Action 183 – CJ confirmed that some changes were made around the wording and it has gone through Audit Committee with no further action required.

/ 5. Escalated Items

SH raised two points for information/discussion following a discussion with Lynne Mellor, Resources Assurance Committee Chair.

- The lack of CIPHER funding and the associated impact on ED
- Conflicting financial issues e.g. £1m EPMA allocation that cannot be funded and care group requests totalling c.£3.5m that may be funded

LB noted that EPMA also features on the IBR under medication incidents and said that DIS have also highlighted several safety issues around EPMA. CJ said this is regularly discussed at the weekly Quality & Safety meeting, noting that EPMA has not been fully rolled out to all departments (e.g. Paediatrics). JT said his biggest concern was the use of EPMA in ED, particularly around managing critical medication for long-wait patients and said there needs to be roll-out to all areas. There was a group discussion about lack of digital capacity and capability and how this limits integration progress. EPMA sits within CPD, which needs development but there is an issue with developer capacity.

SH noted the imminent Committee structure change and confirmed that digital discussions will become more prominent in the Digital, Performance & Finance Assurance Committee. SH asked if there would be a link between committees and MT confirmed yes via respective escalations. LS gave assurance that the DIS team have developed a prioritisation framework based on factors including Trust priorities, clinical harm and funding streams that is reviewed by Executive Directors and Care Group Directors.

There was a discussion about risk and impacts on clinical safety and LB said this needs to be a factor when prioritising digital work. JT said our lack of capital and digital results in constant changing of prioritisation order and SH said it would be helpful to have a paper supporting patient safety priorities alongside digital progress. The Committee noted that the ICS has mandated 'Optica' as a new digital system to be used by all Trusts, which could reprioritise our position.

Action: JT to work with Executive colleagues to develop a report summarising digital risk/progress and how this is specifically applied to patient safety priorities

/ 6. IBR Overview to look at Performance

LS highlighted that stroke performance dropped to category D in one area. This has been escalated around supportive care and there is an ongoing action plan.

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

ML2 highlighted the following key headlines:

The Trust remains under significant operational pressure. There has been a recent significant upturn with 85 Covid-positive patients. Most patients have not been unwell but have tested positive due to being slightly symptomatic or through the discharge swabbing for care homes. We still have Covid wards and we are reviewing demand with Covid-designated beds, wards and side rooms.

UEC performance remains a concern, mostly due to exit blocks out of ED, ongoing high numbers of ambulance handover delays and patients waiting 12+ hours. Length of stay is now being monitored from time of arrival to ED instead of ready for transfer. There is ongoing system work around ambulance handovers and CIPHER has played a significant part in our progress via two components:

1) Front door to support ambulance handovers. There has been an improvement in handover times when CIPHER has been on-site, and we are working with YAS to see if they can provide the equivalency of the CIPHER service.

2) Supporting hospital discharge to improve back door exit block. CIPHER supplemented patient services to allow discharge earlier in the day. Additionally, for cases where patients had their own transport and were ready to discharge but were delayed due to waits for medicine/equipment, CIPHER were able to transport these to the patient's home when ready following discharge.

Both elements have been successful as pilots but there has not been funding for this.

A bid has been submitted to NHSE/I for potential allocation of funds to support discharge, which will include the CIPHER component and a funding request to support Bridlington Care Unit with a supplementary offer for social care beds (currently running at 18 beds – the bid is to fund 30). This work is being replicated at York for a care unit with 30 beds, including additional orthopaedic beds and additional capacity for CRT. ML2 noted that the number of patients without right to reside are causing the main pressure on beds. Workforce risk has been identified but ML2 said the benefit of the care unit model is that the workforce model is significantly different to a normal acute ward. Work is underway with local primary care colleagues re primary provision of medical input. SH asked if the CQC would support the care unit approach and HM said this would require discussion first along with clear SOPs for escalation.

SH asked ML2 for an update on two concerns - the fragility of SDEC services and optimal cross-working between ED staff and medical in-patient teams. ML2 said that CG1 are working on a proposal (due for 01 July) around moving to a 24/7 EAU on YH site to mirror that on SGH site. They are working through workforce challenges and opportunities and progress feels positive. ML2 said there has been less traction around cross-working to date.

LS highlighted the following key points for the Committee and Board to note:

We are on track as of 21 June to meet the national trajectory for 0 104-week waits. Most patients were urology, which will result in future work to review what is classed as urgent in this specialty.

Our planning position has been affected by the delay of the elective hub opening at Ramsay Clifton Park Hospital (now due to open in June). This has had a significant impact on our ordinary elective delivery.

A key focus moving forward is our non-admitted position. Following a performance workshop last week, it was agreed that first outpatient appointments will be our next focus. Head and neck services are under particular pressure and is a comparatively small service. Risk needs to be triangulated and from an assurance perspective, we need to review our operational grip on waiting list management.

We are under a higher level of organisational scrutiny and the National Elective Recovery Programme has stratified Trusts into levels of confidence. We are more at risk of not delivering the national ask, which is predominantly due to long routine and cancer performance.

LS referred to the care group requests totalling c.£3.5m and said much is linked to diagnostic provision. There was a discussion around our endoscopy position, particularly around outsourcing. LS said this was a workforce issue and that, whilst capacity will be increased by opening an additional room this year, there is a significant volume of backlogs and surveillance. LS said we have taken an insourcing approach for additional teams to use our endoscopy facilities. JM said that if there is private sector capacity and staffing is our main obstacle, it might be worth revisiting how to make our organisation a

more desirable place to work. LS said that creating a shared service workforce model to allow flex within one resource is an opportunity, but not one that will be achieved this year. Diagnostic meetings are being reinstated to review broader physiological services and there is now an ICS Director of Elective Recovery in post, so we will be looking to them for guidance and additional challenge to improve plans.

Re action 178, LS said the cancer harms report has not been completed in detail but has been escalated to the Cancer Delivery Group. Currently, over half of our patients not yet diagnosed are over 28 days - 128 are over 62 days. There are significant challenges in endoscopy but particularly in histopathology due to workforce challenges.

There was a discussion about how best to track safety and performance following the new Committee structure and SH said he was uncomfortable with not having the same performance insight going forward. MT said that there will be escalations between the two but not a natural shared forum for discussion. There was a discussion about whether the COO Report could be shared in the Blue Box or sent to SH via email and MT agreed to pick this up outside the meeting.

Action: ML2 to bring report on UEC performance progress to August/September meeting

Action: LS to bring cancer harms report to July meeting

Action: MT and WS/LS to discuss COO Report and how best to share with SH following new Committee structure

/ 8. IBR Overview to look at Quality and Safety

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

/ 9. Ockenden Update

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

ML gave an overview of the key points within the report.

Following the relaunch of CNST there is a risk around training compliance. Another significant risk is around MVP (Maternity Voices Partnership), which should have three functioning branches. We are working closely with regional leads to support more chairs. The leads for this are the commissioners.

We are making progress with Ockenden and the risks are not dissimilar to those reported last month. There is work to do with LMS around our SI processes. Our labour ward handovers remain a concern on SGH site. Comparatively we are in a similar position to other Trusts for twice daily MDT ward round handovers, but the Committee agreed that the priority is achieving patient safety and what is expected of us.

The Committee noted that there is an active business case regarding scrub nurse recruitment and LB asked if this could be fast-tracked. SG said that conversations are ongoing with the Associate Chief Operating Officer and Associate Chief Nurse for CG3 to clarify the role. We are looking at workforce models where nurses can both scrub in theatre and care for high-dependency women on delivery suites and prepare them for c-

sections. We are speaking with Mid Yorkshire and Harrogate Hospitals, who have this model in place, and will attempt to fast-track if deemed a safe service.

LB flagged the audit on antenatal risk assessments and the significant drop in second assessments. ML said this was likely an error in the May audit figures.

LB asked about the rise in cold baby incidents over the last 3 months. ML gave assurance that there is an action plan in place for this.

There was a discussion about the upcoming Ockenden visit and HM asked ML where the risk lies. ML said she thought the only element that we could be downgraded on is MVP as we cannot evidence collaborative working. We will likely be questioned on MDT attendance at labour ward handovers, risk assessments, personalised care planning and digital system.

Continuity of carer (CoC) remains suspended and there is no change in the national direction around trajectories. We will revise our workforce plan and need Board agreement to finance the enaction of CoC, which is a significant investment in midwives that we do not have. Even with available revenue recruitment it will be challenging. ML said that Andrew Bertram, Finance Director, has taken this to the ICS for discussion about how to fulfil Ockenden requirements.

ML gave an update on maternity safety champions and confirmed the Trust legal scorecard has been introduced into meetings, which will need to include patient experience and training requirements information.

Action: ML to link in with Hannah Gray (Patient and Public Involvement Lead) re MVP (Maternity Voices Partnership) and patient experience

/ 10. Nurse Workforce Report

HM highlighted the following key points:

Fill rate has improved, and this is evident through reduced sickness and reduced movement of staff.

Re international recruitment, the test of competency (OSCE) should be completed within 4 weeks but we still have nurses who joined us in early 2022 that have not completed this. Leeds and Newcastle have now opened test centres but there has been a significant delay in signing them off. HM said we will request additional funds for international recruitment via Executive Committee and added this is a necessary investment to save in the long term. There was a discussion about the experience level of international recruits and HM said they often have years of experience but do not have the confidence to put themselves forward for leadership roles. The Florence Nightingale Foundation offer a leadership course for BAME international nurses and HM said we are working to send some staff onto this to inspire confidence. ML2 said that there is now a national push around AHP international recruitment of radiographers and occupational therapists. HM asked about the competencies compared to English-trained AHPs and ML2 said she had asked the same question to understand what level of training would be needed in the event of successful recruitment.

HCA recruitment continues to be a focus and Emma George, Assistant Chief Nurse, is working to reduce the recruitment timeline following the national team suggestion of a 4-

week process. Suggestions have been made to improve recruitment. The retention strategy is key to underpinning this work.

HM asked the Committee to note that the University of York have asked us to support their offer of RN apprenticeships.

/ 11. Infection Prevention & Control Update

IPC Monthly Report - May

There are still challenges around C.Diff and HM is now chairing a focused group around this. CG2 are making good progress and are up to date with PIR as well as closing 100% of complaints within the timeline. There remains work to do on YH site around clinical engagement.

The built environment remains an issue. There is a decant ward at YH being utilised both for a short-term HPV and upgrading of minimum one ward, which will take 12 weeks. There is no decant space available at SGH, but they are hoping to do some HPV at the ED front door. SH expressed disappointment at some of the cleanliness issues flagged and HM agreed, noting a lack of basic IPC practice due to senior nurses being redirected to wards rather than having senior oversight. HM said we need to look at how sites are being run as well as the on-call system and bed managers, which will have a cost attached. ML2 agreed and said we need to strengthen our out of hours service and ensure we have greater levels of senior presence, leadership and decision-making within this period. Tara Filby, Deputy Chief Nurse, and Alison Pollard, Associate Chief Nurse, are revisiting this piece of work. HM said IPC staff training compliance is good, but the challenge appears to be translating the learning into practice.

LB asked about the ICNET business case and HM said it was not progressed as it was not deemed a priority.

JM said the action plan (see blue box) may need further work for clarity and HM agreed that the trajectories needed to be clearer and risks more evident.

Since writing the report, there has been a case of monkeypox in YH with further cases expected.

/ 12. Serious Incidents Report

JT talked through the SI reports detailed in Appendix A-D and said he felt there were recurrent themes including high lactate recurring in ED, delayed / mis-diagnosis, diagnostic bias and failure to escalate.

2022/262 – SH asked if the congestion in ED was a significant factor in the outcome. JT said yes and added that the investigator felt the patient's learning disability was also a barrier to care. CJ said another factor was accessibility to learning disability passports on CPD and said work is underway to ensure staff know where to access these.
2022/259 – SH said this was another example of the patient safety risks within ED.

JM asked about the SI process and there was a group discussion about capturing learning and allowing reflection. JT said there is often informal feedback at the time of the incident and a more formal process for clinicians within the appraisal and revalidation process. LB gave assurance that, following a never event in maternity, all staff on the ward were

aware, analytical, and reflective. CJ said the initial incident review is discussed with relevant clinicians at the Quality & Safety meeting to agree whether it is classed as an SI. There is also scheduled training for after-action reviews, which will allow more opportunity for facilitated discussions.

Review of Electrolyte disturbance deaths

The Committee expressed concern about the context of the report considering our regulatory CQC action. The Committee agreed that it was important to differentiate between the CQC concern around nutrition and hydration on wards and this report, which was triggered by our outlier status despite our SHMI being in a reasonably good position. SH suggested a conclusion stating that although deficiencies in care remain and need addressing, we have not found evidence of systemic fault in terms of this question.

Action: JT and MT to discuss the report in more detail and bring update to July meeting under 'Matters Arising'

/ 13. QPaS Quality & Safety Update

Escalation and Assurance Report

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

QPaS Minutes - May

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

/ 14. CQC Compliance Update Report

SM gave an overview of the report and confirmed that we received a Section 29A Warning Notice following the CQC visit. We did not contest this but requested further context and amendments to some minor factual inaccuracies – these requests were declined by the CQC except for one sentence being removed. The draft report has been received – we did not contest but requested minor amendments. These were permitted and the CQC made changes re NIV patients who were not cared for by the correct ratio of nurses as this was incorrect and we were able to provide evidence of this. Our action plan must be submitted by 06 July, which is in progress, and there is an engagement session planned with CG1 to look at any improvement actions that could be included in the plan.

The two main risks are the lack of a PEM consultant at SGH (linked to our previous Section 29A Warning Notice) and our Section 31 Warning Notice from our last inspection regarding mental health care within ED and an inconsistency with the audit results.

JM asked HM how confident she was that we can show evidence of significant improvements. HM said she was relatively confident as we can demonstrate actions taken to improve e.g. introducing support workers to clinical areas to help deliver fundamentals of care as well as appropriate signposting where we cannot. HM said it was important to focus on the elements that were not raised at the last visit. JM said it would be helpful to see progress at Board following the CQC expectations in the form of request and response. SM gave assurance that there is significant background work around the action

plan, which now has more engagement from wards and care groups. SH said it was vital for Board to be sighted on progress.

There was a discussion about digital documentation and HM said the pilot will commence in late July in a medical and surgical ward across both sites with an aim to roll out before Christmas. HM asked the Committee to note that the second phase (to digitalise all records from September onwards) will require business case approval.

/ 15. Integrated Business Report

The report was received and no further discussion was required

/ 16. Consider other potential or new emerging risks

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

/ 17. Patient Experience Update

Annual Complaints Report & Q4 PET Report

HM confirmed the Patient Experience Team will be moving to CJ's portfolio to encourage cohesion between incidents, complaints, and patient experience. There is an additional 8b senior to concentrate on experience, a Patient and Public Involvement Lead and two roles focusing on inclusion, which should now provide the resource to drive the agenda forward.

The Committee was disappointed by staff attitude findings. CJ said a more proactive approach is being adopted to actively seek feedback to triangulate with patient safety data. This will also allow staff a direct insight into their contribution towards patient experience. A patient and carer panel has also been approved for the band 8b recruitment.

There was a discussion about the misalignment between staff perception and patient experience. HM said there is cultural work to do around this as some staff do not seem to recognise how they are perceived by patients.

Item for discussion or escalation

/ 18. Consideration of items to be escalated to the Board or other committees

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

- *For information:* Escalated Items (Digital developments) - Delay in digital developments was escalated from Resources Committee and discussed. It was agreed that there were potentially significant risks to patient safety and further assurance would be sought at a future meeting.

- *For information and escalation:* COO Report - Overall our position with regard to both planned and unscheduled care remains a very significant concern. The position with regard to diagnostic waiting times was discussed as being a particularly worrying situation with associated risk and additional impact on both overall waiting times but also specifically those for cancer. Delay in histopathology reporting times was also flagged.

- *For information:* Maternity Services (Ockenden) - Concerns remain regarding some aspects of maternity services and work to achieve Ockenden standards but recent inspection has had positive outcome.

- *For information and escalation:* IPC - Continued concern around levels of C. diff infections. Lack of decant facility at SGH noted to be a particular concern.

- *For escalation:* CQC - This remains a primary focus of the Committee. There was an ask for more clarity around improvement work. Lack of resolution of long-standing regulatory action from previous inspections was flagged.

/ 19. Any other business

There was no further business to discuss.

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Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Chief Operating Officer's Report
Director Sponsor:	Melanie Liley, Chief Operating Officer
Author:	Lynette Smith, Deputy Director of Planning and Performance

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☐ Our People	☐ Quality Standards
☐ Quality and Safety	☐ Workforce
☒ Elective Recovery	☐ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

The Trust remains under significant operational pressure, with resultant delays to patient pathways across emergency care, elective care and cancer.

- 72.7% of emergency department patients were admitted, transferred, or discharged within four hours.
- The Trust reported 727 twelve-hour Trolley Breaches.
- May 2022 saw challenging cancer performance with the Trust achieving two out of the eight core national standards (Cancer is reported a month in arrears).
- 3,102 fifty-two week wait pathways have been declared for the end of June 2022.
- Eight 104+ week wait pathways have been declared for the end of June 2022 (one COVID positive patient and seven patients who were offered a date before the end of June).

- The Trust saw a small reduction against the overall Referral to Treatment backlog, with the percentage of patients waiting under eighteen weeks at month end increasing from 59.4% in May 2022 to 59.0% at the end of June 2022.

The Trust has an agreed programme of work 'Building Better Care' to improve acute flow and support elective and cancer recovery.

The Trust is below plan for activity in Quarter 1, notably for first appointments and ordinary elective activity.

Recommendation:

That the Board of Directors notes the operational position and associated actions detailed in the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
N/A	N/A	N/A

Chief Operating Officer's Report

1. Introduction and Background

This report sets out the key performance issues as reported in the Integrated Business Report (IBR) and the operational update for Finance and Performance Assurance Committee oversight.

2. Considerations

That the Board of Directors notes the operational position and associated actions detailed in the report

3. Current Position/Issues

3.1 NHS Oversight Framework

The new NHS Oversight Framework has been published at the end of June setting out the revised arrangements for oversight at both a system and provider level (https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/). This includes the updated oversight metrics which align to the national operational planning priorities for 2022/23These have been incorporated into the updated proposals for the integrated Business Report for activity and performance.

3.2 Operational Position

The Trust has seen a recent increase in the number of COVID-19 positive patients with 145 patients in our acute and community hospitals confirmed with COVID-19 at the time of writing the report. The Trust's Pandemic Command and Control structure was stepped down on the 13th June with a return to 'Business as Usual' operational management. COVID-19 management is now supported by the 'Living with COVID-19' working group.

3.3 June 2022 Performance Headlines:

- 72.7% of emergency department patients were admitted, transferred, or discharged within four hours.
- The Trust reported 727 twelve-hour Trolley Breaches.
- May 2022 saw challenging cancer performance with the Trust achieving two out of the eight core national standards (Cancer is reported a month in arrears).
- 3,102 fifty-two week wait pathways have been declared for the end of June 2022.
- Eight 104+ week wait pathways have been declared for the end of June 2022.
- The Trust saw a small reduction against the overall Referral to Treatment backlog, with the percentage of patients waiting under eighteen weeks at month end increasing from 59.4% in May 2022 to 59.0% at the end of June 2022.

3.4 Emergency Care

The Trust continued to experience sustained pressure on the emergency care pathways at both York and Scarborough Hospitals, with both sites declaring severe or extreme pressure for the majority of June.

Non-elective admissions have returned to 19/20 levels (96% of 19/20 admissions for Quarter 1) however flow of patients from the Emergency Department to ward based care remains a significant challenge. The management of COVID-19 patients within the bed base combined with increasing numbers of delayed patients has limited the available admitting capacity at both hospitals. The Trust has seen a 165% increase in average bed days for super stranded patients compared to June 21, and overall, the Trust has seen an increase in Length of Stay (LoS) compared to June 21. This is notable at York Hospital where LoS increased from 3.3 days in June 21 to 5.0 days in May 22 (excluding Same Day Emergency Care Patients).

The Trust has also made the decision to close a ward ay York Hospital to support safe nurse staffing levels and act as a decant ward to facilitate the Infection Prevention and Control cleaning programme.

The delays to patient flow have resulted in 727 patients waiting more than 12 hours to admission to a ward, and 15% of all patients attending an emergency department (Type 1 patients) waiting more than 12 hours in the department. Ambulance handovers continue to see extended delays, with 672 handovers over 1 hour in June. The latter does however represent an improvement in performance compared to March – May 22.

Handover delays reduce the capacity of the Ambulance service to respond to emergencies. The Yorkshire Ambulance Service (YAS) is experiencing significant challenges affecting both category 1 and 2 reported response times.

The Trust has agreed acute flow as one of the four priorities of the Board this year. This is being delivered through the Building Better Care Programme and Care Group plans. The operational and clinical teams are focussed on improving timeliness of ambulance handover and initial assessment of patients, increasing the range of Same Day Emergency Care to reduce demand on the wards and improving discharge before 5pm.

The new Emergency Department builds at both York and Scarborough will facilitate improvements in flow through increased assessment and Same Day Emergency Care clinical space.

3.5 Elective Recovery and Diagnostics

The Trust has achieved the ask of the national team to be able to offer all patients waiting two years a treatment date by the end of June. One patient caught COVID 19 before surgery, and seven patients chose to delay their offer date for a variety of reasons (P6 patients).

The Elective Hub at Clifton Park Hospital (Ramsay Health Care Group) is now operational, providing a separation of acute and some elective work for orthopaedic and urology services.

The Trust is seeing a significant rise in the Referral for Treatment Times total waiting list (RTT TWL), with a 43% rise in patient pathways on the waiting list compared to June 21 (30,707 to 44,103 June 22). The main driver in this is a reduction in 'clock stops' rather than a significant increase in referrals.

The extended waiting times to first appointment, balancing between first appointments and overdue follow up appointments and an overall reduction in outpatient capacity had contributed to this rise. Elective capacity has been affected by theatre staffing shortfalls, overnight bed capacity and a delay in the Elective Hub at Ramsay site commencing.

The Trust remains at risk of not treating all 78 week patients by the end of March 23 and as a result the Trust has been placed in 'Tier 2' monitoring for elective recovery. This will include more regular assurance meetings with NHSE/I to report on progress, in addition to weekly data submissions.

Elective Backlogs is one of the four priorities of the Board. This is being delivered through the Building Better Care and includes:

- Increasing theatre and outpatient productivity
- Creating additional capacity – outsourcing/ insourcing/ separation of acute and elective
- Helping patients remain fit for treatment (reduce on the day cancellations)
- New pathways for outpatients, including referral triage, patient initiated follow ups and digital communications.

Urology and Colorectal specialities remain at high risk for 104 week waiters. Both specialties have been involved in the Integrated Care System elective recovery work, with Urology supported through mutual aid by both Hull University Teaching Hospital (HUTH) and North Lincolnshire and Goole NHS Foundation Trust (NLaG). In respect of Outpatients, Head and Neck services are working to recover their first appointment and waiting list position and Ophthalmology are a specific focus due to the volume of high-risk patients within the follow up backlogs.

The Trust is an outlier for the diagnostic 6 week target, at 51.8% (target 99%). Improvements in the times to diagnostics are critical to improving timely treatment in cancer and routine elective services. The Cancer and Support Services Care Group have provided a recovery plan to Executive and the Trust has requested support from the new Director of Elective Recovery for the ICS.

3.6 Cancer

The Trust has seen improved performance at the start of the cancer pathways (two week wait from GP referral and Breast Symptomatic) because of the breast service recovery. While not yet achieving the breast symptomatic targets, the service has improved from 16% in January to 87.5% in May. The Trust narrowly missed the target for 31 days from diagnosis to treatment (96%) at 95.5%, this continues to be a risk for the organisation due to the oncology workforce challenges and ongoing theatre staffing shortfalls.

The delays in the diagnostic pathways continue to be the most significant contributor to the delays to the 62 days position (62% for May). The Building Better Care Early Staging and Diagnosis Programme is focussed on extending Rapid Diagnostic Centre principles across more tumour pathways, implementation of the national timed pathways and the role of pathway navigators to support patients and expedite their care.

4. Operational Activity Plan

4.1 The Operational Activity Plan for 2022-23 is in delivery.

Activity position:

The Trust has delivered the following activity against plan and 19/20 outturn.

Point of Delivery	Q1 Actuals	% 2022-23 plan	% of 19-20 outturn
First Appointment	39,847	75%	95%
Follow Up	96,378	112.6%	102%
Day Case	18,343	88%	101%
Ordinary Elective	1553	75.5%	75.8%

The risks around COVID-19 prevalence, operational pressures, theatre staffing and sickness absence materialised in Quarter 1 and is reflected in the surgical position. In addition, the delay to the Elective Hub has affected the Orthopaedic position, which has a material effect on the Q1 weighted activity position.

5. Recommendation:

That the Board of Directors notes the operational position and associated actions detailed in the report.

Date: 18th July 2022

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 July 2022 (June data)
Subject:	Integrated Business Report Executive Summaries
Director Sponsor:	Shown on individual Executive Summaries
Author:	Shown on individual Executive Summaries

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☒ Our People	☒ Quality Standards
☒ Quality and Safety	☐ Workforce
☒ Elective Recovery	☒ Safety Standards
☒ Acute Flow	☒ Financial
	☒ Performance Targets
	☒ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:
As contained in individual summaries

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

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History
(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
N/A	N/A	N/A

Quality & Safety

Incidents:

- The number of patient falls has reduced in June however is still showing a higher incidence than any month in 2021 so remains a concern. When converted to falls per 1000 bed days, we have seen a slight reduction over the last 3 months which is indicative of progress. Quality targets have been agreed for the remainder of this year and the improvement plan refreshed in accordance with these. A full time Band 7 Falls Prevention Lead post is currently out to advert and will aim to be in post by Q3.

- The incidence of pressure damage has increased again in month, which is evidence of the ongoing high acuity of patients and the workforce challenges in providing care to the prescribed frequency. Adverts have been placed to recruit 2 additional Tissue Viability Nurses to support ward-based education and this will also help to improve the categorisation of pressure ulcers, ensuring reporting is accurate.

Medication Incidents/Pharmacy:

- There continues to be a run above average for anticoagulant incidents, although remains in normal variation. The anticoagulant incidents are reviewed by the VTE committee and the Medication Safety Officer.
- The percentage of VTE risk assessments continues to fall below the target of 95%, deteriorating by 1% in June 2022 to 86.2%.

Complaints:

- Overall Trust performance with complaints has increased to 59% (from 57%), the targeted aim is to achieve above 90%. Only Care Group 2 and 4 met this target. Each Care Group meets with the Patient Experience Team weekly to address this performance and progress complaint investigations. All complaints are now overseen by the Quality and Safety Group for oversight of safety concerns.

Deteriorating Patient:

- Observation (NEWS2) compliance across the York has improved slightly and now sits at 85.7%. There is a run of 10 data points below the mean. Scarborough maintains above 90%. NEWS2 performance is an agenda item at the Deteriorating Patient Group.
- 14 hour post take percentage deteriorates further at York, there is a downward trend since February from the mean to current performance at now 74.9%. Scarborough have improved in the last month and are now up to 85.9%.
- The recently created 7 day standards service meeting will concentrate on improvements with this performance metric.

Infection Prevention & Control:

- The incidence of C.difficile remains high in the organisation. The C-Difficile target for 2022/23 is 117 cases. Three Wards across the organisation received a bay by bay HPV program; and 1 ward received a full decant and HPV program. Ward 26 is planned for decant, full refurbishment and HPV commencing on 30/6/2022. This is a strategy to reduce the incidence of *C.difficile.*

Maternity:

- There are some missing metrics on the dashboards this month due to Covid and staff shortages.
- Vacancies and sickness continue to be the barriers to providing a consistent homebirth service. Recruitment continues.

- There is an increase in 3/4th Degree tears; this is also mirrored in the shoulder dystocia figures. These have all been looked into and no concerns raised regarding trends. Screening and subsequent management of LGA pregnancies is now being discussed at consultant level.

Mortality:

- ED deaths now demonstrate normal variation with no cause for concern. From May 2022, the Medical Examiner team has prioritised reviewing all ED deaths to ensure scrutiny occurs as close to the death as possible. An audit of 12 hour stays in ED continue, which shows areas for improvement in risk assessments for Falls and Pressure Ulcers.

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

Finance

Financial Position – June 2022 (Month 3)

1. Summary Plan Position

At its June 2022 meeting the Board of Directors approved the final I&E balanced annual financial plan, which formalised the e-mail acceptance of the plan previously received by the Finance Director from Board members. The final plan replaced the draft £11.8m I&E deficit annual financial plan previously approved by the Board. The final plan is now set into the ledger and is being used to monitor current performance. Operational budgets have been set on this basis.

2. Income and Expenditure Position

The I&E table below confirms an actual deficit of £0.51m against a planned deficit of £0.03m for June. The Trust is £0.48m adversely adrift of plan. Notable variances include an overspend on pay of £0.6m, an overspend on drugs of £0.1m (£1.2m relating to out of tariff drug income from NHSE), an underspend on clinical supplies and services and other costs of £2.4m, and the CIP position is behind plan by £2.5m. At this stage the clinical supplies and services position is partially compensating for the under delivery of the efficiency programme.

Also of note is that we spent £2.528m for the year to date on covid costs compared to a plan of £1.872m; therefore we are £0.656m adversely adrift of our covid plan. The plan is net of the £3.5m funding removed in discussion with the ICS to help reduce the I&E deficit plan. Although the Q1 position on Covid spending is an adverse one, it should be noted that spending levels have gradually declined month on month during the quarter. This expenditure relates to, so called, inside the envelope covid funding where the spending is against a fixed allocation. There remains some covid expenditure, relating in the main to testing, that is outside of the envelope and is subject to its own direct funding recharge arrangements.

Income and Expenditure Account

	Annual Plan	YTD Plan	YTD Actual	YTD Variance	FOT
	£000's	£000's	£000's	£000's	£000's
NHS England	74,545	18,636	19,844	1,208	74,545
Clinical commissioning groups	519,650	129,913	129,867	-46	519,650
Local authorities	4,793	1,179	1,182	4	4,793
Non-NHS: private patients	514	129	88	-41	514
Non-NHS: other	1,186	296	339	43	1,186
Operating Income from Patient Care Activities	**600,688**	**150,152**	**151,320**	**1,168**	**600,688**
Research and development	1,815	454	662	209	1,815
Education and training	20,871	5,218	5,936	718	20,871
Other income	50,310	12,575	10,616	-1,960	50,310
Other Operating Income	**72,995**	**18,247**	**17,214**	**-1,033**	**72,995**
Employee Expenses	-441,175	-109,954	-110,559	-604	-441,175
Drugs Costs	-63,694	-15,924	-16,067	-143	-63,694
Supplies and Services - Clinical	-68,353	-17,095	-14,772	2,323	-68,353
Depreciation	-18,291	-4,573	-4,573	0	-18,291
Amortisation	-1,521	-380	-380	0	-1,521
CIP	13,499	2,527	0	-2,527	13,499
Other Costs	-76,062	-18,509	-18,427	83	-76,062
Total Operating Expenditure	**-655,597**	**-163,908**	**-164,777**	**-869**	**-655,597**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**4,491**	**3,757**	**-734**	**18,086**
Finance income	30	8	121	114	30
Finance expense	-975	-244	-106	138	-975
PDC dividends payable/refundable	-8,014	-2,003	-2,004	-1	-8,014
NET FINANCE COSTS	**9,127**	**2,251**	**1,768**	**-483**	**9,127**
Other gains/(losses) including disposal of assets	0	0	0	0	0
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0
Movements in fair value of investments and liabilities	0	0	0	0	0
Corporation tax expense	0	0	0	0	0
Surplus/(Deficit) for the Period	**9,127**	**2,251**	**1,768**	**-483**	**9,127**
Remove Donated Asset Income	-9,607	-2,402	-2,402	0	-9,607
Remove Donated Asset Depreciation	452	113	113	0	452
Remove Donated Asset Amortisation	28	7	7	0	28
Remove net impact of DHSC centrally procured inventories	0	0	0	0	0
Remove Impairments	0	0	0	0	0
Remove Gains/(losses) from transfers by absorption	0	0	0	0	0
NHSI Adjusted Financial Performance Surplus/(Deficit)	**0**	**-31**	**-513**	**-483**	**0**

3. Cost Improvement programme

The core efficiency programme requirement for 2022/23 is £15.5m. This is the core value to be removed from operational budgets as we progress through the financial year and deliver cash-releasing savings.

The Board will be aware through the financial plan presentations that NHSE/I required technical efficiencies, covid spend reductions and estimated productivity gains to be expressed as CIPs. These total a further £16.9m (shown against Corporate CIP below) and increase the full programme value to £32.4m. The table below details the full programme.

2022/23 Cost Improvement Programme - June									
		June Position			Planning Position		Planning Risk		
Care Group	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£3,015	£651	£52	£599	£699	£2,315	£447	£252	£0
2. Acute, Emergency and Elderly Medicine (Scarborough)	£1,404	£303	£303	£0	£498	£906	£498	£0	£0
3. Surgery	£3,008	£649	£136	£514	£2,199	£809	£1,701	£498	£0
4. Cancer and Support Services	£2,552	£551	£29	£522	£855	£1,697	£519	£0	£336
5. Family Health	£1,595	£344	£8	£336	£701	£893	£140	£60	£501
6. Specialised Medicine	£1,639	£354	£177	£176	£1,606	£33	£1,500	£106	£0
7. Corporate Functions									
Chief Exec	£65	£14	£0	£14	£1	£65	£1	£0	£0
Chief Nurse Team	£164	£35	£0	£35	£64	£100	£64	£0	£0
Finance	£184	£40	£17	£22	£148	£35	£148	£0	£0
Medical Governance	£15	£3	£0	£3	£0	£15	£0	£0	£0
Ops Management	£101	£22	£0	£22	£0	£101	£0	£0	£0
Corporate CIP	£16,890	£4,223	£4,223	£0	£24,280	-£7,390	£19,854	£507	£3,920
DIS	£289	£62	£0	£62	£30	£259	£30	£0	£0
Workforce & OD	£314	£68	£0	£68	£412	-£98	£412	£0	£0
				£0					
Sub total	**£31,234**	**£7,319**	**£4,945**	**£2,374**	**£31,495**	**-£261**	**£25,314**	**£1,423**	**£4,758**
YTHFM LLP	£1,123	£242	£90	£153	£862	£261	£423	£364	£74
Group Total	**£32,357**	**£7,561**	**£5,035**	**£2,527**	**£32,357**	**£0**	**£25,737**	**£1,787**	**£4,832**

Delivery in month 3 remains poor in terms of the core programme delivery but of significant note is that plans have now been identified to deliver the total programme of £32.4m, and of this sum £25.7m (79.3%) is identified as low delivery risk.

4. Unfunded Revenue Schemes

There are a small number of revenue schemes running that do not currently have funding. These are outside of our plan. The table below confirms the schemes and the current position in terms of action being taken.

Scheme	Annual Cost	Comments	Funding Action	Timeline for Resolution	Update
Mobile CT	**£1,400,000**	This relates to a fully staffed and fully utilised mobile CT facility. This is key to our diagnostic recovery work. The scanner has previously been funded through the national diagnostic programme and more latterly the community diagnostic programme. No funding has been agreed but we continue with the hire of the scanner.	NHSE/I are involved, along with the ICS, in seeking to secure funding as a pre-commitment from this year's community diagnostic hub. No further action is required from the Trust at this time. At present this is reported as a gross cost in our position.	Urgent. Further update requests sent to NHSE/I but no funding identified yet.	Continuing in operation. NHSE/I and ICS aware. Causing £0.23m pressure on our plan. ICS CDH team are submitting national case for support, working with the Trust. No timeline information available, expect 1-2 months for clarity.
CG1 Discharge Command	**£115,000**	This initiative was funded last year through Hospital Discharge Programme funding. We have been requested to cease all HDP funded schemes, but this is deemed a priority to continue to support discharge at a time of such significant operational pressure. This is not funded within our plan.	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working through a prioritisation process in order to identify funds that can be diverted to support this.	End of May 22	Agreement reached with CG1 for covering expenditure non-recurrently using temporary vacancies elsewhere in the CG.
CG2 Weekend Therapy Service	**£93,000**	This initiative was funded last year through additional winter funding. This has now been withdrawn. The service provides a weekend therapy team to continue therapy	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working	End of May 22	Agreement reached with CG2 for covering expenditure non-recurrently using temporary

		intervention and to support discharge.	through a prioritisation process in order to identify funds that can be diverted to support this.		vacancies elsewhere in the CG.
CIPHER Ambulance Cohort Service	**£1,000,000**	This is a new service, deployed in order to respond to the requirement to release ambulance crews in a timely way given the significant operational pressure on the York site and the significant number of delayed ambulance handovers. CIPHER provide a nurse/paramedic and a care assistant to provide cohorted care for ambulance patients pending ED capacity becoming available. Data shows a marked improvement in ambulance release times when deployed.	The service has been used at peak times and over bank holiday weekends and is expected to cost in excess of £50k through to the Jubilee weekend. Requests to deploy are increasing and full 24/7 cover would equate to £1m in full year terms. This is not included in our plan and is a new service development. Discussions are underway with the ICS and NHSE/I as to where the liability lies for the cost and how best the service can be provided. At present this is reported as a gross cost in our position.	End of June 22	Confirmation received from ICS that there is no external funding to support this cost at the Trust. Discussions continue between ICS and YAS as to the future arrangements. The Trust has ceased used after the Jubilee bank holiday weekend to limit expenditure.

5. Next Steps

The rules around exactly how ERF will operate in 2022/23 are still being finalised but based on current national guidance, ERF funding received by the Trust as part of our contract baseline values, are subject to repayment where the weighted activity levels in 2022/23 fall below the 104% target of 19/20 levels.

If the rules were to be strictly applied to quarter 1 then we would potentially lose ERF income of £3.0m. In summary, this is calculated by taking the Trust's current year to date (Q1) performance in terms of weighted activity (89.1%) and assessing it against the 19/20 baseline and the 104% weighted target.

This variance is then converted to a financial value using 19/20 baseline data and then a 75% adjustment is made to reflect the ERF rule that any underperformance is only paid back at 75%. A final check and adjustments against the lower ERF floor level cap is applied where applicable.

The calculation is as follows:-

- Weighted target baseline at M3 is £45.6m (104% of 19/20 baseline of £43.8m)
- Trust actual weighted activity M3 is £39.1m (89.1% of 19/20 baseline of £43.8m)
- Difference between weighted target baseline and actual weighted activity is £6.5m
- Apply 75% lower floor adjustment (£6.5m x 75%) = £4.9m potential clawback
- Check value against ERF funding received at M3 and where lower limit clawback to 75%
- ERF funding received at M3 = £4.0m
- Clawback limited to 75% (£4m x 75%) = £3.0m

At this stage there does not appear to be any clawback action being taken at a national level, recognising the nationally experienced difficulties in recovering activity, the continued presence of covid and the exceptional non-elective pressures. It has been agreed across the ICS to not assume in our reported position any clawback of ERF for Q1.

The Board are aware that the plan is required to deliver 104% of the 2019/20 baseline activity level. Our plan seeks to do this. We have also been asked to identify what we believe would be our core activity delivery, where we have good confidence in delivery levels. The Care Groups have identified this to be at 99.6% of the 2019/20 baseline level.

Should the ERF policy be invoked in full and care groups hit the 99.6% level then we would expect to lose income of £5.6m. This calculation is summarised as:-

- Target performance less actual performance (104% less 99.6%) = 4.4%
- 4.4% of 19/20 weighted baseline value at month 12 (4.4% x £170.34m) = £7.5m
- Apply 75% adjustment = 75% x £7.5m = £5.6m potential clawback

We have also assessed that we would avoid costs of £1.7m. This would result a net risk impact on Trust I&E plan of £3.9m. This information was shared with the ICS as part of the final plan submission process.

In light of the actual performance in Q1 of 89.1%, the achievement of the Care Group assessed realistic level of 99.6% during 2022/23 appears to becoming even more challenging; and would require performance to improve to 103.1% for the remaining 9 months of the year to meet the assessed realistic level. Is it therefore possible that the Trust being able to limit the potential clawback of ERF to £5.6m as identified above, is at risk.

Finally, it should be noted that ERF is calculated across ICB level, so the above figures are indicative based on Trust current performance only and that final adjustment could vary based on overall ICB system performance.

6. Current Cash Position

June cash balance showed a £7.4m adverse variance to plan; this is mainly due to capital payables being settled earlier than expected in the plan. The table below shows our current planned month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	64,116	51,724	46,792	45,940	36,713	28,767	29,536	25,914	24,971	26,746	29,538	41,600
Actual	51,793	45,722	39,382									

There is more analysis to do in relation to cash management this financial year as we start to understand how ERF will flow into the Trust and as we map out the non-recurrent timing benefit we will have from national funded capital schemes. At this stage we are not predicting cash problems will emerge in the next 12 months, but this is conditional on managing all aspects of the income and expenditure plan.

7. Current Capital Position

The total capital programme for 2022-23 is £86.5m; this includes £22.8m of lease budget that has transferred to capital under the new lease accounting standard and £50m of external funding that the Trust has secured via Public Dividend Capital funding (nationally funded schemes) and charitable funding.

Capital Plan 2022-23 £000s	Mth 3 Planned Spend £000s	Mth 3 Actual Spend £000s	Variance £000s
86,513	11,103	3,688	(7,415)

Prioritisation of the discretionary element of the capital programme has now concluded and was approved by the Board at its June meeting.

All capital schemes are now progressing.

8. Risk Overview

The financial plan includes significant risk, discussed and acknowledged at the time of Board approval. The table below summarises the risks, the mitigation and the latest update.

Risk Issue	Comments	Mitigation/Management	Current Update
Delivery of the efficiency requirement	At 2.4% the cost out efficiency programme is arguably manageable in comparison to previous years but the programme has been halted for the last 2 years and clinical teams are focused elsewhere in terms of workforce issues and elective recovery.	The Corporate Efficiency Team has restarted its full support programme. The BBC programme is linked to efficiency delivery opportunities. Full CIP reporting will recommence. CIP panel meetings will be reconvened with the CEO.	Whilst delivery of the Core Programme has remained poor in month 3 the work with Care Groups and Corporate Teams has identified plans equal to the full value of the required programme. Notably 79% of plans are categorised as low risk. Best practice would suggest plans should exceed target in order to hold contingency against delivery shortfall.
Retention of ERF Funding through delivery of 104% activity levels	ERF is lost at the rate of 75% of tariff value for under recovery of the 104% required activity level.	A full 104% activity plan has been devised. Full monitoring of delivery will be implemented. The BBC programme picks up elective recovery as a specific work stream.	Monitoring data awaited and detailed ERF operating rules are yet to be properly understood as to how the programme will be operated.
Managing the Covid spend reduction	The plan proposed with the ICB requires a £3.5m reduction on covid spend linked to reducing IPC requirements and the national covid expenditure reduction programme.	Work is underway with the CGs and YTHFM to look for opportunities. If necessary a formal task and finish group will be required to work alongside IPC and the Care Groups to manage covid expenditure down. Formal monitoring in now in place.	This review work has commenced with the Care Groups and is looking to specifically step down spend later in the year to coincide with expected continued downward patient trends. Currently £1.5m has been identified against the £3.5m target
Managing the investment reduction programme	£2m of the required £4.3m investment reduction programme had been identified at the original time of planning. The remaining reduction will require management through the release of activity pressure funding into operational budgets.	Formal monitoring will be required to track progress. This has been implemented.	The first stage of this review work has been completed and £3.6m of the £4.3m reduction requirement has been identified. Work continues to close this gap and will scrutinise the release of additional funding into budget going forward.
Expenditure Control	Formal budgets identified through this planning process will require careful management to ensure expenditure compliance and to ensure that any investments made are matched with identified funding sources.	Finance reporting will require enhanced variance analysis and assurance processes. Reporting into the Exec Committee and Board of Directors will be refined to provide greater assurance and transparency. Compliance with the scheme of delegation regarding expenditure approval will be monitored.	This report identifies unfunded expenditure along with details of action being taken regarding funding. There are no control issues at this stage to highlight.
Winter funding pressures	The plan removes the Trust's typical winter contingency that would normally allow further	Full knowledge has been shared to ensure that the ICB and regional teams are aware that	Early information has been shared that suggests £250m will be released

	investments to be made at peak activity times.	providers are not holding winter contingencies on the grounds of affordability. Additional funding would need to be sought in the evet of material pressures. Our approach is consistent with other providers.	nationally for additional winter capacity. We expect to be working with ICS colleagues on this programme in the coming month.
The ICB may seek to further reduce expenditure to manage with overall resources.	We will be required to work with the ICB should this prove to be the case. Clinical teams would be required to work alongside the Exec Team and the ICB.	Formal monitoring would be required alongside a quality impact assessment programme in the event of real service expenditure reductions being required.	This risk is reducing with the release of national funding to the ICS to part-close the financial plan gap. The proposed ICS solution for the remainder does not impose further savings requirements on the Trust beyond those already committed to.
Management of the Capital Programme	The 2022/23 capital programme is the largest programme the Trust has ever undertaken. There is significant risk in managing to approved CDEL limits; both in terms of pressure on the programme for additional spend but also difficulty in spending due to construction industry difficulties associated with Brexit, the pandemic and the Ukraine conflict.	The programme is managed by CEPG. Monitoring provided at Board level. Prioritisation exercise has now concluded to agree the final discretionary elements of the programme for 22/23.	The key risk just now is the York ED scheme with a predicted overspend of £3.7m. Discussions are underway with Kier and other partners to limit the impact of this overspend on the available discretionary funding.

9. Recommendation

The Board of Directors is asked to discuss and note the June 2022 financial position for the Trust.

Date: July 2022

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

Research & Development

Our key outcomes in the last month are as follows:

- We have submitted several grants for funding in the month of June, as follows:
    - 200K to **Wellbeing of Women** ICalM - Intraoperative Calcium to reduce Maternal Haemorrhage: Dr Mo Williams
    - 500K to **CRUK**- Extending the evidence base for Colon Capsule Endoscopy (CCE) in symptomatic patients: Dr James Turvill
    - 131K to **Wellbeing of Women-** Lifestyle and workplace risk factors for menopausal symptoms among perimenopausal and menopausal NHS shift workers: Dr Sarah Baker
    - We have supported Dr Adam Odell (YSJU) for Springboard application to the Springboard scheme for biomedical scientists run by the Academy of Medical Sciences. Dr David Yates supported the application that is focusing on analysing immune cell activation and soluble marker levels, before, during pre-hab, and post-surgery/recovery.

- A grant we submitted few months ago has been successful

- Dr James Turvill has applied to Innovate UK. The consortium aims to use artificial intelligence (AI) to develop a multi-variable algorithm to improve diagnostic yield of Faecal immunochemical testing (FIT) for symptomatic patients presenting at primary care. Total award was £500K with £86K coming to the Trust.

- We are currently trying to build local collaborations to allow us to bid for a national call out in September to build capacity and capability in liver disease research
- We have been informed by NIHR that we will keep our research budget for the text two financial years whilst new funding models are considered (£1.3M per annum)
- We have also been informed by NIHR that our accrual target has dropped to 3506
- We have had our annual CRN review that went very well and we received excellent feedback. The review team loved the initiatives we are undertaking in the team and the way we work together across all our teams to deliver a very impressive portfolio of research through an agile workforce.
- We have held a Critical Friend Review at Mid Yorks NHS Trust and we ourselves will be reviewed in October
- A New Clinical Lecturer (University of York employed) has started this month under the HYMS Integrated Academic Training Programme
- The R&D team and our researchers have had a large input into this month's HYMS Research Day and York's St John's Research Day; both events were well attended, led to some good contacts being made and were a great success.
- Upcoming events- dates for your diaries

  21st November we are going to host our first Annual Celebration of Research event that will be held at the Principal Hotel York. Details will follow

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

Operational Performance

Nationally, the COVID-19 Pandemic NHS Emergency Preparedness, Resilience and Response incident level moved down to a level three regional response on the 19th of May 2022. A level 3 regional response is defined as "An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England will coordinate the NHS response in collaboration with local commissioners at the tactical level".

The Trust's Pandemic Command and Control structure was stepped down on the 13th June. The Trust's 'Living with Covid' group will continue to meet to respond to national and regional 'asks'; and how the Trust responds and manages this.

As at the 11th of July there were 132 COVID-19 positive inpatients in our acute and community hospitals. A steady increase was seen through June having been at fifty-six on the 10th of June. The Trust's COVID-19 inpatients peaked at 287 on the 30th of March 2022 (reported via Trust's external SitRep submission).

The Trust has had 6,189 COVID-19 positive inpatients since 17th March 2020, with 5,019 patients discharged, sadly 1,015 patients have died. Since the beginning of July 2021 there have been 3,377 new COVID-19 positive inpatients and 401 deaths.

As at the 11th of July, York Hospital has one dedicated COVID-19 positive ward and one COVID-19 positive wards/areas at Scarborough Hospital with several wards managing COVID-19 positive patients in side rooms and/or cohorting in bays where there is a specific specialty clinical need. The majority of COVID-19 positive patients are not being treated for COVID-19 as their primary complaint. However, the need to manage high risk patients separately and cohort COVID-19 positive patients due to Infection Prevention Control (IPC) requirements creates flow (bed) issues and impacts on the Trust's ability to admit elective patients as patients cannot be admitted onto wards where there are COVID-19 positive patients.

The Trust's COVID-19 surge plan remains in place to respond to further requirements for additional beds.

Trust Planning

The workforce risk that the Trust highlighted as part of 2021-22 activity plan materialised to a greater extent than was anticipated and has continued into 2022-23. This has affected not just the Trust but all partners. NYCC, TEWV, YAS, Primary Care and Vocare who have all been operating at their highest level of escalation due to workforce pressures over the last year, limiting the availability of support from the system to reduce delays to patients or support urgent care demand. Overall, the Trust's sickness absence rate is 7.4% with 724 absent as at the 8th of July, 30% of the absences relate to COVID-19.

The pressure on medical staffing contributed to the cancellation of 222 outpatient clinics within fourteen days of the planned date and there were 124 elective patients cancelled by the Trust within forty-eight hours of their intended surgery date due to non-clinical reasons.

Compared to the activity outturn in June 2019 the Trust delivered the following levels of elective care activity:

Point of Delivery	June 2019 Outturn	June 2022 Actual	Variance	Proportion of June 2019 delivered in June 2022
Advice & Guidance	1,955	4,099	2,144	210%
First Outpatient Appts	14,114	13,588	-526	96%
Follow up Outpatient Appts	30,878	32,155	1,277	104%
Ordinary Electives*	730	518	-212	71%
Day Cases	5,982	6,096	114	102%

*Ordinary Elective figures are based on discharge date.

June 2022 Performance Headlines:

•72.7% of ED patients were admitted, transferred, or discharged within four hours.

•The Trust reported 727 twelve-hour Trolley Breaches.

•May 2022 saw challenging cancer performance with the Trust achieving two out of the eight core national standards.

•3,102 fifty-two week wait pathways have been declared for the end of June 2022.

•Eight 104+ week wait pathways have been declared for the end of June 2022. This number, as per updated national guidance, includes those patients who have requested to defer their treatment. There were seven such patients at the end of May 2022. The final patient was COVID-19 positive at the end of June and could not be treated. The Trust therefore achieved our target of treating all our 104 weeks wait patients by the end of June.

•The Trust saw a small reduction against the overall Referral to Treatment backlog, with the percentage of patients waiting under eighteen weeks at month end increasing from 59.4% in May 2022 to 59.0% at the end of June 2022.

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

Digital and Information Service

People

- James Hawkins, incoming CDIO will start on 30th August 22. Knowledge transfer from Interim CDIO has begun.
- The Head of Digital Delivery (Jane Clayson) started on 4th July.
- The CTO (Luke Stockdale) continues with successful probationary period. Phase 2 Operating Model now developed and early engagement with HR/Finance colleagues further improving the capability of the CTO Function. Significant improvement in the working environment at Park House/Scarborough DIS office - i.e. set up room/installation of Service Desk dashboards
- The CNIO (Nik Coventry) continues with successful probationary period.
- CPD Developer recruitment continues to prove difficult despite a number of different avenues being pursued.

Processes

- Refreshed EPR Strategic Outline Case has been completed as part of alignment with the overall ICS EPR Strategy and submitted to the NHSEI Regional Finance team for ‘early healthcheck'.
- NHS England have indicated that YSTHFT is eligible for £45.7m funding (85% Capital allocated to the Trust, 15% Revenue allocated to the ICS) from the Frontline Digitisation Programme to support affordability over the next 3 years. This represents 80% of the expected costs of procuring a new EPR system, with the remaining 20% expected to be match funded by the Trust over 5 years.
- YSTHFT will collaborate with partners in the ICS to explore the level of ambition for joint procurement of new EPR system with approximately ~£90-£100m of funding in total across the ICS partners.
- The DIS Team have worked with Finance colleagues on prioritising the discretionary capital schemes for FY 22/23, with the priority on risk mitigation, operational effectiveness and service transformation. The EPR Funding may provide an avenue to support Essential Services Programme work to underpin EPR and release pressure on the discretionary Capital programme this FY.

- Work continues on the Service Management, with early benefits been realised around the Problem Management work improving first time fix rate.

  Aggressive timelines for the holistic partner tender for infrastructure, hardware provision and telecoms for completion in September 22.
- The CTO team, alongside Becky Bradley and the IG have worked closely with Audit to complete the Trusts DSP Toolkit regulatory compliance report in line with expectations.

Technology

- Agreed at ESP Board to put VDI Solution on hold to ensure we are not incurring burn rate without any delivery due to resource implications will review at the next-board meeting.
- Office 365 continues with multiple workstreams in place, corporate areas nearing completion on track with plan.
- Whilst upgrades happening plans are currently been drawn up for migrating Mailboxes and prerequisites work on shared mailbox are taking place.
- Estate work within Trust Data Centres to increase cooling is progressing - actively monitoring as on critical path.

Author(s)	Andy Williams, Interim Chief Digital Information Officer
Director Sponsor	Andy Williams, Interim Chief Digital Information Officer

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Report to:	Board of Directors
Date of Meeting:	27 July 2022
Subject:	Financial Position – June 2022 (Month 3)
Director Sponsor:	Andrew Bertram, Finance Director
Author:	Graham Lamb, Deputy Finance Director

Status of the Report (please click on the appropriate box)

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ A Regulatory Requirement ☐

Trust Priorities	Board Assurance Framework
☒ Our People	☐ Quality Standards
☒ Quality and Safety	☐ Workforce
☒ Elective Recovery	☐ Safety Standards
☒ Acute Flow	☒ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

The Trust is reporting an adjusted deficit of £0.51m against a planned deficit of £0.03m at June 2022 (month 3). The Trust is £0.48m adversely adrift of plan. The plan being used is the final I&E balance approved Board plan.

Recommendation:

The Board of Directors is asked to discuss and note the June 2022 financial position

Report Exempt from Public Disclosure

No ☒ Yes ☐

(If yes, please detail the specific grounds for exemption)

Report History

(Where the paper has previously been reported to date, if applicable)

Meeting	Date	Outcome/Recommendation
Digital, Performance &	19 July 2022	

Finance Assurance Committee		

Financial Position – June 2022 (Month 3)

1. Summary Plan Position

At its June 2022 meeting the Board of Directors approved the final I&E balanced annual financial plan, which formalised the e-mail acceptance of the plan previously received by the Finance Director from Board members. The final plan replaced the draft £11.8m I&E deficit annual financial plan previously approved by the Board. The final plan is now set into the ledger and is being used to monitor current performance. Operational budgets have been set on this basis.

2. Income and Expenditure Position

The I&E table below confirms an actual deficit of £0.51m against a planned deficit of £0.03m for June. The Trust is £0.48m adversely adrift of plan. Notable variances include an overspend on pay of £0.6m, an overspend on drugs of £0.1m (£1.2m relating to out of tariff drug income from NHSE), an underspend on clinical supplies and services and other costs of £2.4m, and the CIP position is behind plan by £2.5m. At this stage the clinical supplies and services position is partially compensating for the under delivery of the efficiency programme.

Also of note is that we spent £2.528m for the year to date on covid costs compared to a plan of £1.872m; therefore we are £0.656m adversely adrift of our covid plan. The plan is net of the £3.5m funding removed in discussion with the ICS to help reduce the I&E deficit plan. Although the Q1 position on Covid spending is an adverse one, it should be noted that spending levels have gradually declined month on month during the quarter. This expenditure relates to, so called, inside the envelope covid funding where the spending is against a fixed allocation. There remains some covid expenditure, relating in the main to testing, that is outside of the envelope and is subject to its own direct funding recharge arrangements.

Income and Expenditure Account

	Annual Plan	YTD Plan	YTD Actual	YTD Variance	FOT
	£000's	£000's	£000's	£000's	£000's
NHS England	74,545	18,636	19,844	1,208	74,545
Clinical commissioning groups	519,650	129,913	129,867	-46	519,650
Local authorities	4,793	1,179	1,182	4	4,793
Non-NHS: private patients	514	129	88	-41	514
Non-NHS: other	1,186	296	339	43	1,186
Operating Income from Patient Care Activities	**600,688**	**150,152**	**151,320**	**1,168**	**600,688**
Research and development	1,815	454	662	209	1,815
Education and training	20,871	5,218	5,936	718	20,871
Other income	50,310	12,575	10,616	-1,960	50,310
Other Operating Income	**72,995**	**18,247**	**17,214**	**-1,033**	**72,995**
Employee Expenses	-441,175	-109,954	-110,559	-604	-441,175
Drugs Costs	-63,694	-15,924	-16,067	-143	-63,694
Supplies and Services - Clinical	-68,353	-17,095	-14,772	2,323	-68,353
Depreciation	-18,291	-4,573	-4,573	0	-18,291
Amortisation	-1,521	-380	-380	0	-1,521
CIP	13,499	2,527	0	-2,527	13,499
Other Costs	-76,062	-18,509	-18,427	83	-76,062
Total Operating Expenditure	**-655,597**	**-163,908**	**-164,777**	**-869**	**-655,597**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**4,491**	**3,757**	**-734**	**18,086**
Finance income	30	8	121	114	30
Finance expense	-975	-244	-106	138	-975
PDC dividends payable/refundable	-8,014	-2,003	-2,004	-1	-8,014
NET FINANCE COSTS	**9,127**	**2,251**	**1,768**	**-483**	**9,127**
Other gains/(losses) including disposal of assets	0	0	0	0	0
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0
Movements in fair value of investments and liabilities	0	0	0	0	0
Corporation tax expense	0	0	0	0	0
Surplus/(Deficit) for the Period	**9,127**	**2,251**	**1,768**	**-483**	**9,127**
Remove Donated Asset Income	-9,607	-2,402	-2,402	0	-9,607
Remove Donated Asset Depreciation	452	113	113	0	452
Remove Donated Asset Amortisation	28	7	7	0	28
Remove net impact of DHSC centrally procured inventories	0	0	0	0	0
Remove Impairments	0	0	0	0	0
Remove Gains/(losses) from transfers by absorption	0	0	0	0	0
NHSI Adjusted Financial Performance Surplus/(Deficit)	**0**	**-31**	**-513**	**-483**	**0**

3. Cost Improvement programme

The core efficiency programme requirement for 2022/23 is £15.5m. This is the core value to be removed from operational budgets as we progress through the financial year and deliver cash-releasing savings.

The Board will be aware through the financial plan presentations that NHSE/I required technical efficiencies, covid spend reductions and estimated productivity gains to be expressed as CIPs. These total a further £16.9m (shown against Corporate CIP below) and increase the full programme value to £32.4m. The table below details the full programme.

2022/23 Cost Improvement Programme - June									
		June Position			Planning Position		Planning Risk		
Care Group	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£3,015	£651	£52	£599	£699	£2,315	£447	£252	£0
2. Acute, Emergency and Elderly Medicine (Scarborough)	£1,404	£303	£303	£0	£498	£906	£498	£0	£0
3. Surgery	£3,008	£649	£136	£514	£2,199	£809	£1,701	£498	£0
4. Cancer and Support Services	£2,552	£551	£29	£522	£855	£1,697	£519	£0	£336
5. Family Health	£1,595	£344	£8	£336	£701	£893	£140	£60	£501
6. Specialised Medicine	£1,639	£354	£177	£176	£1,606	£33	£1,500	£106	£0
7. Corporate Functions									
Chief Exec	£65	£14	£0	£14	£1	£65	£1	£0	£0
Chief Nurse Team	£164	£35	£0	£35	£64	£100	£64	£0	£0
Finance	£184	£40	£17	£22	£148	£35	£148	£0	£0
Medical Governance	£15	£3	£0	£3	£0	£15	£0	£0	£0
Ops Management	£101	£22	£0	£22	£0	£101	£0	£0	£0
Corporate CIP	£16,890	£4,223	£4,223	£0	£24,280	-£7,390	£19,854	£507	£3,920
DIS	£289	£62	£0	£62	£30	£259	£30	£0	£0
Workforce & OD	£314	£68	£0	£68	£412	-£98	£412	£0	£0
				£0					
Sub total	**£31,234**	**£7,319**	**£4,945**	**£2,374**	**£31,495**	**-£261**	**£25,314**	**£1,423**	**£4,758**
YTHFM LLP	£1,123	£242	£90	£153	£862	£261	£423	£364	£74
Group Total	**£32,357**	**£7,561**	**£5,035**	**£2,527**	**£32,357**	**£0**	**£25,737**	**£1,787**	**£4,832**

Delivery in month 3 remains poor in terms of the core programme delivery but of significant note is that plans have now been identified to deliver the total programme of £32.4m, and of this sum £25.7m (79.3%) is identified as low delivery risk.

4. Unfunded Revenue Schemes

There are a small number of revenue schemes running that do not currently have funding. These are outside of our plan. The table below confirms the schemes and the current position in terms of action being taken.

Scheme	Annual Cost	Comments	Funding Action	Timeline for Resolution	Update
Mobile CT	**£1,400,000**	This relates to a fully staffed and fully utilised mobile CT facility. This is key to our diagnostic recovery work. The scanner has previously been funded through the national diagnostic programme and more latterly the community diagnostic programme. No funding has been agreed but we continue with the hire of the scanner.	NHSE/I are involved, along with the ICS, in seeking to secure funding as a pre-commitment from this year's community diagnostic hub. No further action is required from the Trust at this time. At present this is reported as a gross cost in our position.	Urgent. Further update requests sent to NHSE/I but no funding identified yet.	Continuing in operation. NHSE/I and ICS aware. Causing £0.23m pressure on our plan. ICS CDH team are submitting national case for support, working with the Trust. No timeline information available, expect 1-2 months for clarity.
CG1 Discharge Command	**£115,000**	This initiative was funded last year through Hospital Discharge Programme funding. We have been requested to cease all HDP funded schemes, but this is deemed a priority to continue to support discharge at a time of such significant operational pressure. This is not funded within our plan.	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working through a prioritisation process in order to identify funds that can be diverted to support this.	End of May 22	Agreement reached with CG1 for covering expenditure non-recurrently using temporary vacancies elsewhere in the CG.
CG2 Weekend Therapy Service	**£93,000**	This initiative was funded last year through additional winter funding. This has now been withdrawn. The service provides a weekend therapy team to continue therapy	There is no additional financial support available for this scheme. The CG, Ops Team and Finance Team are working	End of May 22	Agreement reached with CG2 for covering expenditure non-recurrently using temporary

		intervention and to support discharge.	through a prioritisation process in order to identify funds that can be diverted to support this.		vacancies elsewhere in the CG.
CIPHER Ambulance Cohort Service	**£1,000,000**	This is a new service, deployed in order to respond to the requirement to release ambulance crews in a timely way given the significant operational pressure on the York site and the significant number of delayed ambulance handovers. CIPHER provide a nurse/paramedic and a care assistant to provide cohorted care for ambulance patients pending ED capacity becoming available. Data shows a marked improvement in ambulance release times when deployed.	The service has been used at peak times and over bank holiday weekends and is expected to cost in excess of £50k through to the Jubilee weekend. Requests to deploy are increasing and full 24/7 cover would equate to £1m in full year terms. This is not included in our plan and is a new service development. Discussions are underway with the ICS and NHSE/I as to where the liability lies for the cost and how best the service can be provided. At present this is reported as a gross cost in our position.	End of June 22	Confirmation received from ICS that there is no external funding to support this cost at the Trust. Discussions continue between ICS and YAS as to the future arrangements. The Trust has ceased used after the Jubilee bank holiday weekend to limit expenditure.

5. Next Steps

The rules around exactly how ERF will operate in 2022/23 are still being finalised but based on current national guidance, ERF funding received by the Trust as part of our contract baseline values, are subject to repayment where the weighted activity levels in 2022/23 fall below the 104% target of 19/20 levels.

If the rules were to be strictly applied to quarter 1 then we would potentially lose ERF income of £3.0m. In summary, this is calculated by taking the Trust's current year to date (Q1) performance in terms of weighted activity (89.1%) and assessing it against the 19/20 baseline and the 104% weighted target.

This variance is then converted to a financial value using 19/20 baseline data and then a 75% adjustment is made to reflect the ERF rule that any underperformance is only paid back at 75%. A final check and adjustments against the lower ERF floor level cap is applied where applicable.

The calculation is as follows:-

- Weighted target baseline at M3 is £45.6m (104% of 19/20 baseline of £43.8m)
- Trust actual weighted activity M3 is £39.1m (89.1% of 19/20 baseline of £43.8m)
- Difference between weighted target baseline and actual weighted activity is £6.5m
- Apply 75% lower floor adjustment (£6.5m x 75%) = £4.9m potential clawback
- Check value against ERF funding received at M3 and where lower limit clawback to 75%
- ERF funding received at M3 = £4.0m
- Clawback limited to 75% (£4m x 75%) = £3.0m

At this stage there does not appear to be any clawback action being taken at a national level, recognising the nationally experienced difficulties in recovering activity, the continued presence of covid and the exceptional non-elective pressures. It has been agreed across the ICS to not assume in our reported position any clawback of ERF for Q1.

The Board are aware that the plan is required to deliver 104% of the 2019/20 baseline activity level. Our plan seeks to do this. We have also been asked to identify what we believe would be our core activity delivery, where we have good confidence in delivery levels. The Care Groups have identified this to be at 99.6% of the 2019/20 baseline level.

Should the ERF policy be invoked in full and care groups hit the 99.6% level then we would expect to lose income of £5.6m. This calculation is summarised as:-

- Target performance less actual performance (104% less 99.6%) = 4.4%
- 4.4% of 19/20 weighted baseline value at month 12 (4.4% x £170.34m) = £7.5m
- Apply 75% adjustment = 75% x £7.5m = £5.6m potential clawback

We have also assessed that we would avoid costs of £1.7m. This would result a net risk impact on Trust I&E plan of £3.9m. This information was shared with the ICS as part of the final plan submission process.

In light of the actual performance in Q1 of 89.1%, the achievement of the Care Group assessed realistic level of 99.6% during 2022/23 appears to becoming even more challenging; and would require performance to improve to 103.1% for the remaining 9 months of the year to meet the assessed realistic level. Is it therefore possible that the Trust being able to limit the potential clawback of ERF to £5.6m as identified above, is at risk.

Finally, it should be noted that ERF is calculated across ICB level, so the above figures are indicative based on Trust current performance only and that final adjustment could vary based on overall ICB system performance.

6. Current Cash Position

June cash balance showed a £7.4m adverse variance to plan; this is mainly due to capital payables being settled earlier than expected in the plan. The table below shows our current planned month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	64,116	51,724	46,792	45,940	36,713	28,767	29,536	25,914	24,971	26,746	29,538	41,600
Actual	51,793	45,722	39,382									

There is more analysis to do in relation to cash management this financial year as we start to understand how ERF will flow into the Trust and as we map out the non-recurrent timing benefit we will have from national funded capital schemes. At this stage we are not predicting cash problems will emerge in the next 12 months, but this is conditional on managing all aspects of the income and expenditure plan.

7. Current Capital Position

The total capital programme for 2022-23 is £86.5m; this includes £22.8m of lease budget that has transferred to capital under the new lease accounting standard and £50m of external funding that the Trust has secured via Public Dividend Capital funding (nationally funded schemes) and charitable funding.

Capital Plan 2022-23 £000s	Mth 3 Planned Spend £000s	Mth 3 Actual Spend £000s	Variance £000s
86,513	**11,103**	**3,688**	**(7,415)**

Prioritisation of the discretionary element of the capital programme has now concluded and was approved by the Board at its June meeting.

All capital schemes are now progressing.

8. Risk Overview

The financial plan includes significant risk, discussed and acknowledged at the time of Board approval. The table below summarises the risks, the mitigation and the latest update.

Risk Issue	Comments	Mitigation/Management	Current Update
Delivery of the efficiency requirement	At 2.4% the cost out efficiency programme is arguably manageable in comparison to previous years but the programme has been halted for the last 2 years and clinical teams are focused elsewhere in terms of workforce issues and elective recovery.	The Corporate Efficiency Team has restarted its full support programme. The BBC programme is linked to efficiency delivery opportunities. Full CIP reporting will recommence. CIP panel meetings will be reconvened with the CEO.	Whilst delivery of the Core Programme has remained poor in month 3 the work with Care Groups and Corporate Teams has identified plans equal to the full value of the required programme. Notably 79% of plans are categorised as low risk. Best practice would suggest plans should exceed target in order to hold contingency against delivery shortfall.
Retention of ERF Funding through delivery of 104% activity levels	ERF is lost at the rate of 75% of tariff value for under recovery of the 104% required activity level.	A full 104% activity plan has been devised. Full monitoring of delivery will be implemented. The BBC programme picks up elective recovery as a specific work stream.	Monitoring data awaited and detailed ERF operating rules are yet to be properly understood as to how the programme will be operated.
Managing the Covid spend reduction	The plan proposed with the ICB requires a £3.5m reduction on covid spend linked to reducing IPC requirements and the national covid expenditure reduction programme.	Work is underway with the CGs and YTHFM to look for opportunities. If necessary a formal task and finish group will be required to work alongside IPC and the Care Groups to manage covid expenditure down. Formal monitoring in now in place.	This review work has commenced with the Care Groups and is looking to specifically step down spend later in the year to coincide with expected continued downward patient trends. Currently £1.5m has been identified against the £3.5m target
Managing the investment reduction programme	£2m of the required £4.3m investment reduction programme had been identified at the original time of planning. The remaining reduction will require management through the release of activity pressure funding into operational budgets.	Formal monitoring will be required to track progress. This has been implemented.	The first stage of this review work has been completed and £3.6m of the £4.3m reduction requirement has been identified. Work continues to close this gap and will scrutinise the release of additional funding into budget going forward.
Expenditure Control	Formal budgets identified through this planning process will require careful management to ensure expenditure compliance and to ensure that any investments made are matched with identified funding sources.	Finance reporting will require enhanced variance analysis and assurance processes. Reporting into the Exec Committee and Board of Directors will be refined to provide greater assurance and transparency. Compliance with the scheme of delegation regarding expenditure approval will be monitored.	This report identifies unfunded expenditure along with details of action being taken regarding funding. There are no control issues at this stage to highlight.
Winter funding pressures	The plan removes the Trust's typical winter contingency that would normally allow further	Full knowledge has been shared to ensure that the ICB and regional teams are aware that	Early information has been shared that suggests £250m will be released

	investments to be made at peak activity times.	providers are not holding winter contingencies on the grounds of affordability. Additional funding would need to be sought in the evet of material pressures. Our approach is consistent with other providers.	nationally for additional winter capacity. We expect to be working with ICS colleagues on this programme in the coming month.
The ICB may seek to further reduce expenditure to manage with overall resources.	We will be required to work with the ICB should this prove to be the case. Clinical teams would be required to work alongside the Exec Team and the ICB.	Formal monitoring would be required alongside a quality impact assessment programme in the event of real service expenditure reductions being required.	This risk is reducing with the release of national funding to the ICS to part-close the financial plan gap. The proposed ICS solution for the remainder does not impose further savings requirements on the Trust beyond those already committed to.
Management of the Capital Programme	The 2022/23 capital programme is the largest programme the Trust has ever undertaken. There is significant risk in managing to approved CDEL limits; both in terms of pressure on the programme for additional spend but also difficulty in spending due to construction industry difficulties associated with Brexit, the pandemic and the Ukraine conflict.	The programme is managed by CEPG. Monitoring provided at Board level. Prioritisation exercise has now concluded to agree the final discretionary elements of the programme for 22/23.	The key risk just now is the York ED scheme with a predicted overspend of £3.7m. Discussions are underway with Kier and other partners to limit the impact of this overspend on the available discretionary funding.

9. Recommendation

The Board of Directors is asked to discuss and note the June 2022 financial position for the Trust.

Date: July 2022

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York Teaching Hospital Facilities Management

Board of Directors – 27 July 2022
YTHFM LLP Final Operational Financial Plan

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 note and approve the YTHFM LLP final Operational Financial Plan for 2022/23.

Approved by YTHFM LLP Management Group June 2022 and Northumbria Healthcare Facilities Management Ltd July 2022.

Executive Summary – Key Points

Following receipt of priorities and operational planning guidance the national NHSE/I team released further funding to each ICS to help close the outstanding financial gaps and required resubmission of balanced plans. The Group and the ICS have subsequently developed balanced financial plans and this report provides the final YTHFM LLP plan that is part of the Group's final plan.

Recommendation

The Board of Directors is asked to note and approve the YTHFM LLP final Operational Financial Plan 2022/23.

Author: Jacqueline Carter, Governance Manager
Director Sponsor: Penny Gilyard, Director of Resources

NHS
York Teaching Hospital
Facilities Management

Management Group – 28th June 2022
Operational Financial Plan 2022/23

Trust Strategic Goals:

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

Recommendation

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

Purpose of the report

To report on the YTHFM LLP's final Operational Financial Plan for 2022/23 (April 2022 – March 2023).

Executive Summary – Key Points

At its March meeting the Management Group received a report on YTHFM LLP's draft operational plan for 2022/23. The Group's plan at that time delivered a substantial I&E deficit, which was significantly out of step with NHSEI's expectation of a balanced planned I&E position.

This position was replicated in many ICS communities around the country. Following this submission, the national NHSE/I team released further funding to each ICS to help close the outstanding financial gaps and required resubmission of balanced plans.

The Group and the ICS have subsequently developed balanced financial plans and this report provides the final YTHFM LLP plan that is part of the Group's final plan.

Recommendation

The Management Group is asked to:

- Note and approve the YTHFM LLP's final Operational Financial Plan for 2022/23.
- Note the final Operational Financial Plan will also require approval from the Trust Board of Directors and NHFML.

Authors: Penny Gilyard, Director of Resources, YTHFM LLP
Steve Bennison, Finance Manager, YSTHFT
Director Sponsor: Delroy Beverley, Managing Director

1. Introduction

1.1 At its March meeting the Management Group received a report on YTHFM LLP's draft operational plan for 2022/23. The Group's plan at that time delivered a substantial I&E deficit, which was significantly out of step with NHSEI's expectation of a balanced planned I&E position.

1.2 This position was replicated in many ICS communities around the country. Following this submission, the national NHSE/I team released further funding to each ICS to help close the outstanding financial gaps and required resubmission of balanced plans.

1.3 The Group and the ICS have subsequently developed balanced financial plans and this report provides the final YTHFM LLP plan that is part of the Group's final plan.

2. Updated Income & Expenditure (I&E) Plans

2.1 The vast majority of the £11.8m gap from the Groups financial plan is being closed by additional income of £10.3m. This is directly related to the additional income NHSE have released to systems and has been supplemented by further stretch savings targets for the CCGs and the ICB committing to a running cost saving. The balance of £1.5m is being addressed through expenditure issues. The Group have been able to manage the impact of these at a corporate level and so are not seeking any further savings targets from Care Groups, Directorates or YTHFM.

2.2 The YTHFM LLP final operational I&E plan for 2022/23 is presented in **Appendix A,** and now illustrates a Profit Before Tax for 2022/23 of £1.327m.

2.3 Changes from March's Draft Plan

- New Leases for 2022/23 have increased by £8.000m. As the contract for additional space at the Community Stadium was not signed in 2021/22 as planned this has now been included in this year's plan.
- Increase to Car Parking visitor income of £0.233m. This increase moves visitor income to 80% of pre Covid level to recognise the re-instatement of clinical activity through 2022/23.
- Increase to Catering Income of £0.176m, this is based on a 10% increase of the average income per month received during H2 to recognise increased use of the restaurants as covid measures are eased and clinical activity is re-instated.
- Utility inflation increased by a further £1.428m based on the strategic report on market prices received at the end of March.
- Further reduction in covid funding allocation of (£0.598m), this is a pro rata share of the £3.500m reduction across the Group.
- Increase to general inflation by 0.7% from 2.80% to 3.50% of baseline budgets excluding utilities and inflationary pressures identified elsewhere such as Agenda for change increments and Employers National insurance increases.
- Reduction to cost pressure funding of (£0.044m) following review across the Group of investments including approved business cases.

2.4 The marginal revenue operational expenditure changes over the baseline plan represent an increased spend of £3.031m and are presented in **Appendix B.**

3. Cost Improvement Programme 2022/23

3.1 The required CIP for YTHFM at the final plan is £1,123k in 2022/23. This comprises of a 2022/23 target of £854k plus a carry forward of £269k from 2021/22.

3.2 The cost improvement plan for YTHFM is presented at **Appendix C**

4. Balance Sheet and Cash Flow Forecast

4.1 The balance sheet and the cash flow forecast have been prepared base on the final YTHFM plan. The balance sheet is presented at **Appendix C** and the cash flow is presented at **Appendix D.**

5. Capital Expenditure

5.1 The capital programme remains unchanged from that reported under the March report.

6. New Leases 2022/23

6.1 The IFRS16 value for new leases has increased by £8.000m as the lease for the additional space at the Community Stadium was not completed in 2021/22 as planned and has subsequently been added to the plan for 2022/23.

7. Projected Profit

7.1 The projected profit in 2022/23 of £1.327m is available for distribution to LLP partners. In accordance with clause 9 of the Members Agreement between the Trust and NHFML regarding profit share and distribution; the lower of £25k or 20% of the LLP's profit for 2022/23 will be distributed to NHFML, with the balance being distributed to the Trust.

8. Recommendation

8.1 The Management Group is asked to:

- Note and approve YTHFM's operational financial plan for 2022/23.
- Note the operational financial plan will also require approval from the Trust Board of Directors and NHFML.

York Teaching Hospital Facilities Management LLP
Summary Income & Expenditure 2022/23

	2022/23 £000
Income	
York Teaching Hospital NHS Foundation Trust	
Unitary Payment	
Other income	-5,296
Other income: Covid lost car parking income	0
Payroll expenditure	27,463
Non-pay direct expenditure	18,641
Non-pay indirect expenditure - pass through	10,888
Property rental charge	18,723
Lifecycle - backlog maintenance	900
Profit - lifecycle (3.5% on Direct pay and non-pay)	32
Profit - operations (3.5% on Direct pay and non-pay)	1,526
	72,876
Capital Revenue	
Capital Revenue	29,191
New Leases 2022/23	22,933
	52,124
	125,001
Other Income	
Accommodation	183
Car Parking Services & Security	1,533
Catering - Scarborough	364
Catering - York	764
EBME	16
Energy & Sustainability	152
Estate Services - Scarborough	53
Estate Services - York	48
Estates & Facilities Management	0
Finance	0
Operational Facilities - Scarborough	0
Operational Facilities - York	186
Postage	40
Property Management	1,681
Special Programs	216
Switchboard	0
Trust Transport Department	61
	5,296
	130,296
Operating Expenditure	
Capital Expenditure	
Capital Expenditure	-29,046
New Leases 2021/22	-22,819
	-51,865
Revenue Expenditure	
Payroll expenditure	-27,463
Non-pay direct expenditure	-19,495
Non-pay indirect expenditure - Utilities and Rates pass through	-11,135
Annual lease rental	-18,723
Lifecycle - backlog maintenance	-900
Less: CIP	1,123
	-76,593
	-128,458
Operating Profit	**1,838**
Interest Receivable - Financial Debtor	1,627
Interest Receivable - Leases	566
Interest Payable - Loans	-2,141
Interest Payable - leases	-563
	-511
Profit Before Tax	**1,327**
LLP Share of profit: allocated to YTHFT	-1,302
LLP Share of profit: allocated to NHFML	-25
Profit for the Year	**0**
Retained Profit	**0**

Appendix B

York Teaching Hospital Facilities Management LLP
Draft Financial Plan 2022/23
Marginal Expenditure Plans

MARGINAL EXPENDITURE CHANGES	2022/23 £000
1. Inflationary Issues	
Employers NI increase from 13.8% to 15.05%	149
Agenda for Change incremental growth	131
Utility price inflation	4,248
Pay & non pay inflation on issues not covered elsewhere	1,412
	5,940
2. Cost Pressures	
Medical gas usage	103
LLP Notional Apprenticeship Levy Costs	216
Revenue cost of additional HPV machines	25
Increased provisions cost linked to increase in catering income target.	27
	371
3. Other Costs	
Transfer of Medical Gases from Trust to YTHFM	245
Community Stadium revenue impact excluding rent & service charge.	125
Transfer of LSMS role from YTHFM to Trust	-49
Reduction in expenditure on Covid initiatives	-1,152
Lifecycle backlog maintenance	-2,450
	-3,281
TOTAL	**3,031**

APPENDIX C

York Teaching Hospital Facilities Management LLP
Efficiency Programme 2022/23

Themes		
	Recurrent/Non-recurrent (R/NR)	**2022/23**
		£000
LLP share of 2022/23 efficiency requirement		854
Prior year underachieved/(overachieved) carry forward		269
Gap to delivery		**1,123**
		£000
1 Identified with high achievability		
Low risk		
1 Profit on Non MSA Work	NR	10
2 Gas usage savings at Clementhorpe	R	1
3 Gas usage savings at Malton	R	3
4 Rates review Malton Hospital	R	6
5 Rates review Clementhorpe HC	R	1
6 Rates review Occupational Health	R	2
7 Rates reviewSelby Hospital	R	51
8 Rates review Tadcaster HC	R	2
9 Rates review Tribune House	R	2
10 Rates review Bridlington Hospital	R	20
11 Rates review Scarborough Hospital	R	82
Low risk		**180**
2 Identified with medium achievability		
Medium risk		
1 Savings on Schneider Maintenance Contract	R	9
2 Replace MRI boilers with plate heaters	R	3
3 Upgrade vee belt drives of 50 AHU's	R	111
4 In-house cleaning of Smith & Nephew TNP Pumps	R	25
5 Maintenance savings from replacement of medical devices	NR	12
6 Print Shop expansion	R	122
7 Review of Residential accommodation budget	R	40
8 Charge for replacement ID cards	R	3
9 Patient food waste savings	R	54
Medium risk		**378**
3 Identified with Low achievability		
High risk		
1 Catering VAT savings	R	5
2 Identify 3rd Party EBME contracts that can be brought in-house	R	50
3 Schneider BMS contract savings	R	19
High risk		**74**
Grand Total		**632**
Surplus/ (Deficit) against Target		**-490**

York Teaching Hospital Facilities Management LLP
Cash Flow
For the Period Ending

	2022/23
	£000
CASH FLOW FROM OPERATING ACTIVITIES	
Surplus/(deficit) after tax	1,838
Non Cash Income and expense	
Movement in Inventories	-3,210
Movement in Financial Debtor	-52,548
(Increase)/decrease in Trade receivables	6,000
(Increase)/decrease in Other receivables	0
Increase/(decrease) in other Capital Trade payables	6,000
Increase/(decrease) in trade payables	0
Increase/(decrease) in other liabilities	-150
Net cash generated from / (used in) operations	**-42,070**
CASH FLOW FROM FINANCING ACTIVITIES	
Interest received	2,193
Loans from York Teaching -Capital funding received	30,000
Loans from Leases	22,933
Loans repaid	-2,698
Lease payments	-3,700
Interest loans	-2,142
Interest leases	-563
Partners Equity	-2,003
Net cash generated from/(used in) financing activities	**44,020**
Increase/(decrease) in cash and cash equivalents	**1,950**
Cash and cash equivalents at start of period	1,518
Net increase/(decrease) in cash	1,950
Cash and cash equivalents at end of period	**3,468**

York Teaching Hospital Facilities Management LLP
Balance Sheet
For the Period Ending

	2022/23
	Memo: Full Year
	£000
ASSETS, NON CURRENT	
Finance Debtor - Built Assets	59,583
Finance Debtor - Leases	20,609
Other Debtors	262
Total Fixed Assets	80,454
ASSETS, CURRENT	
Inventories - Stock	842
Inventories - Work in Progress	25,769
Interest Receivable	0
Trade Receivables	6,471
Prepayments	1,405
Amounts due from Members - < 1 year Financial Debtor	1,931
Amounts due from Members - < 1 year Leases	3,700
Amounts due from Members - Trade Receivables	10,804
Other receivables	138
Cash in Commercial Accounts/in Hand/Other	3,468
Total Current Assets	54,528
CURRENT LIABILITIES	
Trade and Other Payables: Capital	-18,827
Trade and Other Payables: Non-Capital	-7,315
Current Tax Payables	-420
Borrowings	-2,585
Leases	-3,700
Provisions	0
Deferred Income	-15
Total Current Liabilities	-32,862
TOTAL ASSETS LESS CURRENT LIABILITIES	**102,120**
NON CURRENT LIABILITIES	
Trade and Other Payables: Non-Capital	-19
Borrowings	-78,114
Non current lease	-22,660
NON CURRENT LIABILITIES	**-100,793**
TOTAL ASSETS EMPLOYED	**1,327**
PARTNERSHIP FUNDS	
Partners Debt	25
Retained Profit	1,302
TOTAL TAXPAYERS' AND OTHERS' EQUITY	**1,327**

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Minutes

Resources Assurance Committee
21 June 2022

Attendance:
Lynne Mellor (Chair), Denise McConnell Non-executive Director, Jim Dillon Non-executive Director, Andrew Bertram Finance Director, Polly McMeekin Director of Workforce & Organisational Development, Andy Williams Interim Chief Digital Information Officer (online from 10:00am), Mike Taylor Associate Director of Corporate Governance, Cheryl Gaynor, Corporate Governance Manager (for the minutes)

Apologies:
No apologies received.

Welcome and Introductions
The meeting was declared quorate.

22/78 Declaration of interest
There were no changes to the declarations and no declared conflicts of interest arising from the agenda.

22/79 Minutes of the meeting held on the 17 May 2022
The minutes of the last meeting held on 17 May 2022 were agreed as an accurate record.

22/80 Matters arising from the minutes and any outstanding actions

- **Action 116 (Social Media Workstream):** confirmed that this would be picked up through a future meeting of the Digital, Performance and Finance Committee as work was in progress and likely to be picked up through the new CDIO when in post from September 2022.
- **Action 115 (National Data Opt-Out (NDOO) Programme):** Included in the agenda, discussed and agreed to remain open until assurance that the extended deadline will be met for Trust compliance by the end of July.
- **Action 114 (Digital 2021/22 expenditure summary report):** portfolio delivery pack included in the agenda which outlined the roadmap of planned development. Item now closed.
- **Action 113 (Digital Programmes):** Included in the agenda. This item was now closed.

- **Action 112 (Cyber-attack from the YTHFM):** A plan was in place for the desktop exercise, with collaborative team-working including those who lead on disaster recovery and business continuity for the Trust. Revised date for delivery end of July.

22/81 Escalated Items

Nil.

22/82 Finance Report

Andrew Bertram presented a new narrative report which detailed the Financial Position for May 2022 (Month 2). Andrew reported that there was an adjusted deficit of £2.17m against a planned deficit of £1.99m at May 2022 (month 2). The Trust was £0.18m adversely adrift of plan. The plan currently being used was the £11.8m deficit approved Board annual financial plan (approved at April Board of Directors meeting) and remained subject to further Integrated Care System (ICS) and NHS England & Improvement (NHSE/I) discussion. The plan reported set into the ledger and was being used to monitor current performance and Trust operational budgets had also been set on this basis.

Andrew also reported that he had written to the Board of Directors on 1st June 2022 to advise of further funding having been released from the Centre to ICS's and Trusts. This was specifically to address some of the exceptional inflationary issues placing pressure on financial plans. In the case of the Trust's ICS, the current deficit plan of £56m had been supplemented with additional central funding of £32m taking the deficit plan down to £24m. The condition of accepting the supplementary funding was that this must then support delivery of a balanced plan. Andrew had previously outlined the implications for the Trust which essentially equated to an additional income of £10.3m coming into the Trust with the deficit balance of £1.5m being met through corporate expenditure issues with no further savings expectation being placed on any individual area. This consequently balanced the Trust's income and expenditure plan.

The Committee noted that the Board members had confirmed their acceptance of the plan via email which was to be submitted to the ICS and NHSE/I later in June. Assuming this was approved, it would become the new plan used for monitoring and operational budgets would be updated to reflect.

The report included the income and expenditure which confirmed the actual deficit of £2.17m against a planned deficit of £1.99m for May. The report describes some notable variances.

Andrew highlighted the planning and delivery work that had been completed around the £15.5m efficiency programme was good however the actual delivery of the programme looked concerning in the first few months of the year. He assured the Committee that there was a significant amount of work being put into the delivery of the programme and he was reassured by the level of low risk described in the plans but clearly there was a significant work programme to deliver going forwards. The Committee noted the risk around delivery and the plans in place to address any shortfall.

Currently the CIPHER service was non funded, it was a private service, which would cost the Trust over a £1M per annum to offer nurses/paramedics and care assistants to provide co-horted care for ambulance patients pending delay to the Emergency Department. Andrew advised the service had spent £50,000 to date but following the last shifts over the Jubilee Bank Holiday weekend and following confirmation from the ICS that they would not support funding, the service had ceased. Yorkshire Ambulance Service (YAS) and the ICS

were in discussions to deliver a similar service to CIPHER. Polly McMeekin suggested that the Trust consider how it could handle co-horted care. Lynne Mellor asked that the CIPHER non funding issue was an important item to discuss at Board. The Committee agreed that this would be escalated to Board for further discussion as part of a strategic debate.

The Committee:

- **Received and noted content of the report.**

Actions:
The CIPHER non funding risk is to be discussed at Board to determine strategically, how as a Trust, we want to provide co-horted care.

22/83 Capital Programme Update

Andrew Bertram presented the report and updated the committee as to the current position in relation to the Trust's Capital Programme. It was reported that Each Care Group, Corporate Directorate and the Group Wholly Owned Subsidiary (YTHFM) have provided their initial requirements for prioritisation, primarily for 2022/23, but also for the 2 subsequent financial years of 2023/24 and 2024/25.

Andrew advised that the report was the third version of the initial papers presented in March 2022 and a follow up in April. The original list of schemes had since been streamed to appropriate finding sources where they existed and left a number of schemes which required prioritising in line with the available funding.

Andrew reported that the capital requests received for 2022/23 totalled £50.8m of which £20.4m had been removed (as those were schemes that were too large to fund from Trusts depreciation finding and alternative external funding sources would most likely be required to progress those schemes). A further £14.5m of schemes had been identified funding sources but primarily through leasing arrangements.

The Committee noted that the overall Capital shortfall for 2022/23 was assessed at a minimum of (£3.5m) along with £9.2m of schemes not currently prioritised or costed. It was understood that discussions had commenced with the ICS to work to identify a funding source for the (£3.5m) shortfall. Internally the Trust would continue to seek alternative funding for example through further lease opportunities and reviewing DIS plans.

Andrew highlighted that the new structure of Board and sub-committee meetings would enable a solid assurance link-up to the performance activity against spend.

The Committee welcomed the news that the Care Group programme reviews had reconsidered where the 'red line' was for budget cut off, so that the 'must have requirements' to address patient needs could be considered. This exercise had resulted in £3.5M extra capital needed. The Committee was assured that plans were being explored on how to fund the £3.5M including for example reviewing lease and DIS plans.

Lynne Mellor raised whether any communication strategies had been considered around capital funding and Denise McConnell highlighted that there was a key message to challenge and provide an understanding of the capital funding. It was confirmed that any key messages would be delivered in the first instance through the reinstated Trust Staff Briefings as an avenue if communication.

The Committee:

- **Received and noted content of the report.**

Actions:

- **No actions**

22/84 Integrated Business Report – Finance

The Committee raised no further comment in relation to content of the finance element included in the published integrated business report.

The Committee:

- **Received and noted content of the report.**

Actions:

- **No actions**

22/85 EPAM Minutes and Assurance Escalation Report

The Committee received and noted the minutes of the Executive Performance Assurance Meeting from 31st May 2022 meeting.

The Committee welcomed the news that the VIU scheme was resolved and requested that at an appropriate juncture that the lessons learnt from that exercise were presented.

The Committee:

- **Received and noted content of the report.**

Actions:

- **Lessons learnt presented by LLP from the VIU scheme**

22/86 Digital and Information Report Update

Andy Williams joined the meeting to present the interim report and provided the committee with an update and assurance against actions taken by Digital and Information Services (DIS) in previous Committee meetings.

The Committee noted the progress made on addressing the cyber action on YTHFM with this remaining as an action from the committee until the end of July when it was expected that the Trust would have completed a full comprehensive exercise. Scenario being developed in June, seek approval of the scenario end of June, discuss with Chair of the Committee early July to ensure approval of the objectives and expected outcomes, mid-July plan the exercise in with a view to be completed at the end of July and a final report presented to the Digital, Performance and Finance Committee.

As part of the item the Committee also received an update on progress with the Essential Services Programme and welcomed the new dashboards and roadmap described in the report. Jim Dillon commented that he would like to see a simpler ‘executive summary’ on the dashboard.

Andy reported on the risk analysis for unscheduled projects, the committee raised the risks associated to the eight projects not selected for implementation during FY 22. The Committee welcomed the report. Lynne Mellor requested further clarification and action to

mitigate the critical high/risk of 'Risk 10 EPMA Safety Risk' being delayed as it was understood that there was a high risk of medication errors and patient safety incidents if this was not progressed. Lynne agreed to notify the Chair of the Quality & Safety Committee. Andy Williams agreed further clarity was needed and would come back to the Committee with an update. Andrew Bertram raised that the report noted a phase 2 business case approved by the Executive Committee however the funds were not released and agreed to follow this up.

In terms of the National Data Opt-Out, which enabled patients to opt out from the use of their identifiable data for research or planning purposes, the Committee requested that the report be clear as to whether the Trust would meet the extended deadline for compliance of 31st July 2022. Andy assured the committee that he would clarify that the Trust was on track to meet the 31st July 2022 extended deadline. On this basis the Committee reviewed the NGOO action (Action 115) and requested this action is now red with an ask for assurance that the Trust will meet the requirements by the end of July. Andy Williams agreed to follow up with more detailed assurance.

The general consensus of the committee was the report was complex and key points/messages where unclear and would have been supported by the inclusion of an executive summary and delivered as an executive report with reference to a benefits realisation to understand the progress. The ask was that this be considered in future reports.

The Committee:

- **Noted contents of the report**
- **Raised concerns**

Actions:

- **Action 115 (National Data Opt-Out) programme. This remained an open action to assure on compliance with the NDOO and the data the Trust holds and be reported back to the Committee.**
- **EPMA - Andrew Bertram to follow up on Phase 2 business case described in EMPA safety risk comments where funds were noted as being withheld.**
- **EPMA - Andy Williams to follow up to seek further clarity on issues including what resource was needed to mitigate the EPMA risk.**
- **EPMA - Lynne Mellor to notify the Chair of the Quality and Safety Committee**

Essential Services Programme (ESP)

The committee noted the progress of the DIS ESP and the 2022/23 delivery plan with forecasted benefits the Trust were to expect to be realised throughout the financial year.

Andy presented the committee with information on key areas of the reiterated ESP 2022/2023 Plan:

- Projects initiated to deliver remediation against long term, large scale technical debt within the Trusts IT Infrastructure, IT Operations and Service provision
- Projects initiated to provide the foundations to enable the Trust to deliver the technology required to support the Trusts key strategic programmes
- A summarised view of the benefits the Trust can expect to be realised through the delivery of the ESP projects in 2022/2023
- A summarised view of the work required in 2022/2023 to enable the next stage of the Essential Services Programme

- The new ESP governance model after changes in Leadership and Delivery.

The Committee welcomed the news that the Trust was set to secure some potentially significant central funding to provide the much needed uplift to the Electronic Patient Record System.

It was raised that the report

The Committee:

- **Received and noted content of the report.**

Actions:

- **No actions**

22/87 Integrated Business Report – Digital

The Committee raised no further comment in relation to content of the digital element included in the published integrated business report.

The Committee:

- **Received and noted content of the report.**

Actions:

- **No actions**

22/88 Integrated Business Report – Workforce

Polly McMeekin presented the report and briefly reported on the following key areas:

- **Staff retention** – sickness absence had been steadily reducing at latest figures reported 6% reduction. Board discussions around staff retention being a key priority and what speaks to the heart of how staff feel was their redeployment and not working in the areas that had been applied for. Helpful part of the workforce resilience initiative, from December 2021, there was an introduction of 'flexibility payments' for nurses and (registered and unregistered). For a registered nurse this was a gross payment of £50 per shift (unforeseen redeployments covering staff absences). This payment allowed the Trust to monitor how many shift deployments were happening. The total cost of this initiative was declining with February the cost being £28,000 down to £6,000 in May. This was a good indicator of how often the Trust was moving its staff on a shift by shift basis and consequently really spoke to staff retention in the longer term.

- **Financial Wellbeing Initiatives** – this is a national issue and a lot is coordinated from NHS Employers to support Trusts. NHS Employers had helpfully supplied some suggested initiatives around financial wellbeing and the Trust is currently completing around 85% of those. However, there was an introduction of 'real living wage' with a report developed to be presented to the Executive Committee in July. This report proposed the uplift of real living wage and the cost implications (approximately £189,868), worked based on a top up to ensure a gross salary payment of £9.90 per hour. At the same time the Trust is also awaiting news of the NHS pay rise which could temporarily remove the requirement for a local solution to

increase pay. In addition, the Trust is reviewing several other schemes including a review of mileage rates and extra restaurant food being given at a 'reduced' rate.

- **Review of Mileage rates –** Mileage rates for Trusts were set by National Terms and Conditions and are from 1st July each year. Standard rate for the first 3,500 miles was 56p per mile, beyond this the allowance dropped to 20p. A report had been developed for the Executive Committee to approve an increase of this allowance from 1st April for the reserve rate and then perceptively increase it depending on what fuel costs were going to be. There was no appetite nationally to review the national mileage rate. The Committee discussed this issue and welcomed the news that the Trust was reviewing mileage rates for staff.

The Committee:

- **Noted contents of the report**

Actions:

- **No actions**

22/89 Documents for consideration

There were no documents for consideration

22/90 Reflection on the Meeting and Any Other Business

It was agreed reflections would be captured post meeting.

The Committee noted that this was the final meeting of the Resources Assurance Committee as the move to the new committee structure commenced from 1st July 2022. The Chair subsequently thanked via email all committee attendees for their contributions, dedication and commitment to the Resources Assurance Committee, across Digital, Workforce, Finance and the LLP.