York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 2nd November 2022
Time: 9:00am – 12.00pm

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 2nd November 2022

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:30 – 2:00	Board of Directors – Private	Board of Directors
2:30 – 4:00	Annual General Meeting and Annual Members' Meeting	Board of Directors Members of the Public

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 28 September 2022** To be agreed as an accurate record.	Chair	Report	07	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	19	
6.	**Patient Story**	Chief Nurse	Verbal	-	9.05
7.	**Chief Executive's Report** To receive:	Chief Executive			9.25
7.1 7.2	• Chief Executive's Update • The October 2022-23 Trust Priorities Report		Report Report	23 27	

Item	Subject	Lead	Report/Verbal	Page No	Time
Trust Priority: Our People					
8.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 7.1).	Director of Workforce & OD	Report	59	9.45
9.	**Nurse Staffing Report** To receive the report.	Chief Nurse	Report	67	9.55
10.	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report and Action Plan** To receive the report.	Director of Workforce & OD	Report	77	10.05
Trust Priority: Quality and Safety					
11.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 7.1).	Medical Director/Chief Nurse	Verbal	-	10.30
12.	**Ockenden Report Update** To receive the report to include: • Perinatal Clinical Quality Surveillance Report	Chief Nurse	Report	121	10.40
Trust Priority: Acute Flow & Acute Flow					
13.	**Trust Priorities Report: Elective Recovery and Acute Flow** To receive an update on the Elective Recovery and Acute Flow priorities of the Trust Prorities Report (TPR) (Item 7.1).	Interim Chief Operating Officer	Report	139	11.00

Item	Subject	Lead	Report/Verbal	Page No	Time
14.	**Emergency Prepardness Resilience and Response (EPRR) Core Standards** To receive and approve the report.	Interim Chief Operating Officer	Report	175	11.10
Governance					
15.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 7.1).	Finance Director	Verbal	-	11.20
16.	**Communication Strategy** To receive and approve the strategy.	Director of Communications	Report	185	11.35
17.	**Risk Management Update - Risk Management Framework, Board Assurance Framework and Corporate Risk Register** To receive the Q2 Board Assurance Framework and Corporate Risk Register. Risk Management Framework	Associate Director of Corporate Governance	Report	203	11.50
18.	**Items for Information**	All			
18.1	• September Board Sub-Committee minutes		Report	229	
18.2	• Annual Committee Reviews		Report	243	
18.3	• HEE Self Assessment Return 2022		Report	259	
18.4	• Executive Committee Minutes				
18.5	• Star Award nominations				
19.	**Any other business including questions from the public**	Chair	Verbal	-	11.55
20.	**Time and Date of next meeting** The next meeting held in public will be on 30 November 2022.				

Item	Subject	Lead	Report/Verbal	Page No	Time
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**				12.00

Minutes
Board of Directors Meeting (Public)
28 September 2022

Minutes of the Public Board of Directors meeting held on Wednesday 28 September 2022 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:00am and concluded at 12:05pm.

Members present:

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

Associate Non-executive Directors
- None present

Executive Directors
- Simon Morritt, Chief Executive
- Andrew Bertram, Deputy Chief Executive/Finance Director
- Heather McNair, Chief Nurse
- Melanie Liley, Interim Chief Operating Officer
- Polly McMeekin, Director of Workforce and Organisational Development
- James Hawkins, Chief Digital Information Officer
- 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

Observers:
- Julia Unwin, external consultant and mentor
- Clare Hermon, Maxxima Ltd
- Steve Leggett, Alcidion UK

The Chair welcomed everyone to the meeting.

57 22/23 Apologies for absence

- Matt Morgan, Non-executive Director
- Ashley Clay, Associate Non-executive Director

58 22/23 Declaration of Interests

There were no declarations of interest to note.

59 22/23 Minutes of the meeting held on 27 July 2022

The Board approved the minutes of the meeting held on 27 July 2022 as an accurate record of the meeting.

42 22/23 Chief Executive's Update (Priorities Plan)
Prompt cards was one of the options proposed but there was also an ask to have a clear priorities document with a running commentary which describes where the Trust was in terms of successes and achievements. Non-Executive Lynne Mellor agreed to work with the Associate Director of Corporate Governance offline in terms of wording. The Director of Communications confirmed in the action log as part of the communications strategy and suggested a process of how updating and sharing would be achieved such as reporting updates to the Board and Executive Committee on a monthly basis.

Subject to the amendments agreed offline to minute 42 22/23 the minutes were approved as an accurate record.

The Board:

- **Approved the minutes of the meeting held on 27 July 2022 with the inclusion of the above.**

60 22/23 Matters arising from the minutes

Action 38 – follow up to a patient story. We need a report back therefore invited Kath Sartain and Jane Miller back to the Board to highlight some of the work that has been done since the initial attendance to the Board. **The Chief Nurse and Medical Director agreed to bring a report in advance of the next Board meeting.**

Action 41 – item now closed

Action 42 – Communication Strategy to be presented to the next Board meeting to include the process around key messages.

61 22/23 Patient Story

Karen, the daughter of a patient (Mr T), attended the Board meeting to share her father's patient journey. Karen was also supported by Lead for Patient and Public Involvement, Hannah Gray, and Associate Chief Nurse, Alison Pollard. Karen explained that Mr T was 88 years old. Prior to this admission he wasn't on any regular medication and was independent at home in Bridlington. His journey was described as follows:

- Admitted to the Emergency Department (ED) with low sodium on 18 July 2022.
- Remained on the ambulance and was eventually cohorted in outpatients.
- Assessed as being fit to sit and was transferred to chair and moved into the main ED on the corridor. He needed two people to transfer from the trolley to the chair.

- Then transferred to first assessment and eventually to yellow Bay, where he spent approximately 20 hours in ED.
- Whilst in ED he fell from his trolley sustaining a fracture to his left hip that required surgery.
- Transferred to Holly Ward on 19 July 2022 and waited until he was medically stable for surgery.
- Surgery went ahead 23 July 2022. He was in PACU (Post Anaesthesia Care Unit) post-surgery and was discharged to Maple Ward. The reason for this was to flip a bay on Holly Ward to female which required a bay to be deep cleaned. This wasn't clearly communicated to Karen who phoned Holly Ward to enquire how her father was, only to be told he wasn't on Holly.
- Mr T remained on Maple Ward until 28 July 2022 where he was then transferred to Holly Ward.
- Remained on Holly Ward until 9 July 2022. He tested positive for COVID along with his daughter and son-in-law. He remained in a side room on Holly Ward.
- He was transferred to Aspen Ward 9 August 2022, as he was still testing positive for COVID after 10 days. While on Aspen Ward he was unable to have a lymph node biopsy because of his COVID status. The biopsy happened a week later.
- Transferred to Lilac on 10 August 2022 and remained there until 14 August 2022 as he was now deemed COVID-recovered and there wasn't a Trauma and Orthopaedic or Surgical bed available. Mr T was still requiring therapy and specialist input.
- Transferred to Maple Ward 14 August 2022 at 12:20am and remained on Maple Ward for 12 hours.
- Transferred back to Holly Ward 14 August 2022 and remained there until his discharge 24 August 2022.

The Board acknowledged that Mr T experienced seven ward moves during his inpatient stay, and the relatives were not always informed each time he was moved. Each move was unsettling and property was lost. The Board also acknowledged that each move added extra workload to nursing and facilities staff already under extreme pressure; different medical teams had to pick up the plan from their colleagues; plans were disjointed and communications between staff and the daughter were clearly strained as a result of the multiple ward moves.

The Chair thanked Karen for attending the Board meeting to share her father's patient journey and offered a sincere apology on behalf of the Board.

Some assurance was taken from some of the actions or processes already in place or in train that were closely related to the experience of this patient. The Associate Chief Nurse described that there had been a number of actions to improve the quality of care including:

- New risk reporting system
- Senior Nurse on site 24 hours to support the management of patient flow
- Flags on the Trust's electronic patient record to highlight movement of patients on handovers
- Improved communication with patients and their relatives

The concerns around basics of care were discussed and assurance was given that the Trust had stepped up its efforts to recruit Healthcare Assistants and Patient Support Officers who were seen as a strong contributors to delivering quality of care, in particular around washing, nutrition and hydration. However, it was highlighted that this was primarily

for the York site and there was further assurance needed around how this would be managed at Scarborough. The Board requested a progress report at the next meeting of the Board to pick up on the staffing concerns. The report was to also describe the progress that either had or hadn't been made in relation to movement of patients, specifically on the Scarborough hospital site, and whether the Trust was managing to reduce the number of unnecessary moves of its patients. The Board also requested that the Trust continue to keep in touch with Karen.

It was suggested that the key outcomes of the patient story also be tracked through the Quality and Safety Assurance Committee. It was similarly discussed that there was a cultural systematic issue and for the Board to support staff by ensuring that staff have the best available facilities and procedures. This should be taken forward by the People and Culture Committee.

The Board:

- **Thanked Karen, Hannah and Alison for their attendance at the meeting.**

Action:

- **Report to the next Board meeting on progress around movement of patients and recruitment of clinical support staff at Scarborough.**
- **Quality and Safety Assurance Committee to track outcomes of patient story (specifically around movement of patients and recruitment of clinical support staff on the Scarborough site)**
- **People and Culture Assurance Committee to work through the cultural issues.**

62 22/23 Chief Executive's Update

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

- Recruitment – The Trust had expedited recruitment to employ more Patient Support Operatives (PSOs) across medicine and elderly medicine wards in York Hospital. As mentioned in the previous item, this will be explored in relation to Scarborough Hospital and would be reported at the next meeting.
- Flu and Covid-19 vaccinations - staff vaccination campaign was up and running and available to all staff.
- Celebration of Achievement Awards - received the highest ever number of nominations. It was encouraging that we are now able to reintroduce the Trust's staff events programme
- 'Our plan for patients' policy paper announced - On 22 September the Secretary of State for Health and Social Care announced the government's plan for addressing the current challenges facing the health and care sector. It focuses on four key areas: ambulances, backlogs, care and doctors and dentists (ABCD). In terms of 'care' one of the areas highlighted was the improvement of discharge from hospital into social care, including a £500m fund to support discharge from hospital and to bolster the social care workforce. It was not yet clear ow the £500m would be allocated.
- Trust Board appointments - new Medical Director, Karen Stone, joining on 28 November 2022. Also welcomed James Hawkins as the Trust's new Chief Digital and Information Officer who commenced employment on 29 August 2022
- York and North Yorkshire devolution announcement - Last month the Government announced its proposed Devolution Deal for York and North Yorkshire
- Collaborative of Acute Providers (CAP) – a workshop was planned for 7 October to discuss, debate and seek views on the emerging priorities and objectives of CAP (and its subsequent work programme and governance arrangements.

Trust Priorities Report

A key point noted was that the Building Better Care Programme was now organised around delivery of the four priorities through the Executive Committee.

The Board did not discuss the priorities report in detail as many aspects where included as part of the main agenda. However, it was acknowledged that the report was a document that needed further development: it should become a living document which is used to inform and drive discussion. To support the shaping of the document and its contents, it was agreed that a separate Board session was required to give it the time and focus needed. Sub-committees were asked to review the relevant parts of the report (e.g. People & Culture Committee to review the section on People.

It was also suggested that the Workforce Group, chaired by the Chief Executive, could also be used to support the development of the priorities report.

The Board

- **Noted the report**

Action

- **The Associate Director of Corporate Governance to work offline to confirm a Trust Priorities Report session with the Board.**

63 22/23 Community Services Presentation

The Head of Integrated Care delivered a presentation (attached) to the Board on his reflections on Community Services.

Board Presentation Sept 22.pptx

Key points discussed in the presentation were:

- Overview of Adult and Community Services and the population served.
- Investing in community care
- Getting the structure right
- Valuing community-based colleagues
- Recommendations:
  - Recognise the value and importance of community care to support people to live independent lives and ensure capacity grows to meet demand
  - Actively explore and support new organisational structures to support integrated models of care delivery and the OD support to manage the transition process
  - Take active steps to make community-based staff feel included and valued
  - Consider how being a provider of community services fits with overall strategic approach and how the Board is assured about its delivery.

It was suggested and agreed that the Board have a future agenda item on how being a provider of community services fits with the overall strategic approach and how the Board can be assured about its delivery.

Action:

- **Schedule Community Services discussion into the Board work plan for a future meeting.**

64 22/23 Nurse Staffing Report

The Chief Nurse presented the report and provided information and assurance to Board on how the Trust had responded to provide safe and effective nurse staffing levels during July 2022. The Board received and understood the requirements to submit safer staffing metrics using Care Hours per Patient Day (CHPPD) and received assurance that nursing establishments had been reviewed utilising best practice guidance, and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce were in place.

The use of Safecare and how red flags were used to escalate and articulate concerns about nurse staffing levels were raised. The Board noted that the National Institute of Clinical Excellence (NICE 2014) highlighted 6 Red Flags detailed in the report, which they believed impacted upon delivering safe patient care.

Although the Trust recently had 17 red flags that were available to use on CPD, in response they had been reviewed and streamlined to 11 Red Flags overall and broken down into 3 categories:

- Fundamentals of Care – 6 Flags
- Staffing Concerns – 4 Flags
- Enhanced Care – 1 Flag

After review each Red Flag will either be closed, mitigated or left open using the professional judgement of the assessor, and an acknowledgement of the actions is recorded on Safecare. The Board were assured that each month any open Red Flags would be investigated within Care Groups to provide assurances at Board level that patients did not come to harm.

It was highlighted that there were some ward areas where Safecare compliance had not been completed and therefore there were some areas where reporting was not accurate. In response it was pointed out that extra support had been provided to the wards which were struggling with timely completion.

Also highlighted was the establishment review, and it was noted that all ward establishments had been completed and would be presented to the Executive Committee in September 2022. The establishment review yielded a requirement for £15,770,503 investment, of which c£3m will come from care group budgets. The investment required is £12,591,108 to the adult inpatient wards, including the inpatient community units that were not factored into the previous review and the changes that have occurred as a result of the pandemic. It was noted that this equates to 134.43 WTE Registered Nurses, 204.26 WTE Health Care Assistants and 103.32 WTE Patient Services Operatives

Staff retention was raised in relation to nurse staffing in particular and an update sought on how this was progressing. The Board were assured that retention around HCAs was improving and this could be demonstrated through the recruitment figures starting to fall. It was thought that this was due to the recruitment of a number of roles to onboard and support newly recruited HCAs. For the registered nurses there was feedback around clinical skills and supporting the clinical areas, in response to which the Trust recruited

Clinical Educators which had been well received. A combination of the new roles and some of the wellbeing work had contributed to improvements in the retention of nurses.

The Board:

- **Received and noted the report.**

65 22/23 Medical Revalidation Annual Report

The Medical Director presented the report and informed the Board of the current appraisal data and the impact of the 2020 appraisal model change.

The Board were advised that the report was an update on appraisal and revalidation, replacing the standard annual revalidation audit report which had been stood down. This will be reported again for 2023/24.

The Board noted that the changes made to the programme for 2020/21 remained in place for 21/22 which were:

- Removal of the Annual Organisational Audit report - NHS E/I cancelled the 2019/2020 Annual Organisational Audit and had stood down the 2020/21 one. For 2021/22 they had requested an update on the appraisal year, and the impact of the amended appraisal model.
- Reduced requirement for supporting information for appraisal - the amount of evidence required had been reduced considerably, with appraisals currently focused on reflecting upon the pandemic, its effects, and any potential learning.
- Shortened appraisal form

The expectation of NHS E/I for 2022/23 was that trusts work to recover the appraisal rate to its pre-pandemic target of 90% of which the Trust was on target to meet. The overall figure for 21/22 was 75% (which was up from 62% in 20/21).

There was a detailed discussion around job planning and the Board received clarity on the appraisal process which supports the recommendation of revalidation of individuals. Following the discussion, it was felt that further consideration should be given to the appraisal requirements to further support the revalidation process. For example, incorporating assessment of clinicians against the Trust values and behaviours framework. The Board agreed that further discussion around this would be picked up through the People and Culture Assurance Committee.

The Board:

- **noted the report.**

Action:

- **People and Culture Assurance Committee to continue discussion in relation to values and behaviours framework alignment with appraisal, job plans and revalidation of doctors.**

66 22/23 Freedom to Speak Up Annual Report

The Freedom to Speak up Guardian joined the meeting to present the report and provided the Board with an overview of the Freedom the Speak Up agenda and an annual overview of the Freedom to Speak Up (FTSU) processes and activities during 2021/2022 including:

- FTSU data between 09/2021 and 08/2022

- A summary of communication activity being undertaken by the FTSUG
- Feedback from those who have spoken up
- Key points about improving FTSU culture including recommendations from the FTSUG.

A number of key points were highlighted around staff being confident in speaking up. In some cases, staff did not feel safe to take an issue beyond raising it initially with the Guardian. The Chief Digital and Information Officer commented that there may be a platform through which individuals could communicate anonymously and would look into this further as part of the recommendations.

The Guardian reported that there were key themes around bullying, behaviours and harassment and around failure to adhere to policies and procedures. It was felt that the launch of the Trust values and behaviours framework should support the reduction of cases around these areas of concern. It was suggested one reason for reluctance to speak up was the mistaken perception that the Guardian was too close to the HR Department. It was agreed that it was important to stress the independence of the FTSU Guardian.

It was important to have clear communication about both the process for speaking up and the independence of the FTSU Guardian role. It was agreed that a key communication route was the Chief Executive Week Ahead email to all staff.

The Board discussed the recommendations detailed in the report and pledged to support staff in speaking up. It was agreed that the People and Culture Committee should provide a definitive response to each of the recommendations in the Guardian's report to the Board. It was also agreed that the Freedom to Speak Up Guardian should be invited to the attend the next meeting of the People and Culture Committee.

The Board:

- **noted the report.**
- **supported the recommendations detailed in the report, subject to a detailed review by the People and Culture Committee.**

Action

- **The People and Culture Committee to provide a definitive response to each of the recommendations and invite the Freedom to Speak Up Guardian to the next meeting.**

67 22/23 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 following key areas were highlighted:

- two Section 31 conditions and four Section 29A warnings associated with registration for regulated activity
- 2 whistleblowing concerns had been raised following the last report.
- recent successful and well attended recruitment event with a repeated event planned for 11th October. 25.86WTE PSO (new role) and going through the check stage. 80.7WTE Healthcare support workers 16.3 of HCA had been allocated and had an imminent start date. Disclosure and Barring system is causing delays and a

DBS check that can't be waivered before any individual commences their employment. However, this can often be balanced through short notice periods
- rollout of InPhase Quality Oversight Platform to be fully rolled out in York by Friday 30th September and has commenced in Scarborough. Results had been phenomenal both in terms of the audit results (95% in risk assessments and care planning) and the staff engagement

The Board highlighted the local clinical audit of inpatient wards across Care Group 1 and Care Group 3 in relation to nutrition and hydration and agreed that the Board were keen to see how this was progressing. It was clarified that the date of 16th September noted in the report for the undertaking of the audit had been achieved.

In response to the delay in disclosure and barring, given the staffing pressures the Trust was facing, the Chief Executive suggested a discussion with the Chief Constable of North Yorkshire Police with data to support the discussion requested.

The Board:

- **acknowledged the status of the CQC action plan and its delivery status within the organisation.**
- **acknowledged the assurance being provided through the audit results presented within the report, recognising that improvements were still required.**

Action:

- **The Chief Nurse to report to the next meeting of the Quality Assurance Committee on the nutrition and hydration local audit insights.**
- **The Director of Workforce and Organisational Development to obtain disclosure and barring data to support discussion between the Chief Executive and Chief Constable.**

68 22/23 Ockenden Report Update

The Chief Nurse presented the report and emphasised that the service remained under immense pressures. The CQC continued to request monthly assurance around Tendable and MEWS compliance on ward G2 as there had been some challenges in providing this information to the CQC. The Board were assured that this has been addressed and there was a plan in place to ensure this was provided in the coming months. There was recognition nationally around the community pressures and roll-out of 'continuity of carer' had therefore been paused from June 2022 with no imminent plans to reinstate.

The Board noted that there were 14 unit diverts or closures at York in August and one at Scarborough which was a concerning increase on previous months. There had also been two notifications for Healthcare Safety Investigation Branch Reports, one maternal death at Scarborough and an intrauterine death at York, both of which had been declared as Serious Incidents.

Progress against compliance with all 10 safety actions for Maternity Incentive Scheme will be reported monthly. The revised version of the scheme emphasises the joint responsibility of the Associate Director of Midwifery and Clinical Director in progressing the MIS standards and they will jointly be expected to present to Board later in the year.

It was highlighted that the training figures for both the Scarborough and York sites were included in Appendix D of the report where it was illustrated that compliance for mandatory PROMPT training levels for maternity and medical staff across both sites was variable with

a large number of Scarborough medical staff being non-compliant. It was discussed that an escalation process was needed. The Board emphasized the need for an action plan to meet compliance with the mandatory PROMT training. The Medical Director agreed to follow this up.

Progress against compliance with all 10 safety actions for Maternity Incentive Scheme will be reported monthly. The revised version of the scheme emphasises the joint responsibility of the Associate Director of Midwifery and Clinical Director in progressing the MIS standards and they were jointly expected to present to the Board. It was agreed to invite them to the next Board meeting.

The Board:

- **received and noted the report.**

Action:

- **Associate Director of Midwifery and Clinical Director for Obstetrics and Gynaecology invited to attend the next Board meeting.**

69 22/23 Operational Performance Update

The Interim Chief Operating Officer presented the report and described that the Trust remained under significant pressure with consequential delays to patient pathways across emergency care, elective care and cancer. The Board noted to key areas that were highlighted:

- sustained OPEL 4 status
- 29.9% of Ambulance handovers took more than 60 minutes.
- 71.7% of emergency department patients were admitted, transferred, or discharged within four hours
- The 24/7 Emergency Assessment Unit (EAU) model had been established on both sites, and the focus was now to extend the range of pathways and criteria for the EAU and to extend the range of surgical services through the Surgical Assessment Units on both sites.
- The Trust reported 924 twelve-hour Trolley Breaches.
- 109 covid positive patients currently through increased numbers of patients admitted with covid and also through a number of outbreaks in wards. Challenge is how this would be managed coming into winter alongside flu and other infection – would be managed through the Winter Planning.
- The Trust had been placed in ‘Tier 2’ regional support for elective recovery, as a result of being off trajectory for Cancer 62-day targets and 78 week waits, with fortnightly meetings with NHSE/I and ICS performance and elective leads.
- The Trust achieved four of the eight core national standards in July 2022, not achieving the 62 day from GP referral target, at 59.4% against a target of 85% (Cancer is reported a month in arrears).
- The Trust is off trajectory for the number of patients over 62 days on a Cancer Fast Track pathway (249 at end of August 2022 against trajectory of 158).
- 3,796 fifty-two week wait pathways have been declared for the end of August 2022.
- 385 seventy-eight week pathways have been declared in August 2022
- Two 104+ week wait pathways have been declared for the end of August 2022, both Priority 6 patients.
- 56.1% of patients waiting under 18 weeks at the end August 2022 on the Referral to Treatment waiting list.

The Board:

- **received and noted the report.**

70 22/23 Winter Plan

The Board received the report presented by the Interim Chief Operating Officer. It was noted that the Winter Plan had been developed with the expectation of high levels of operational pressure over the winter period. The Trust response to COVID-19 had resulted in a strong and well understood command and control system should escalation be required. The newly established Winter Tactical Group was to control and coordinate the Winter Plan until operational pressures may require escalation to a full Trust response when SILVER Command would be formally activated.

There were eight areas of focus that NHS England had described; ambulance handovers, prevent avoidable admission, demand and capacity, Covid-19 and respiratory challenges, discharge, workforce, data and performance, and communications. These areas of focus were described in detail in the report. The plan was framed to provide assurance to the Board against the 8 principles described. It was noted that some of this work was already business as usual and not additional schemes just for winter.

It was noted that the plan was endorsed by the Trust Executive Committee on 21st September 2022.

The Board discussed in detail the concern around boarding of patients. The relationship between emergency care and inpatient medical teams remained a challenge despite recognition of the need for early specialty input in the emergency department when a patient is referred for transfer. There was concern about the safety and ownership of the cohort of patients waiting to be admitted. The Board challenged if there was adequate oversight to ensure that a consistent approach through the standard operating procedure was being followed. It was reported that there were unwarranted variations. On the back of the discussion and the concerns around inconsistencies, the Board agreed that the Care Group Director and Clinical Directors for both the York and Scarborough sites (Care Groups 1 and 2) should be invited to attend the next Board meeting for a discussion.

The Board:

- **endorsed the proposed Winter Plan 2022-2023.**

Action:

- **Care Group Directors and Clinical Directors for Care Groups 1 and 2 be invited to discuss admissions and transfers from ED with the Board at the next meeting.**

71 22/23 Finance Performance Report

The Finance Director reported that the Trust was reporting an adjusted deficit of £3.2m against a planned deficit of £0.3m at August 2022 (month 5). The Trust had an adverse variance to plan of £2.9m. Scrutiny from the Integrated Care Board and NHS England was expected to increase as the year moves into Month 6. Some key messages highlighted were:

- There were no capital concerns raised with the Board however, it was clear that if the Trusts deficit against plan continued and would increase in material way then that would begin to compromise the Trust position.

- A clear message from the Finance Director that financial considerations would not be allowed to compromise the safety of patients.
- Successful recruitment of permanent staff should lead to a reduction is agency spend
- Risk issue – 28th September was pay day and the pay award with backpay had gone through for all staff. Modelling was suggesting that there might be a £2m shortfall in funding issue for the Trust. The Finance Director confirmed this seemed to be emerging as a typical issue across many providers and ICBs. The national team were aware of the anticipated shortfall in funding and were considering options for resolution. The Board was briefed on a specific issue where the pay award caused some staff groups to change pension contribution banding. Notably some Band 8A staff could see a reduction in net pay because of this change. This had been estimated to affect around 100 staff members in the Trust who had been offered a pay advance with a repayment plan to help smooth the impact. This offer was in line with that made by a number of other Trusts. At the time of the meeting 13 members of staff had confirmed they wished to take advantage of the payment plan.

The Board:

- **received and noted the report.**

72 22/23 Constitutional and Standing Orders Review

The Associate Director of Corporate Governance presented the amendments to the Trust Constitution for approval. Amendments were proposed to:

- Section 8 – Council of Governors
- Section 9 – Board of Directors
- Annex 1 Trust Constituencies and Governors
- Annex 2 Election Rules
- Annex 3 Council of Governors: Transitional Provisions
- Annex 4 Standing Orders for the Practice and Procedure of the Council of Governors
- Annex 5 Board of Directors Standing Orders

The Board:

- **approved the proposed amendments.**

73 22/23 Items for Information

There were no further items for information discussed.

74 22/23 Any Other Business

No other business.

75 22/23 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 2 November 2022.

Item 05

Action Log – Board of Directors (Public)

Action No.	Date of Meeting	Meeting	Minute Number Reference	Title	Action (from Minute)	Executive Lead/Owner	Update / comments	Due Date	Status
4	25 May 2022	Public Board of Directors	10-22/23	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. 27.07.22 - added to the Private agenda for discussion 27.07.22 - following private meeting discussion it was agreed to return to Coventry University with thanks but no further progress on this.	Jul-22	Blue
5	25 May 2022	Public Board of Directors	10-22/23	Nurse Recruitment and Retention Report	Investigate DIS resource pressures in relation to the nursing quality indicator dashboard	Interim Chief Digital Information Officer		Jul-22	Blue
6	25 May 2022	Public Board of Directors	11-22/23	Final Ockenden Report	Trust Website - The Director of Communications agreed to assess the site and propose alternative communication practices to meet the compliance required NHS Policy posted on the Trust website	Director of Communications	The Communications team had worked with the Trust's 'Digital Midwife' to make a number of changes to the maternity information on our website. The deadline for this is 23 June, however all of the work was already complete (16.06.22).	Jun-22	Blue
38	27 July 2022	Public Board of Directors	25-22/23	Patient Story - Jane Miller	A progress report be presented to the October Board of Directors on specific outcomes	Chief Nurse and Medical Director	28.09.22 - Chief Nurse and Medical Director to deliver Patient story feedback report to October meeting	Oct-22	Green

					following Jane's attendance to the Board and her continuous improvement work with Kathryn Sartain.				
41	27 July 2022	Public Board of Directors	42-22/23	Chief Executive's update - 100-Day Discharge Challenge	The Chair to write a letter of concern on behalf of the Board to the ICS in relation to the operational pressures and in particular the discharge challenges	Chair	Overtaken by the Rapid Quality Review Meeting held on 22 August. The concerns that would have been raised in a letter were expressed very clearly by the Chief Executive at the meeting and the serious concerns had been considered by ICS colleagues.	Sep-22	Blue
42	27 July 2022	Public Board of Directors	42-22/23	Chief Executive's Update - Key priorities	Develop prompt cards with key priority action messages	Chief Executive & Director of Communications	28.09.22 - Communications Strategy to be presented to October Board meeting	Oct-22	Green
43	27 July 2022	Public Board of Directors	49-22/23	Operational Performance Update	Present SDEC review report for October meeting	Interim Chief Operating Officer		Oct-22	Green
66	28 September 2022	Public Board of Directors	61-22/23	Patient Story	Report to the next Board meeting on progress around movement of patients and recruitment of clinical support staff (HCAs and PSOs) at Scarborough.	Chief Nurse		Oct-22	Green
67	28 September 2022	Public Board of Directors	62-22/23	Chief Executive Report - Trust Priorities	The Associate Director of Corporate Governance to work offline to confirm a Trust Priorities Report session with the Board.	Associate Director of Corporate Governance		Jan-23	Green
68	28 September 2022	Public Board of Directors	63-22/23	Community Services	Schedule Community Services discussion into the Board work plan for a future meeting.	Associate Director of Corporate Governance		Jan-23	Green
69	28 September 2022	Public Board of Directors	67-22/23	Care Quality Commission	The Chief Nurse to report to the next meeting of the Quality Assurance	Chief Nurse	Added as action 70	-	Blue

				(CQC) Report	Committee on the nutrition and hydration local audit insights.				
71	28 September 2022	Public Board of Directors	67-22/23	Care Quality Commission (CQC) Report	The Director of Workforce and Organisational Development to obtain Disclosure and barring data to support a discussion between the Chief Executive and Chief Constable.	Director of Workforce & OD	14.10.22 - We are unable to pull specific data on this. The NHS Trac (recruitment software) had provided us with themes of delays and averages. We therefore knew that some were 'getting stuck' at stage 4 which is the local police force data. The issue does appear to have resolved now so it looks as though it was a time-limited problem.	-	Blue
72	28 September 2022	Public Board of Directors	68-22/23	Ockenden Report Update	Associate Director of Midwifery and Clinical Director for Obstetrics and Gynaecology to be invited to attend the next Board meeting (Ockenden).	Chief Nurse and Associate Director of Corporate Governance		Oct-22	Green
73	28 September 2022	Public Board of Directors	70-22/23	Winter Plan	Care Group Directors and Clinical Directors for Care Groups 1 and 2 be invited to discuss admissions and transfers from ED with the Board at the next meeting.	Medical Director, Chief Operating Officer and Associate Director of Corporate Governance	19.10.22 - agreed to postpone to November	Nov-22	Green
74	28 September 2022	Public Board of Directors	61-22/23	Patient Story	Quality & Safety Assurance Committee to track outcomes of patient story (specifically around movement of patients and recruitment of PSO's on the Scarborough site)	Chief Nurse	Linked with Action 66. Delegated to Q&S Assurance (Action 75)	-	Blue
76	28 September 2022	Public Board of Directors	61-22/23	Patient Story	People and Culture Committee to work through the cultural issues.	Jim Dillon	Delegated to People and Culture Committee (Action 77)	-	Blue
78	28 September 2022	Public Board of Directors	65-22/23	Medical Revalidation Annual Report	People and Culture Assurance Committee to continue discussion in relation to values and behaviours framework	Jim Dillon	Delegated to People and Culture Committee (Action 79)	-	Blue

					alignment with appraisal, job plans and revalidation of doctors.				
80	28 September 2022	Public Board of Directors	66-22/23	Freedom to Speak Up Annual Report	The People and Culture Committee to provide a definitive response to each of the recommendations and invite the Freedom to Speak Up Guardian to its next meeting.	Jim Dillon	Delegated to People and Culture Committee (Action 81)	-	Blue

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 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 areas include: recruitment, industrial action, Care Quality Commission update, support for our improvement journey, digital documentation rollout, operational pressures and winter respiratory viruses, and the Humber and North Yorkshire Collaboration of Acute Providers.

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	2 November 2022	

Chief Executive's Report

1. Our People

1.1 Recruitment

As reported at last month's Board, our efforts to expedite recruitment of Patient Services Operatives (PSOs) and Healthcare Assistants (HCAs) are moving at pace.

Our second recruitment event in early October resulted in 101 offers of employment, and the team is working through these to enable us to welcome our new recruits as soon as practically possible. In the meantime, the staff who were recruited at the first event in September are now arriving and will be making a difference on the medical and elderly wards in York.

These are key roles for supporting delivery of the CQC action plan, and in helping ensure that fundamentals of care are consistently delivered.

Our thanks must go to the recruitment team, who are working tirelessly to meet the demands of this step-up in our recruitment efforts and to ensure we can welcome our new starters as soon as possible.

1.2 Industrial action

The majority of the unions representing healthcare workers have signalled their intention to ballot their members on undertaking industrial action, and are at varying stages of consultation on this issue.

This includes The Royal College of Nursing (RCN) the Royal College of Midwives (RCM), The British Medical Association (BMA, who are considering action in relation to junior doctors), The Chartered Society of Physiotherapy (CSP), GMB Union, Unite, and Unison.

We have put in place a command structure to support our management of this should any action take place.

2. Quality and Safety

2.1 Care Quality Commission (CQC) update

Inspectors from the Care Quality Commission (CQC) visited both the York and Scarborough sites on 11, 12 and 13 October. This was in part to re-inspect the areas they visited at York Hospital in March, but also to carry out a fuller inspection which included the emergency departments, medicine, and maternity at both York and Scarborough Hospitals.

We received initial feedback at the end of the visit, along with some more detailed findings and we are in correspondence with the CQC in response to this. Although the CQC team is no longer on site, the inspection process is still ongoing, and they have made several

requests for further information and evidence and are planning further interviews with senior managers representing the core services they inspected.

The CQC commented positively on the help and cooperation they were offered and thanked us for positively engaging with the process.

I am encouraged that the CQC found improvements against some of the areas of concern that were identified in March. This includes improvements in systems related to nutrition and hydration for patients on medical wards on both sites, and the impact that the introduction of Nucleus is already having on risk assessments in York. They also talked positively about the systems in place to manage demand within the ED in Scarborough.

Their feedback also highlights some areas for improvement, some of which we have been asked to respond to quickly. This includes issues relating to the escalation of deteriorating patients, and general observations about the safe management of patients within the ambulance queue or in the 'ready for transfer' corridor in terms of documentation, observation and checks in the York ED.

The CQC also describe concerns with the impact on labour ward staffing of midwives supporting theatres, and the recent temporary closures of the unit due to staffing. They also raised some general concerns regarding the environment (particularly in the ED and maternity theatres), medicines management and some elements of infection prevention and control.

We have responded to this immediate feedback and have submitted plans to address the issues they raise. We do not anticipate receiving the final report until November.

The CQC has also notified us that they will be undertaking a well led review of the trust from 22-24 November.

2.2. Support for our improvement journey

In recognition of the need to increase capacity to support the improvement work required within the organisation, we have engaged a number of individuals to support in key areas, including nursing and midwifery CQC compliance, quality governance support, maternity quality improvement, maternity specialist support, and infection prevention and control.

Shaun Stacey will also be joining us for the coming months as Improvement Director to lead the work on the elective recovery programme.

2.3. Digital documentation rollout

I want to recognise the fantastic work that has taken place to implement Nucleus, the new digital documentation system for assessments and care planning.

The new software has been developed in house using ideas and feedback from staff and can be used on handheld devices to help reduce duplication of work and help us deliver better care for our adult inpatients.

The phase one rollout is now complete, with all 44 adult inpatient areas up and running with the system.

It facilitates a much quicker admission process and is recorded in real time meaning staff can at a glance know what care has been delivered and what still needs to be done. This is already proving successful in reducing the time taken to complete documentation whilst freeing up time to care for patients, and the response from staff has been overwhelmingly positive.

Thank you to everyone involved, particularly Nicola Coventry (Chief Nursing Information Officer), Vicci Anderson (Lead Nurse for Digital Projects) and Kevin Beatson (Head of Systems Development) for developing the product and driving forward its delivery.

3. Acute flow

3.1. Operational pressures and winter respiratory viruses

As has been the case for a number of months, we continue to experience acute pressures across all of our services. We are also starting to see the anticipated increase in numbers of Covid cases, with 162 patients in the trust at the time of writing. Whilst we are yet to see significant numbers of flu patients, the experience in the Southern Hemisphere suggests that we should expect a difficult flu season this year, and there are reports nationally that admissions for flu are already on the rise.

Humber and North Yorkshire Health and Care Partnership Chief Executive Stephen Eames has written to all organisations in the partnership asking for mitigations to be put in place in anticipation of some of the challenges facing us all this winter, including respiratory infections, the impacts of cold weather on health, and worsening cost of living.

Local Directors of Public Health across Humber and North Yorkshire have collectively advised on a number of actions including reinstating face masks for staff and visitors, encouragement of staff to have their flu and Covid vaccinations, and the continued adherence to rigorous infection prevention and control measures.

As a trust we are already taking these steps, and our flu and Covid surge plans are well rehearsed and will be implemented as necessary.

Meanwhile our staff vaccination programme continues, with a total of over 7,000 vaccines administered so far. Thank you to everyone involved in our vaccination hubs for continuing to deliver this programme on behalf of colleagues.

3.2. Humber and North Yorkshire Collaboration of Acute Providers (CAP)

A development session took place on 7 October for the CAP, which was attended by executive and non-executive board members and senior operational and clinical leaders from the four acute trusts in Humber and North Yorkshire.

The purpose of the day was to consider the collaboration's priorities and to further shape the governance arrangements for how the CAP will operate in a way that adds value and contributes to improvements in acute care for our patients across the ICS.

Outcomes from this session, including the proposed governance arrangements, will be shared and I will keep the Board up to date on developments.

Date: 2 November 2022

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

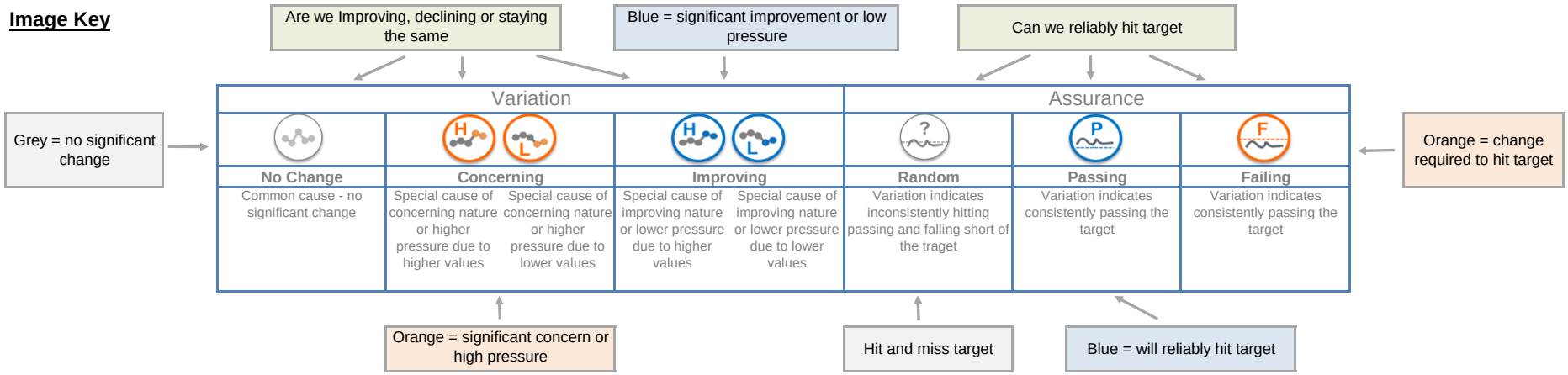
October 2022

Board Assurance Framework supporting information for:
PR1 Quality Standards, PR2 Safety Standards,
PR3 Performance Targets, PR4 Workforce, PR5 Finance,
PR6 DIS Service Standards, PR7 Integrated Care System (identified risk interdependencies)

KEYS

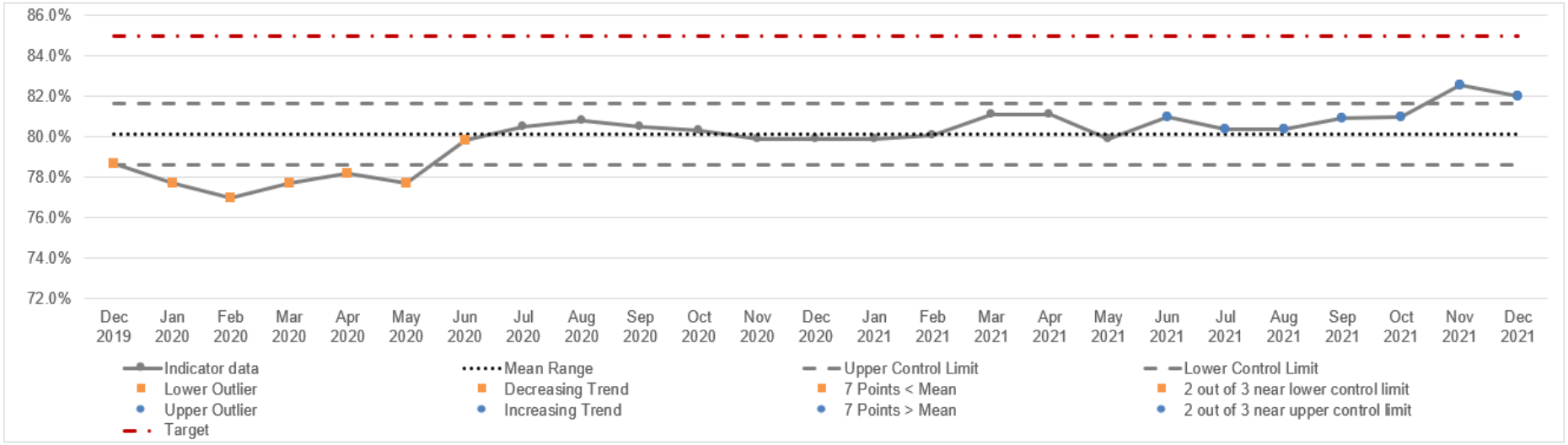
York and Scarborough Teaching Hospitals NHS Foundation Trust

Image Key



Note: 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target (where applicable). This is only applicable where there is sufficient data to present as a Statistical Process Control Chart (SPC).

SPC Key - example SPC chart



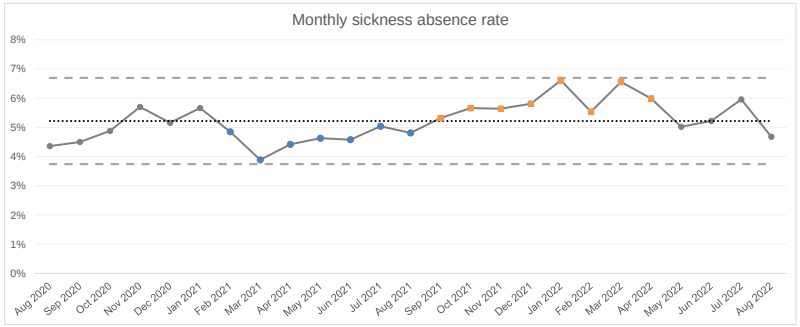
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

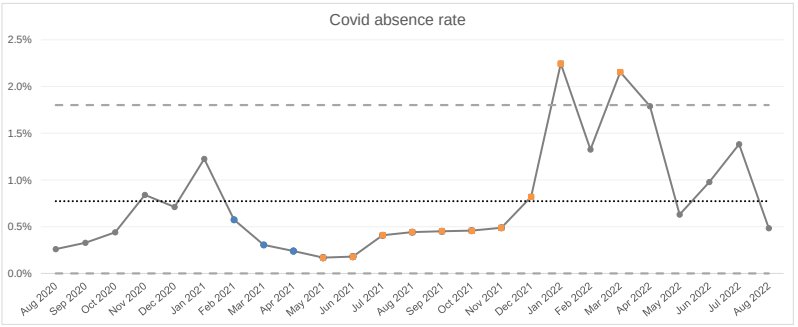
OUR PEOPLE - Sickness Absence

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

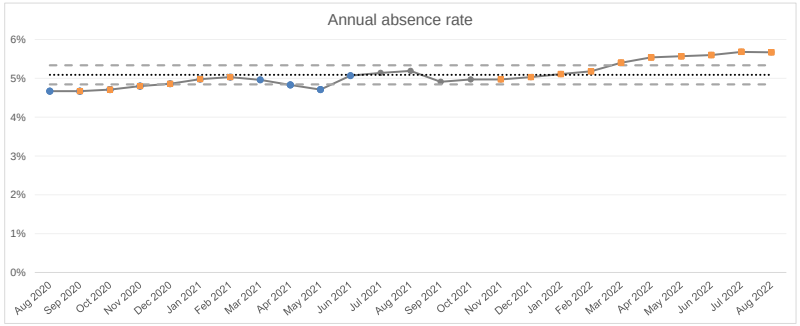
REPORTING MONTH : SEPTEMBER 2022



Aug 2022
4.68%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Aug 2022
0.48%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Aug 2022
5.67%
Target
4.9%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates inconsistently hitting passing and falling short of the target

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Data Analysis:

Monthly sickness absence rate: The indicator is showing common cause variation since May 2022 after a run above the mean for eight months.
Covid absence rate: The indicator is currently showing common cause variation since April 2022, with special cause concern seen in January and March 2022 with both data points above the upper control limit.
Annual absence rate: The indicator is showing special cause concern since November 2022, with an increasing trend. The data points have been above the upper control limit since March 2022.

Challenges:
Staff sickness rates impact availablty of sufficient workforce to safely staff all wards/departments at all times.

Key Risks:
Staff survey results relating to staff engagment are only available once a year. However, staff sickness absence is one more readily available indicator of engagement. Seasonal variations in sickness absence are expected, as shown in the montly sickness absence rates. However, the overall trend in sickness absence is an increasing rate, as shown by the annual absence rate (which is a rolling 12 month figure).

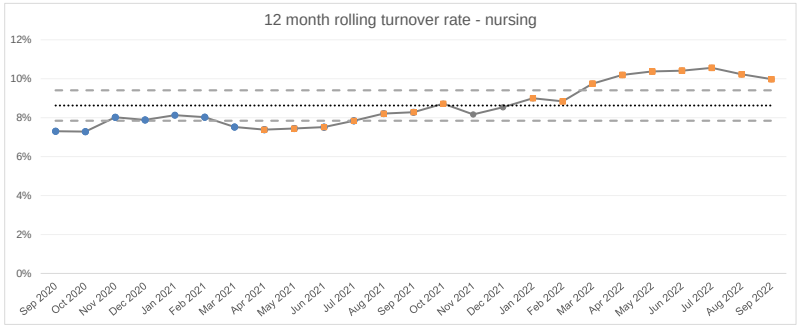
Actions:
Actions being taken as an overall response to improve staff engagement and experience are intended to have an impact on indicators of engagement such as sickness absence and turnover.
Following the launch of the new co-created values a new behavioural framework has been launched into the organisation, this clearly sets out to all staff the behaviours we love to see and those that are not in line with our values. This tool will be used through all of our development programmes to encourage positive behaviours and also give staff the confidence to challenge inappropriate behaviour.
The 'Fixing the Basics' workstream has been running for a number of months now, updates have been published through staff matters to demonstrate that the Trust is taking action following feedback from staff. This has included improved special leave for carers and bereaved staff, encouraging night staff to park in the visitor car park to reduce on going congestion in the morning, changes to the appraisal process, launch of co-created values and behaviours, establishing staff networks to increase staff voice and introducing more environmentally friendly takeaway cutlery and containers.

Mitigations:
The Culture and Engagement steering group has now met and agreed focus going forward. Working groups will be set up, with cross sections of staff from across the organisation to focus on how we improve engagement within the workforce. See also actions detailed under temporary staffing measures.
Evidence has shown that increased Health and Wellbeing support increases staff engagement and therefore will help to reduce sickness absence. The Health and Wellbeing steering group has been set up to focus on positive action, supporting staff in the workplace. In addition the review of the Sickness Absence Policy and Procedure has been brought forward following requests from staff side.

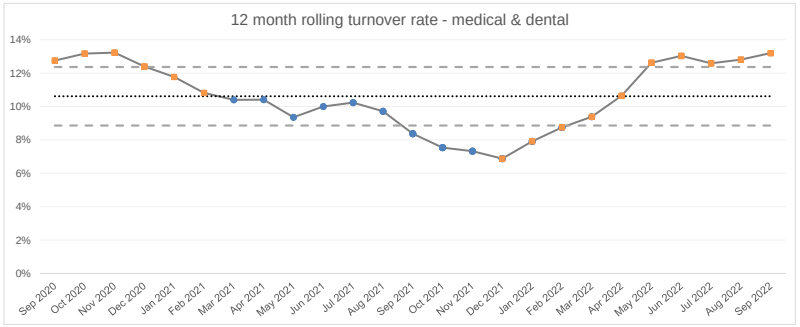
OUR PEOPLE - Turnover Rate

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

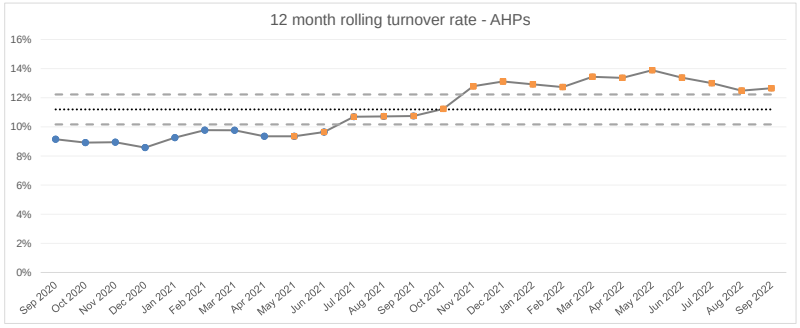
REPORTING MONTH : SEPTEMBER 2022



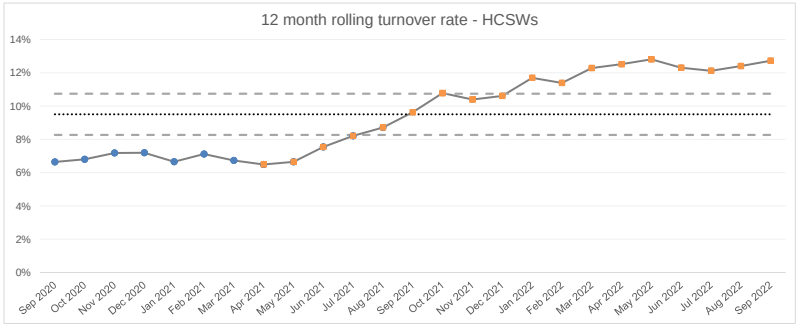
Sep 2022	Target	Variance	Assurance
9.98%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
13.21%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
12.65%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
12.72%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant

Data Analysis:

12 month rolling turnover rate - nursing: The indicator is showing special cause concern above the mean from January 2022, with all data points being above the upper control limit from March 2022.
12 month rolling turnover rate - medical & dental: The indicator is showing special cause concern, with an increasing trend from December 2021 and data points above the upper control limit from May 2022.
12 month rolling turnover rate - AHPs: The indicator is showing an special cause concern from May 2021 with an increasing trend and data points above the upper control limit from November 2021.
12 month rolling turnover rate - HCSWs: The indicator is showing an special cause concern from April 2021 with an increasing trend and data points above the upper control limit from January 2022.

Challenges:
Turnover rates impact availability of sufficient workforce to safely staff all wards/departments at all times.

Key Risks:
Turnover is another indicator of staff engagement, high turnover rates and the vacancies that arise as a result can also further negatively impact staff expereinces at work

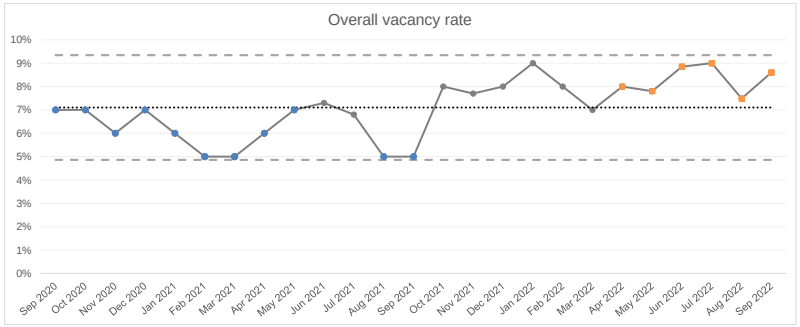
Actions:
An Attraction and Retention Workstream has been established. Through the workstream a number of working groups will be looking at key actions to improve the retention of our staff. Key areas of focus include the on-boarding of staff as they join the organisation, career pathways, talent management and more opportunities for staff to share their views through fresh eyes (new starters) feedback, itchy feet (those who may be thinking about leaving) feedback and exit feedback - exploring if is there anything we could do differently.

Mitigations:

OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022

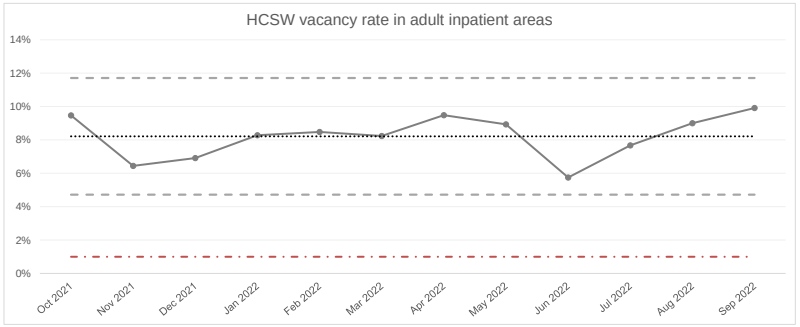


Sep 2022
8.60%

Target
No Target

Variance
Special cause of concerning nature or higher pressure due to higher values

Assurance
There is no target, therefore target assurance is not relevant

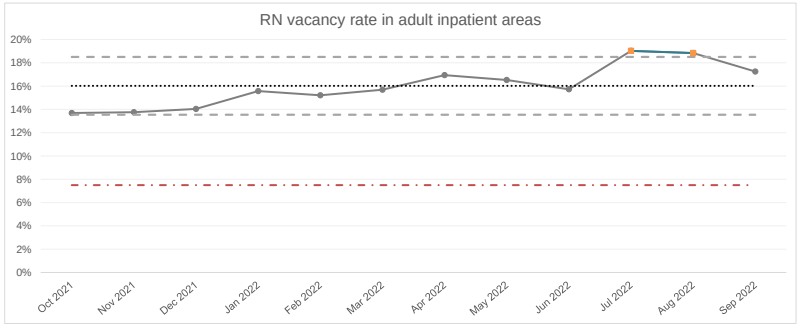


Sep 2022
9.91%

Target
1%

Variance
Common cause - no significant change

Assurance
Variation indicates consistently falling short of the target

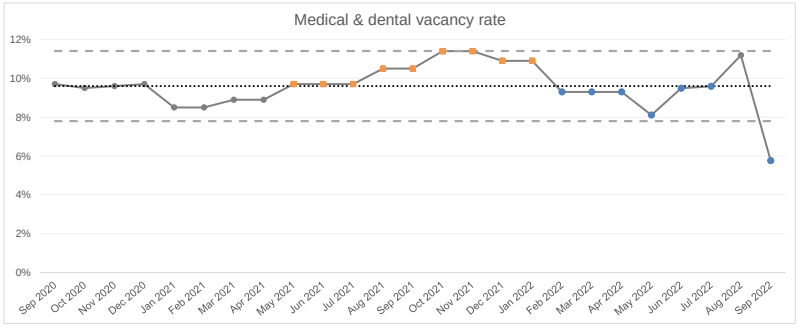


Sep 2022
17.25%

Target
7.5%

Variance
Common cause - no significant change

Assurance
Variation indicates consistently falling short of the target



Sep 2022
5.76%

Target
No Target

Variance
Special cause of improving nature or lower pressure due to lower values

Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

Overall vacancy rate: The indicator is showing special cause concern from April 2022 with a run of points above the mean.
HCSW vacancy rate in adult inpatient areas: The indicator is showing common cause variation, however please note the vacancy rate is shown from October 2021 only. The target is consistently not being met.
RN vacancy rate in adult inpatient areas: The indicator is showing common cause variation, however please note the vacancy rate is shown from October 2021 only. July and August 2022 were both above the upper control limit. The target is consistently not being met.
Medical & dental vacancy rate: The indicator is showing a period of nine points above the mean from May 2021 to January 2022, the latest month is showing special cause improvement in September 2022, below the lower control limit.

Challenges:
Vacancy rates impact availability of sufficient workforce to safely staff all wards/departments at all times.
The Trust has had a number of International Nurses join this year. These staff arrive to fill band 5 vacancies but are paid by the trust as band 4 staff until their complete their OSCEs and receive their PIN. Counting the current international recruits still awaiting OSCE/PINs into the numbers above, this improves the adult inpatient RN vacancy rate to 15.79% (compared to the 17.25% shown above).

Key Risks:
Inability to recruit to all vacancies in a timely way, issues with workforce supply in some cases.

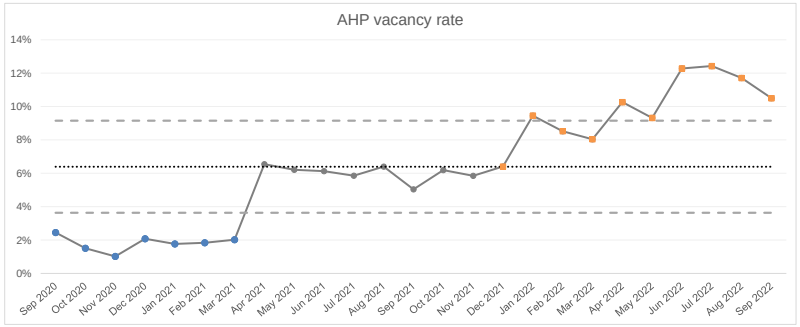
Actions:
An Attraction and Retention Workstream has been established. Through the workstream a number of working groups will be looking at key actions to improve recruitment to the organisation. Key areas of focus include modernisation of our approach to attract individuals to the Trust - the Recruitment Microsite has recently been launched to showcase working in the organisation, review our recruitment events - the Trust held a very successful open day for HCSW's and PSO's in September and there was another event on 11 October to recruit to the same roles with the local authorities in attendance to support their recruitment. 101 offers were made by the Trust at this event. The groups will modernise our recruitment processes - review our selection and application process to make as streamlined as possible and review our international recruitment pathways to ensure we have a clear strategy and consistent model for delivery across all staffing groups - the Trust has recently joined an ICB led initiative to recruit directly from Kerala in India.
The Trust has reached agreement with the University of York to expand its nursing apprenticeship programme to support the delivery of a Nursing Associate top-up programme. The programme will allow Nursing Associates to undertake an 18-month qualification, and practice as a Registered Nurse on successful completion. The programme replicates one already offered by Coventry University Scarborough. The top-up route will provide a route for 90 staff to become Registered Nurses over the next three-years, while 60 staff will be offered places on Registered Nursing Degree apprenticeship over the same period. There are already 51 staff on a programme working towards becoming a Registered Nurse, 16 of whom qualify this month.
The Nursing Associate apprenticeship will provide a development route for 110 staff in Health Care Assistant roles over the next three-years. There are already 54 staff on programme, 28 of whom are due to qualify in January 2023.

Mitigations:

OUR PEOPLE - Vacancy Rate (cont.)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022



Sep 2022
10.5%

Target
No Target

Variance
Special cause of concerning nature or higher pressure due to higher values

Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

AHPs vacancy rate: The indicator is showing an increasing trend from April 2021 with more than seven points above the mean from December 2021 and special cause concern above the upper control limit from March 2022, although is showing some signs of reduction.

Challenges: See vacancy rate (1) sheet

Key Risks: See vacancy rate (1) sheet

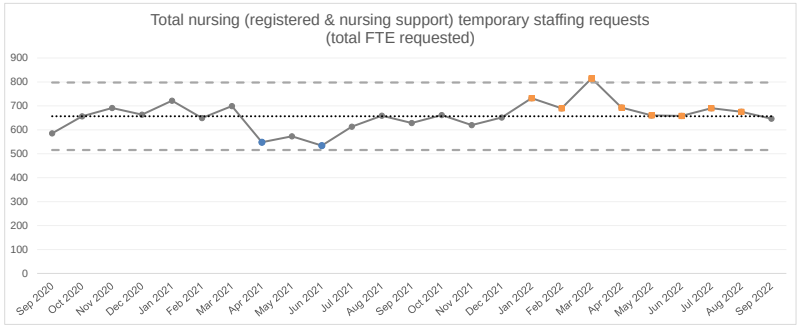
Actions: See vacancy rate (1) sheet

Mitigations: See vacancy rate (1) sheet

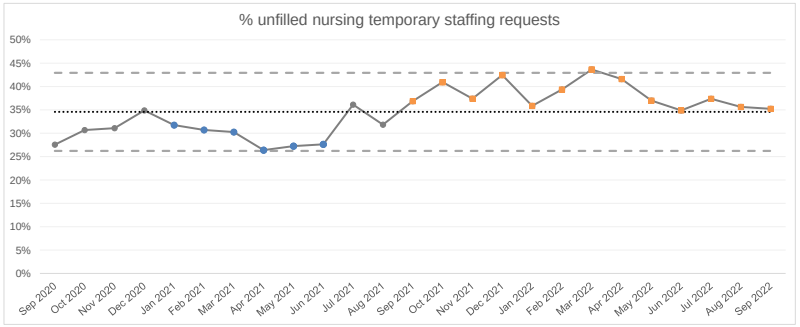
OUR PEOPLE - Temporary Staffing

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

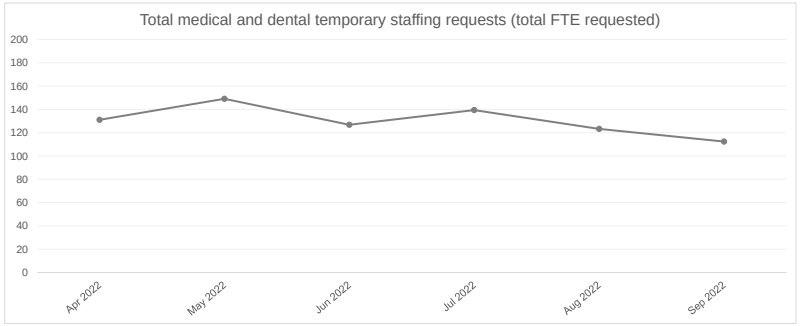
REPORTING MONTH : SEPTEMBER 2022



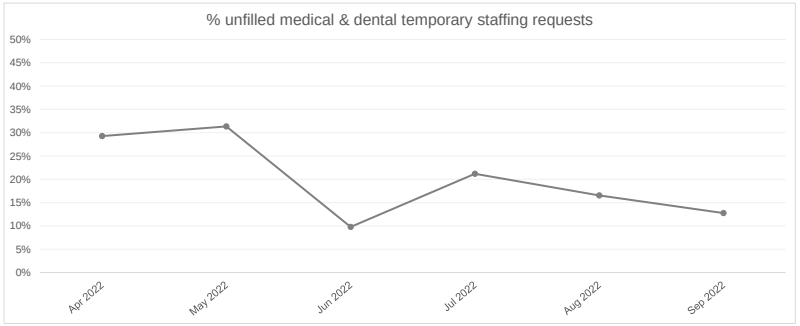
Sep 2022
646.60
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
0.35
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
112.40
Target
No Target
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant



Sep 2022
12.75%
Target
No Target
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant

Data Analysis:

Total nursing (registered & nursing support) temporary staffing requests (total FTE requested): The indicator is showing eight points above the mean from January 2022 to August 2022 and special cause concern above the upper control limit in March 2022. It is showing common cause variation for most recent month.
% unfilled nursing temporary staffing requests: The indicator is showing 13 points above the mean from September 2021 and special cause concern above the upper control limit in March 2022.
Total medical and dental (registered & nursing support) temporary staffing requests (total FTE requested): This indicator is not currently shown as an SPC chart due to insufficient data points.
% unfilled medical & dental temporary staffing requests: This indicator is not currently shown as an SPC chart due to insufficient data points.

Challenges:
Sufficient availability of temporary staff to fill critical shifts left vacant due to sickness absence and turnover/vacancies.

Key Risks:
Availablity of temporary staffing and financial implications of temporary staffing useage.

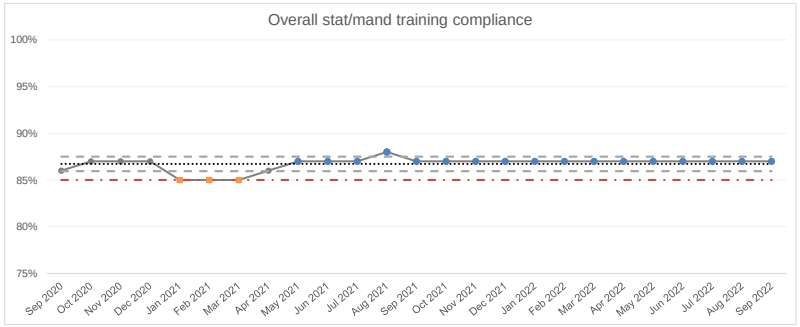
Actions:
The Trust continues to incentivise the bank workforce to pick up additional shifts. A proposal for winter incentives is being put forward to Executive Committee. The ICB is co-ordinating a piece of work to look at introducing a collaborative bank and standard locum rates within the ICS.

Mitigations:

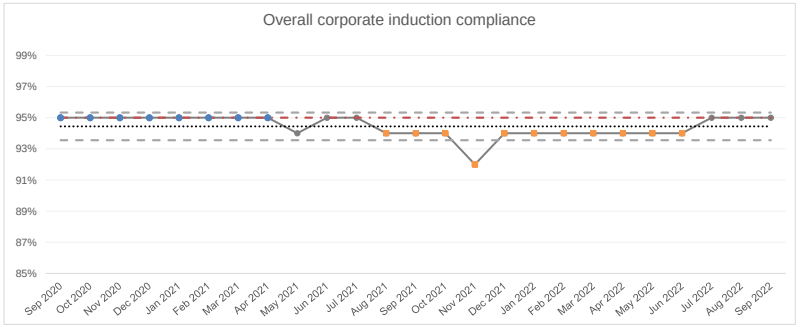
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

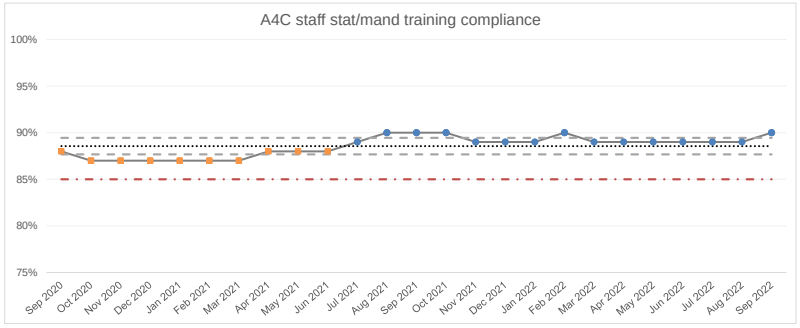
REPORTING MONTH : SEPTEMBER 2022



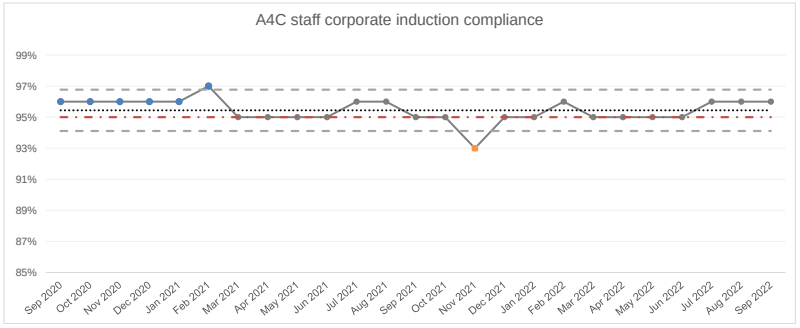
Sep 2022	Target	Variance	Assurance
87.00%	85%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently passing the target



Sep 2022	Target	Variance	Assurance
95%	95%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022	Target	Variance	Assurance
90%	85%	Special cause of improving nature or lower pressure due to higher values	Variation indicates consistently passing the target



Sep 2022	Target	Variance	Assurance
96%	95%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Overall staff stat/mand training compliance: This is indicator is showing special cause improvement since May 2021 with all data points above the mean, and August 2021 being above the upper control limit. The target is consistently being met.
Overall staff corporate induction compliance: The indicator was showing special cause concern with a run of data points below the mean from August 2021 to June 2022, with November 2021 being below the upper control limit. The target however has been met since July 2022 and is currently showing common cause variation.
A4C staff stat/mand training compliance: This is indicator is showing special cause improvement since July 2021 with all data points above the mean, and August to October 2021 being above the upper control limit, along with February 2022 and September 2022. The target is consistently being met.
A4C staff corporate induction compliance: The indicator is currently showing common cause variation with special cause concern seen in November 2021 below the lower control limit. The target has been met since July 2022.

Challenges:
A lack of induction results in a poor staff experience, negatively impacting productivity and retention.

Missed mandatory training leads to gaps in assurance that staff have a current knowledge of key policies and practices.

Key Risks:
The organisation fails to foster a connection with new staff at the beginning of employment resulting in increased turnover during early employment.

A lack of up-to-date knowledge risks deficiencies in care, which may result in poor outcomes.

Actions:
See Training-Induction (2) sheet for coverage of Medical & Dental staff.

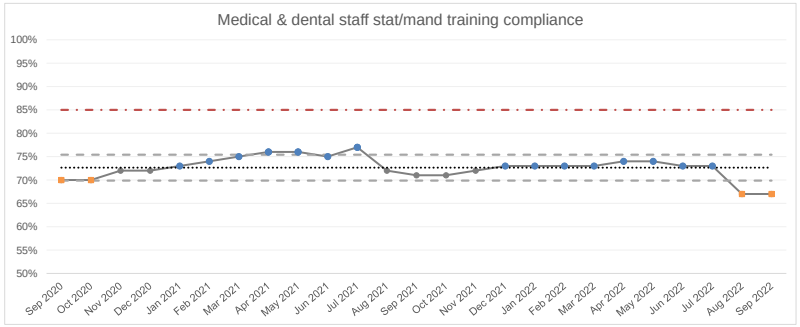
The Trust is devising a new induction package to support new starters with their orientation in the organisation and introduce them to a wider range of people and services who can support them during their employment.

Mitigations:
The Trust has been providing all new starters with a welcome booklet and a video message from the Chief Executive at the beginning of their employment, to complement existing local and job-specific induction.

OUR PEOPLE - Training / Induction (cont.)

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022

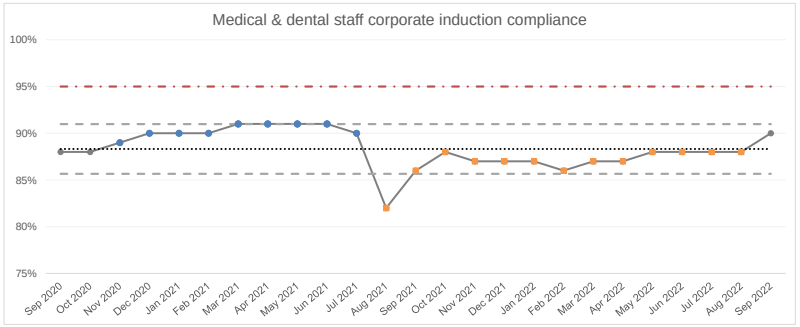


Sep 2022
67.00%

Target
85%

Variance
Special cause of concerning nature or higher pressure due to lower values

Assurance
Variation indicates consistently falling short of the target



Sep 2022
90%

Target
95%

Variance
Common cause - no significant change

Assurance
Variation indicates consistently falling short of the target

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Data Analysis:

Medical & dental staff stat/mand training compliance: The indicator is consistently failing target. Compliance for August and September 2022 was below the lower control limit.
Medical & dental staff corporate induction compliance: The indicator was showing special cause concern with thirteen points below the mean from August 2021. The last time the target was met was July 2020. The indicator is currently showing common cause variation above the mean for September 2022.

Challenges:

Key Risks:

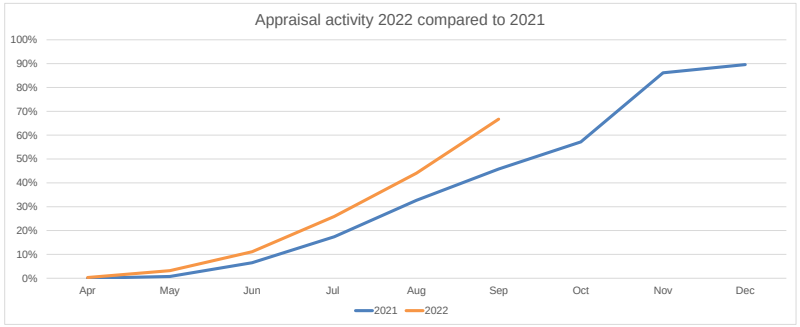
Actions:
The Trust's mandatory training compliance levels remain below target for medical and dental staff. It is normal for there to be a dip in compliance rates in the late summer and autumn months in comparison with the first half of the year due to doctors-in training changeovers in August and September; however, compliance is below where the Trust expects it to be at this point. Anyone whose training record is not compliant is being written to and asked if they require any further support to achieve completion. Alongside this, the Trust is closely tracking subjects where completion rates amongst all staff - including doctors – are below the 85% standard. Deprivation of Liberty Safeguards and Mental Capacity Act training (in particular, DOLS Level 2 training is 66%) and Resuscitation training (in particular, Paediatrics Advance Life training at 41%) are areas where work is being undertaken to improve take-up by refreshing training needs analyses and exploring different options for delivery.

Mitigations:
Medical staff rotating into the organisation in August are provided with a specific induction event to support their orientation in the organisation.

OUR PEOPLE - Appraisal Activity (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022



Sep 2022
66.73%

Target
90%

Variance
There is currently insufficient data, therefore variance and target assurance are not relevant

Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant

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Data Analysis:

Appraisal activity: This indicator is not presented as a statistical process control chart (SPC) due to the nature of the appraisal window being reopened in April of each year. Appraisal activity for 2022 is currently showing above that of 2021 (in September this was 66.73% in 2022 compared to 45.78% in 2021).

Challenges:

Key Risks:
The annual appraisal is an opportunity for staff to talk about their role, professional development and objectives. Where appraisals are not undertaken, there is a risk that this could negatively impact staff engagement with their team/the organisation and there is then potential to impact on other workforce measures such as sickness and turnover.

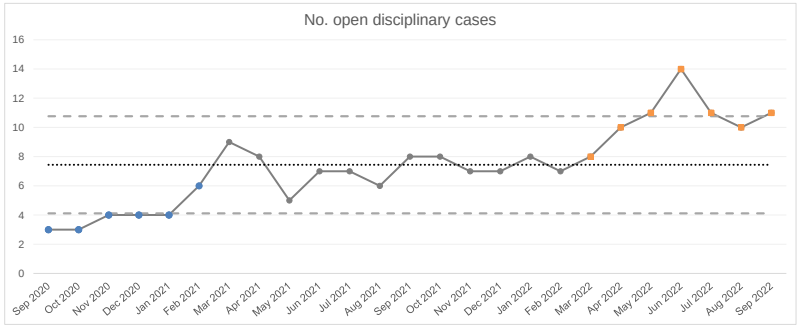
Actions:
The appraisal window was originally due to close in September, this has been extended to November to allow all staf the opportunity for an appraisal discussion with their line manager or supervisor.

Mitigations:

OUR PEOPLE - Employee Relations Activity

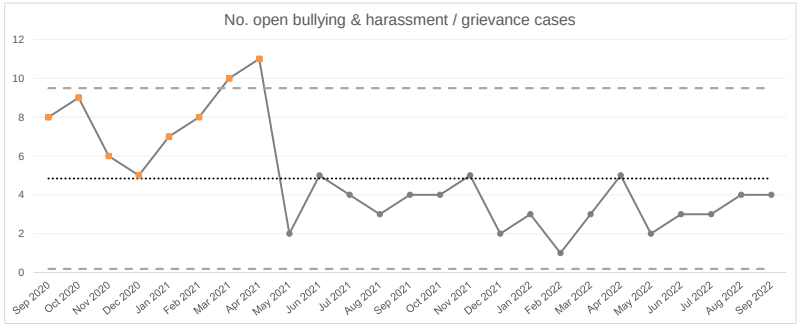
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022

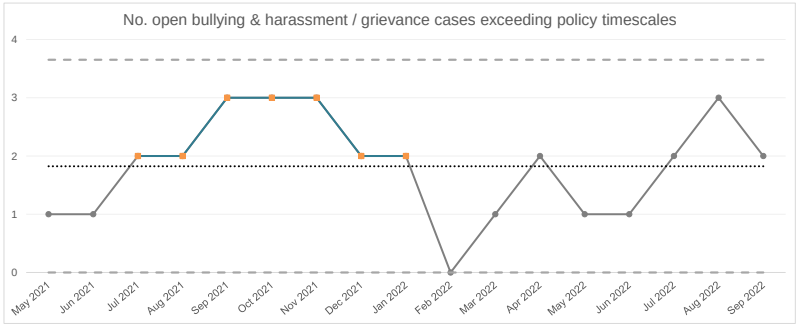


Sep 2022
11
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

Sep 2022
3
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
4
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
2
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

No. open disciplinary cases: The indicator is showing seven points above the mean from March 2022 and special cause concern above the upper control limit in May, June, July and September 2022.
No. open disciplinary investigations exceeding policy timescales: The indicator is currently showing common cause variation, although please note the figures are shown from May 2021 only.
No. open bullying & harassment / grievance cases: The indicator is currently showing common cause variation after a run above the mean from September 2020 to April 2021.
No. open bullying & harassment / grievance cases exceeding policy timescales: The indicator is currently showing common cause variation after a run above the mean from July 2021 to January 2022, although please note the figures are shown from May 2021 only.

Challenges:

Key Risks:

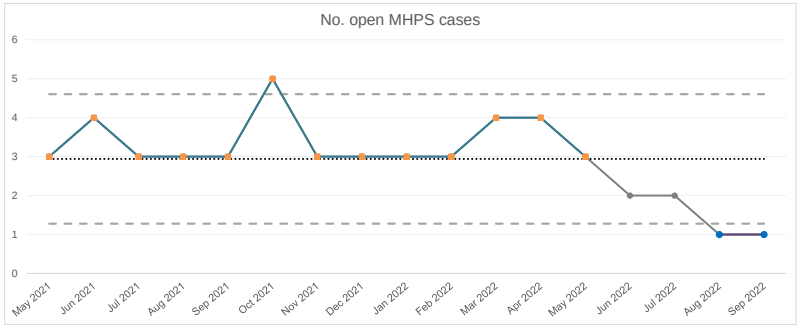
Actions:

Mitigations:

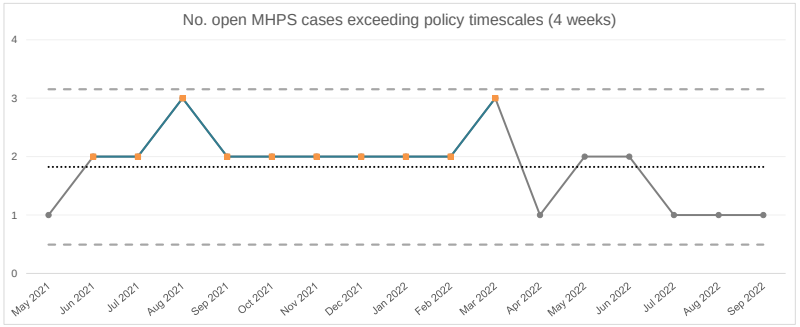
OUR PEOPLE - Employee Relations Activity (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022



Sep 2022
1
Target
No Target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
1
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

No. open MHPS cases: The indicator is showing special cause improvement with August and September 2022 being below the lower control limit. A decreasing trend was seen since May 2022, prior to that the data points were all above the mean. Please note the figures are shown from May 2021 only.
No. open MHPS cases exceeding policy timescales (4 weeks): The indicator is currently showing common cause variation, after a period of data points above the mean from June 2021 to March 2022. Please note the figures are shown from May 2021 only.

Challenges:

Key Risks:

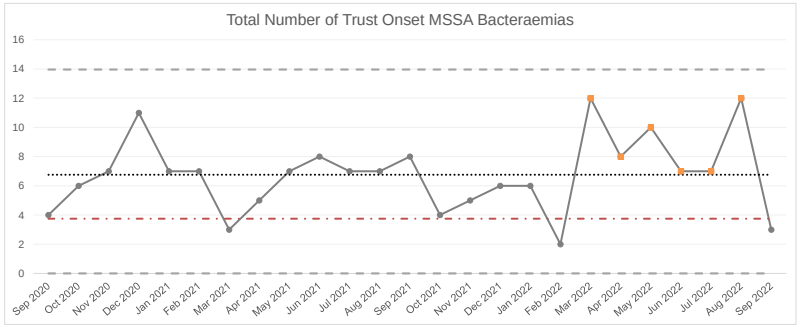
Actions:

Mitigations:

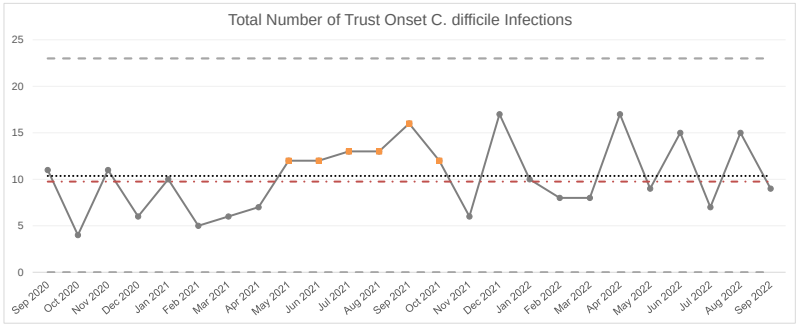
QUALITY AND SAFETY - Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

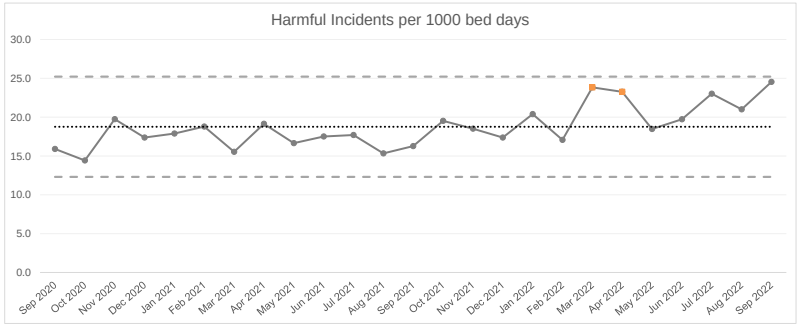
REPORTING MONTH : SEPTEMBER 2022



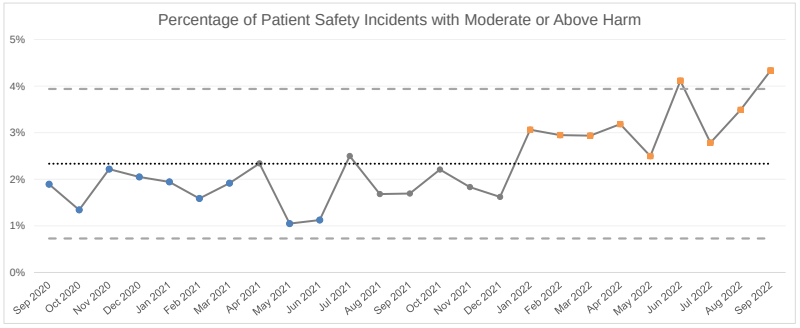
Sep 2022
3
Cumulative 12-month Target
45
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022
9
Cumulative 12-month Target
117
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022
24.5
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
4.3%
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA has shown a trend of six points above the mean, with a total of 12 cases seen in March and August 2022, close to the upper control limit. Only three cases were seen in September 2022 however.
Total Number of Trust Onset C. difficile infections: The number of infections of patients with C.difficile is currently showing common cause variation.
Harmful Incidents per 1000 bed days: The number of harmful incidents per 1000 bed days is currently showing common cause variation with two data points close to the upper control limit in March and April 2022.
Percentage of Patient Safety Incidents with Moderate or Above Harm: The percentage of patient safety incidents with moderate or above harm has shown a trend of nine points above the mean, with June and September 2022 above the upper control limit.

Challenges:
- MSSA: There remains no assurance that all staff that undertake procedures involving ANTT are competent in ANTT. PIRs for MSSA bacteraemia are currently not being carried out because the trust is still embedding the C.difficile PIR process within Care Groups.
- C.difficile: A tired and worn environment remains a significant factor for both acute sites. Additionally, there is no decant space to facilitate refurbishment and a rolling proactive HPV program.
- Undertaking risk assessments consistently
- Delivering care at the prescribed frequency, e.g. position change, intentional rounds, skin inspections – this is compounded by workforce challenges
- Ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams.
- Clear association between pressure on services / staffing issues and patient harms / quality of care.

Key Risks:
- MSSA: Sustained increase in MSSA bacteraemia with an impact on patient safety. VIP scoring training is not embedded for all staff involved with cannula checks such as HCAs. The current electronic system of checking VIP scoring can be bypassed by staff resulting in missed checks.
- C.difficile: The ribotype 001 in Scarborough and the recent ribotype 015 in York are indications of environmental reservoirs and a risk to re-infection for patients.
- Continued high incidence of Pressure Ulcers and Falls
- Inability to deliver ward-based education at the required pace
- Pressures on services and capacity (as per challenges)
- National issues with staff shortages, recruitment and retention

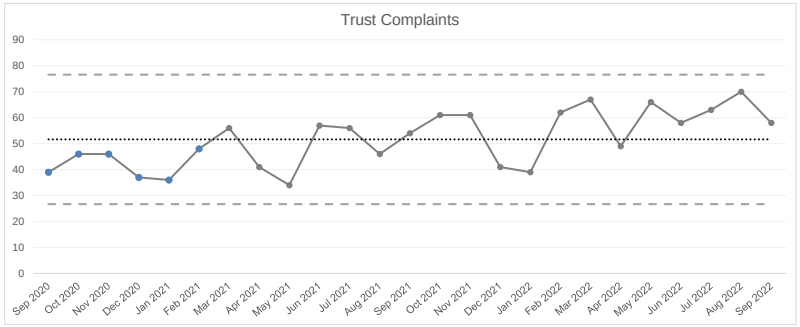
Actions:
- Bite size training from clinical educators
- TVN clinical educator post commenced on 19th September 2022.
- Development of digital documentation aimed at streamlining processes and releasing time to care
- Improvement groups continue to progress initiatives in relation to falls and pressure ulcers.
- MSSA: A meeting to discuss reduction strategies was held in September 2022 with recommendations to carry out a cannula audit on the admission ward in York as a baseline.
- C.difficile: Piecemeal HPV of bays on the Scarborough site although not as effective is being used as an option to eliminate reservoirs of microorganisms from the environment. In York, a program to replace windows is being capitalised on for minor refurbishments and HPV.

Mitigations:
- The C.difficile PIR process will be emulated for MSSA bactraemia to ensure a streamlined process of learning from themes. VIP scoring is planned to be transferred to the new Nucleus app system in phase 2 of the roll out. The C.dificile Improvement Groups is tracking themes from PIRs and sharing this across all Care Groups to improve practice and reduce the incidence of C.difficile. The Cleaning Standards Group is tracking cleaning standards from environmental walk rounds and synbiotix cleaning audits and escalating any issues to IPSAG.
- Launch and roll out of Nucleus digital documentation on track for end of October 2022
- Clinical educators involvement in bite-size training
- Falls e-learning uptake being monitored through Falls Improvement Group with 17% compliance trust wide in the first month. Face to face preceptorship training commenced in September 2022.
- Improvement work in place at Trust-wide level and ward level
- Falls lead now appointed and falls training approved. Pressure ulcer initial assessment shows improved compliance with 6 hour target.
- Weekly harms meeting with Senior Nurses and Patient Safety Team to review falls and pressure ulcer incidents and ensure thorough investigation and escalation to SI Group as required
- Staffing challenges recognised and various measure in place to mitigate risks as much as possible

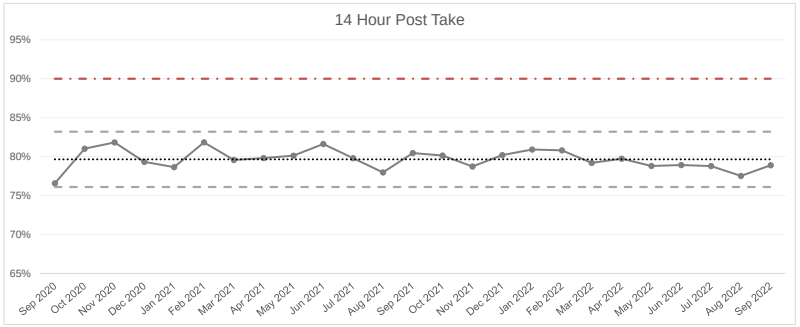
QUALITY AND SAFETY - Priority Metrics (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

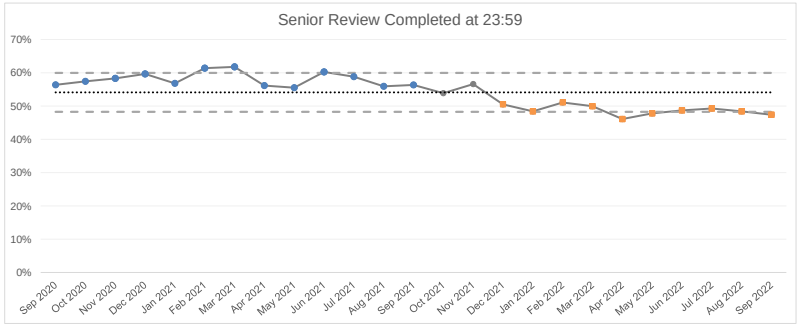
REPORTING MONTH : SEPTEMBER 2022



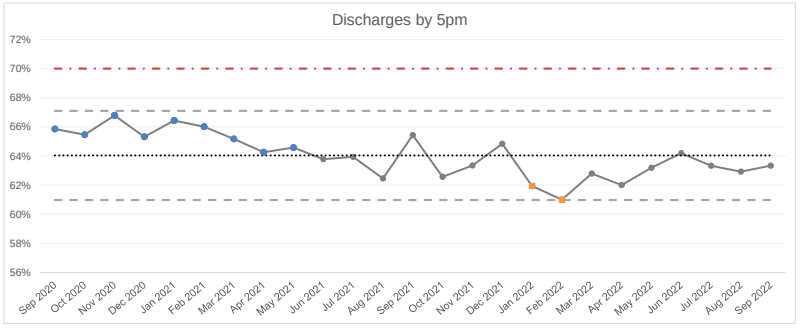
Sep 2022	Target	Variance	Assurance
58	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
78.9%	90%	Common cause - no significant change	Variation indicates consistently falling short of the target



Sep 2022	Target	Variance	Assurance
47.4%	No Target	Special cause of concerning nature or higher pressure due to lower values	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
63.3%	70%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:

Trust Complaints: The number of Trust complaints is currently showing common cause variation.
14 Hour Post Take: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target.
Senior Review Completed at 23:59: Special cause concern is showing with a run of ten months below the mean. April 2022 was below the lower control limit, with September 2022 also slightly below the lower control limit.
Discharges by 5pm: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target. The indicator is currently showing common cause variation just below the mean.

Challenges:
- The performance for 14-hour post-take review remains consistently below expected performance with Scarborough showing a better level of performance than York.
- Daily Senior review is also below performance target and has been drifting around and below the lower control limit for nearly a year. Compliance is significantly lower at the weekend in both York and Scarborough.
- Challenges relate to consistent recording of reviews, medical engagement and medical capacity across the 7-day period.
- Acuity of patients, requiring more medical input
- ED – environment, waiting times, staff attitude and the impact of building works
- Long waits for some appointments, scans, procedures and results
- Unable to achieve cancer pathways due to continued delays in pathology reporting
- Sickness absence and vacancies
- Embedding staff values – increase in the number of complaints about staff attitude

Key Risks:
- Risk of delays in appropriate treatment.
- Overstretched staff and potential burn out.
- Due to service pressures and clinical priorities care groups unable to address complaints in timely way

Actions:
- Medical Director working with clinicians to set the expectations. 7 Day standards group undertaking analysis of the 7-Day standards to support Board discussions regarding the resources required to achieve performance over the 7-day period.
- NEWS2 compliance has been escalated to QPAS.
- Complaint responses are monitored within specialty governance meetings & monitored by care group governance processes

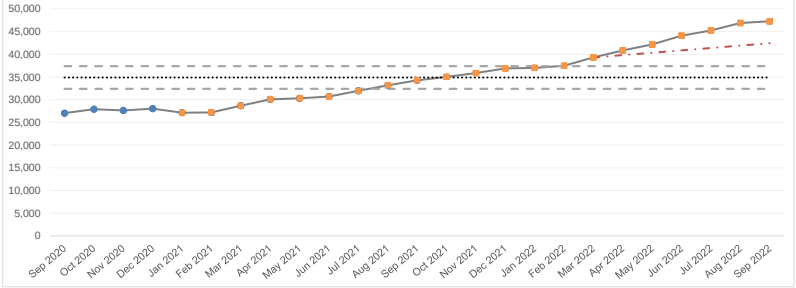
Mitigations:
- Through wider Trust response to current and anticipated service pressures
- Care groups have internal processes to regularly review progress /timescales

ELECTIVE RECOVERY - Priority Metrics

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

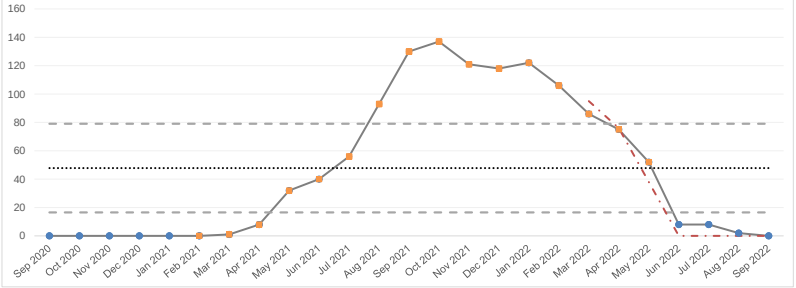
REPORTING MONTH : SEPTEMBER 2022

RTT Total Waiting List



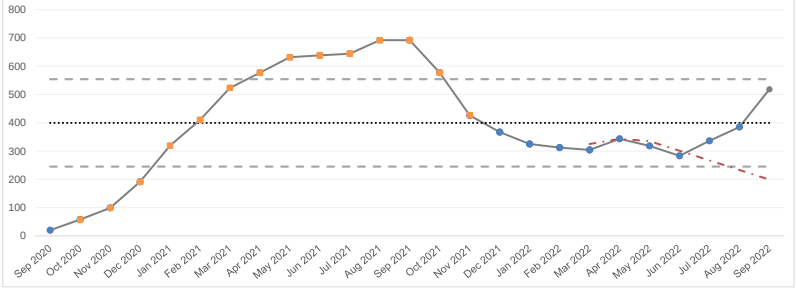
Sep 2022	Target	Variance	Assurance
47289	42445	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently passing the target

RTT Waits over 104 weeks for incomplete pathways



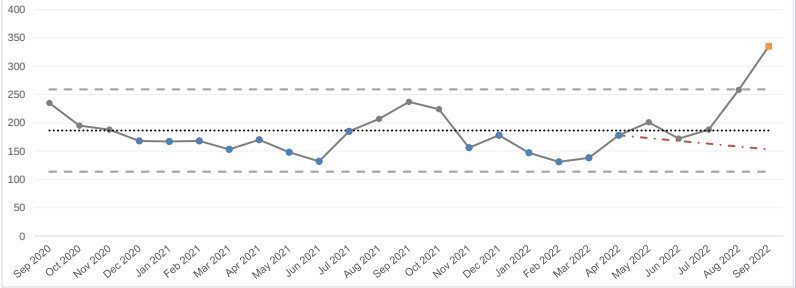
Sep 2022	Target	Variance	Assurance
0	0	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

RTT Waits over 78 weeks for incomplete pathways



Sep 2022	Target	Variance	Assurance
518	199	Common cause - no significant change	Variation indicates consistently falling short of the target

Number of patients waiting 63 or more days after referral from cancer PTL



Sep 2022	Target	Variance	Assurance
335	153	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:
RTT Total Waiting List: The waiting list continues to grow in a steady trajectory month on month and the number of incomplete clocks at end of Sep 2022 is 47,289. This exceeds the internal target of 42,445 for that month.
RTT Waits over 104 weeks for incomplete pathways: The number of 104+ week waiters has been declining since October 2021 and for Sep 2022 there were 0 waiters at Priority 6. The target was to reduce the number of 104+ week waiters to 0 by June 2022.
RTT Waits over 78 weeks for incomplete pathways: The number of 78+ week waiters has been declining since September 2021 and is now showing common cause variation around the mean. The national target is to reduce the number of 78+ week waiters to zero by March 2023, but Sep 2022 is currently below the internal target for this month. Since Jun 2022, we have seen the trend increasing for 78+ week waiters, with Sep 2022 coming just under the upper control limit.
Number of patients waiting 63 or more days after referral from cancer PTL: This indicator has been showing variation within the upper and lower control limit since Sep 2020. The number for Sep 2022 has increased significantly above the upper control limit to 335.

Challenges:
- Theatre capacity affected by short notice sickness, vacancies and an influx of acute activity reducing the number of available theatre lists across the Trust in August.
- Insufficient established workforce in MRI to meet demands on service.
- Gynaecology Nursing capacity to support delivery of planned care.
- Extended times to first appointment resulting in delays for patients and reduction in clock stop activity.
- The reduction of 'stop clocks' combined with pre-pandemic referrals levels has resulting in the waiting list increasing 34.6% from August 2021.
- The Trust has resubmitted a trajectory for 78 weeks, with 3857 clock stops required to meet the target by March 23, with Head and Neck specialities accounting for over 50%.
- The Trust has resubmitted a trajectory to return to plan for patients waiting over 62 days on a cancer pathway
- The 50 week SLA has been agreed, however is not yet mobilised due to job planning arrangements and the reduction in the Trust SLA.
- Mutual aid arrangements have not yet been able to offer significant support for the Trust.

Key Risks:
- The Trust is likely to move to Tier 1 Elective Recovery support (national intervention).
- Potential further COVID-19 variants and/or waves.
- Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work.
- Growth in the non-admitted waiting list.
- Theatre staffing vacancy, retention, and high sickness rates.
- Industrial action

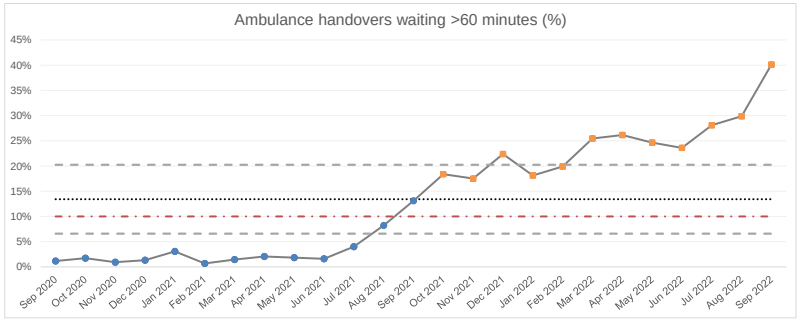
Actions:
1. The 50 week SLA has been agreed, however is not yet mobilised due to job planning arrangements and the reduction in the Trust SLA
2. The Short Form Business Case for additional theatre and outpatient procedures facilities (TIF2) has been submitted to the regional team and is with that national team for assessment.
3. Waiting List Harms Task and Finish Group established.
4. The Community Stadium development is on track for December 2022.
5. The Trust is reviewing the theatre productivity approach and data quality. This will be supported by the new Improvement Director.
6. Insourcing is in place, with a contract extension to March 2023 for theatres. Potential additional insourcing and outsourcing has been scoped by Care Groups.
7. Electronic platform for patients to access guidance on keeping 'fit for surgery'; 'My Planned Care' platform live with review of options for patient specific information underway.
8. The Outpatients Transformation Programme is in place with PIFU moving to business as usual and pilot work for Room Booker. REI to be launched in October.
9. The Executive has approved additional capacity to support patient pathways, including use of Clinical Assessment Services, booking processes and improved PTL management.
10. Training Programme for operational managers to commence in February, with pre-requisite training on RTT, Cancer and Waiting List management.

Mitigations:
- Tier 2 fortnightly meetings with Regional Team on elective recovery. Will move to weekly meetings with the Regional and National Teams if moved to Tier 1.
- Mutual Aid in place for Urology.
- Weekly Elective Recovery Meetings in place for long wait RTT patients and outpatient performance.
- Use of IS capacity to support delivery of diagnostic activity (currently MRI and CT). Additional mobile capacity to be supported by the ICS.

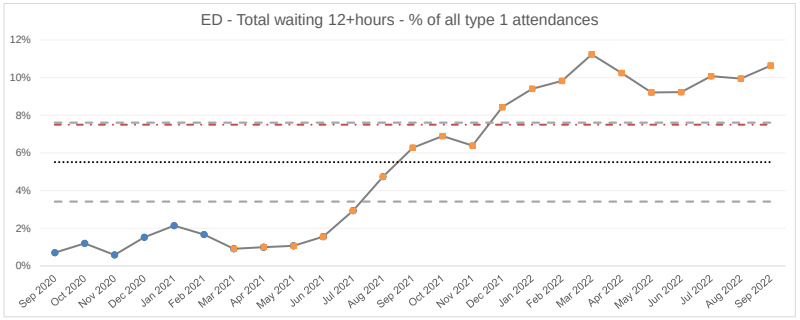
ACUTE FLOW - Priority Metrics

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

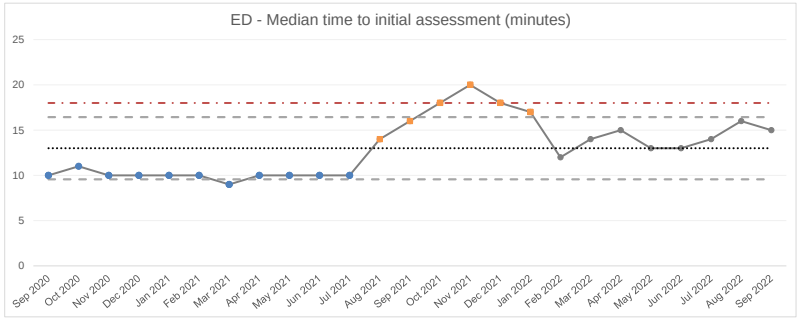
REPORTING MONTH : SEPTEMBER 2022



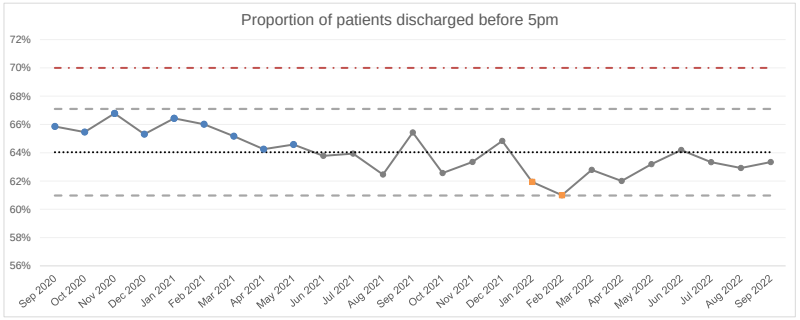
Sep 2022	Target	Variance	Assurance
40.1%	10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022	Target	Variance	Assurance
10.6%	7.5%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022	Target	Variance	Assurance
15	18	Common cause - no significant change	Variation indicates consistently passing the target



Sep 2022	Target	Variance	Assurance
63.3%	70%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:
Ambulance handovers waiting >60 minutes (%): The indicator is showing deteriorating performance over the last year with thirteen points above the mean and an increasing trend above the upper control limit. The target has not been reached since Aug 2021.
ED - Total waiting 12+hours - % of all type 1 attendances: The indicator is showing deteriorating performance with thirteen points above the mean and an increasing trend above the upper control limit. The target has not been reached since Nov 2021.
ED - Median time to initial assessment (minutes): The indicator is showing a trend above the mean in recent months, with Aug 2022 close to the upper control limit. The only months above the upper control limit were between Oct 2021 and Jan 2022. The target was not reached in Nov 2021.
Proportion of patients discharged before 5pm: The indicator is showing common cause variation, with Jan, Feb and Apr 22 being close to the lower control limit. The target will not be met without redesign (the closest data point to 70% was in Mar 2020).

Challenges
- The ED Capital Build at York which commenced at the beginning of November 2021 has meant that York Emergency Department continues to operate out of a smaller footprint.
- High number of patients without a 'Right to Reside' in inpatient beds affecting flow and ability to admit patients from ED in a timely manner.
- Staffing constraints (sickness, vacancies, use of agency and bank staff).

Risks
- Staffing gaps in both medical and nursing reducing the ability to open all bed capacity at York Site and requirement to reduce existing capacity to support safe staffing levels.
- Inability to achieve Ambulance Handover targets due to patient flow within the hospital.
- Inability to meet patient waiting times in ED due to flow constraints at both sites
- Staff fatigue.
- Risk of COVID-19 new variant or surge in respiratory virus
- Risk of Industrial Action

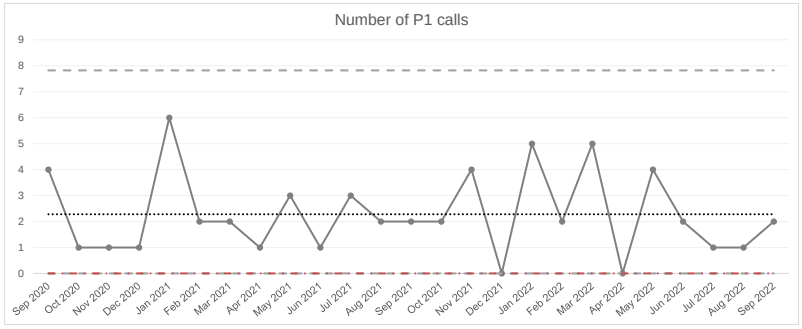
Actions:
1. On track to complete the ED build at York by March 2023 to provide additional clinical space for the urgent and emergency pathways.
2. Business case for revised acute care clinical model for all specialities for ED York to be presented to October Care Board, aligned to winter planning.
3. Refresh of the Urgent and Emergency Care Programme under the direction of the Programme Lead.
4. Work continues to support direct admission from ambulance to assessment units by extending the range of clinical criteria for Paediatrics, Gynaecology and Medicine by March 2023.
5. Emergency Assessment Units now open 24/7, work ongoing to extend the clinical criteria and pathways.
6. Project on track to extend the range of specialities operating through a Surgical Assessment Unit E.g. Orthopaedics and Gynaecology.
7. Work continues on the new ED build at Scarborough due for completion in 2024, with project resource identified to support the development of the revised acute care clinical model with all specialities.
8. Vaccination programme commenced in September 22.
9. Continued focus on the 100-day Discharge Challenge to optimise discharge planning and flow. Ongoing engagement with system partners.
10. Exploration of the development of a domiciliary social care service to support the discharge of patients who do not have the right to reside.

Mitigations:
- Daily review of medical and nursing staffing to ensure appropriate skill mix – ongoing.
- Sustained improvement in September of time to initial assessment to ensure undifferenced risk is assessed in a timely way.
- Weekly meeting to progress the Rapid Quality Review Action Plan.
- Urgent Care System Programme Board established across the Integrated Care System.
- Interim Improvement Director started 10 October 2022 and will support the system strategic plans to reduce the number of patients who do not have a criteria to reside.
- Ambulance Handover Plan in place and updated SOP for escalations, cohorting and diversion requests.

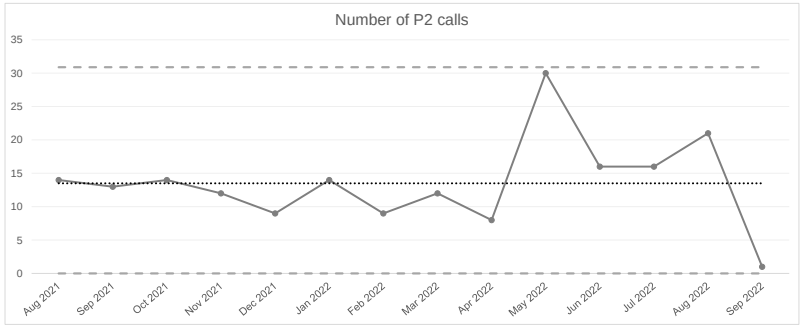
DIGITAL - Digital Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

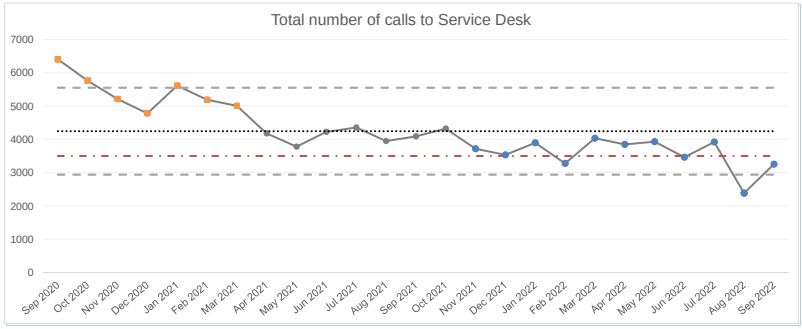
REPORTING MONTH : SEPTEMBER 2022



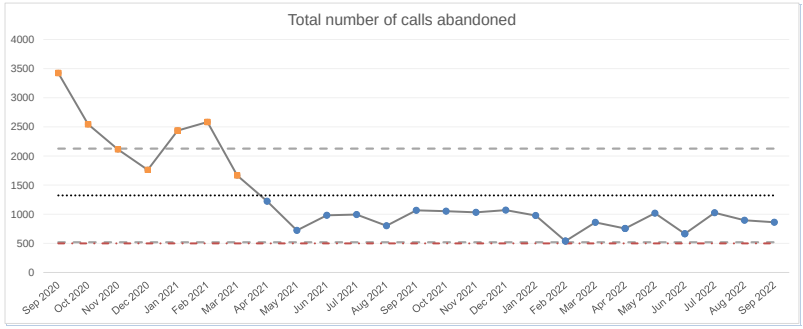
Sep 2022	Target	Variance	Assurance
2	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Sep 2022	Target	Variance	Assurance
1	No Target	There is currently insufficient data, therefore variance and target assurance are not relevant	There is currently insufficient data, therefore variance and target assurance are not relevant



Sep 2022	Target	Variance	Assurance
3256	3500	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Sep 2022	Target	Variance	Assurance
862	500	Special cause of improving nature or lower pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Number of P2 calls: The indicator is currently showing common cause variation, with a sharp increase in P2 calls in December 2021, and only one P2 call showing in September 2022.
Total number of calls to Service Desk: The indicator is showing a run of points below the mean since November 2021. Please note that the September 2022 figure is an estimation based on an average of the previous three months. The indicator is consistently failing the target.
Total number of abandoned calls: The indicator is showing a run of points below the mean since April 2021. Please note that the September 2022 figure is an estimation based on an average of the previous three months. The indicator is consistently failing the target.
Number of open calls (last day of month): The indicator was showing a run of points below the mean since April 2021, however September 2022 was above the mean at 2442 calls. It is consistently failing the target.

Challenges:
The complexity of the application infrastructure and age of some of the end user compute systems leads to a relativley high number of services calls.
The Service Desk Managment software is relatively basic, and does not enable the type of moderm service that we would like to provide.

Key Risks:
DIS 1: Cyber attacks caused by a computer virus or malware, insufficient resources (financial and human), user behaviour, unauthorised access, phishing and unsecure data flows. This leads to patient harm, reputational impact, unavailability of systems, financial costs.
DIS2: A failure of the core technology estate (e.g. CPD or network infrastructure) caused by single points of weakness, loss of power/premises, insufficient funding in the infrastructure or poor data storage/sharing processes. This leads to patient harm, prolonged service disruption, poor quality of patient care, reputational damage, financial costs and regulatory scrutiny/censure.
DIS 5 Failure to effectively manage change due to a lack of oversight over key change programmes, insufficient budget, lack of policies/procedures for managing change or single points of failure e.g. insufficient project/programme resource. This leads to financial costs, patient harm, reputational damage or regulatory fines/censure.

Actions:

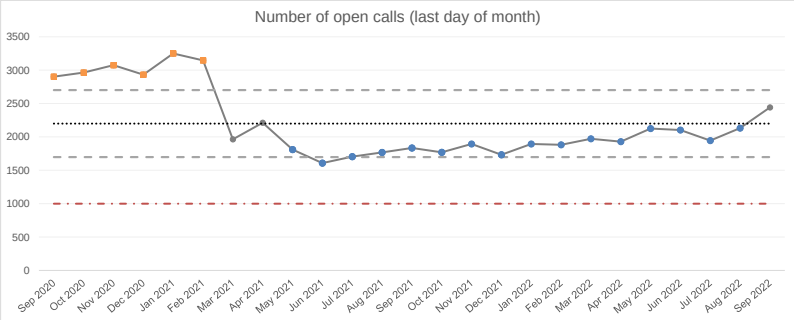
Short term initiatite to recruit additional support for the help desk has been succesful and is aimed to ensure that the service desk has appropriate staffing levels. These staff should be on-boarded by the end of the caledar year. The helpdesk is currently
suplemented when required by using other technical teams to support.

Mitigations:
See DIS Corporate Risk Register

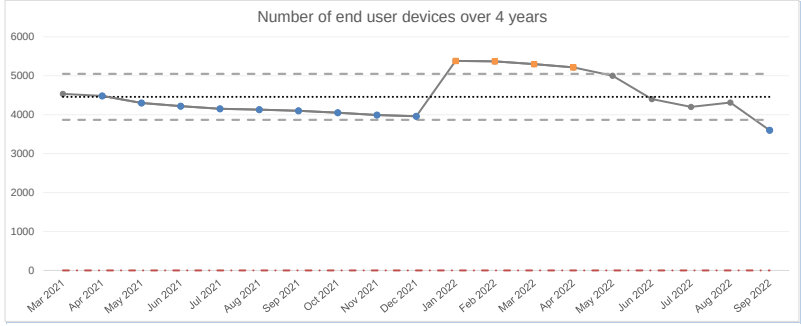
DIGITAL - Digital Indicators (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022



Sep 2022	2442
Target	1000
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



Sep 2022	3600
Target	0
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target

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Data Analysis:

Number of end user devices over 4 years: In Jan 2022 the indicator moved above the upper lower control limit for four months. The number of end user assets (laptops,desktops) over 4 years old rose in Jan 2022 by circa 1500. This is due to a batch of devices triggering their anniversary and moving from 3 year plus to 4. The number of devices has fallen below the lower control limit for Sep 2022 (3600).

Challenges:

By the middle of November, it is anticpated all stock from the previous years funding will have been deployed within the trust. Therefore, November and December will see the figures plateu and then an increase of approx. 1100 from Janurary onwards.
There is currently no recurring capital refresh programme for end user computing.

Key Risks:

There is a risk of the recurrent annual funding required to reduce the number of laptops/desktops under 4 years old is not available resulting us not able to reduce the number.

Actions:

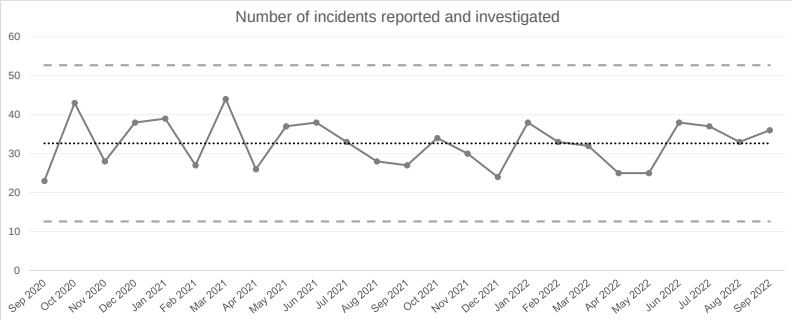
Ensure that all external funding is exploited to improve the position of Devices over 4 years old, in parallel with making the case for a recurring capital refresh programme.

Mitigations:

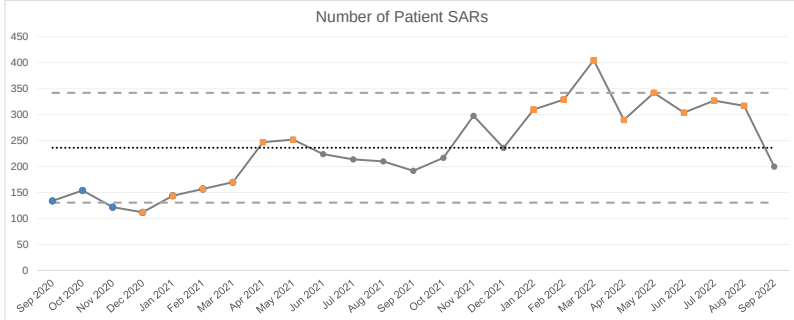
DIGITAL - Information Governance Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

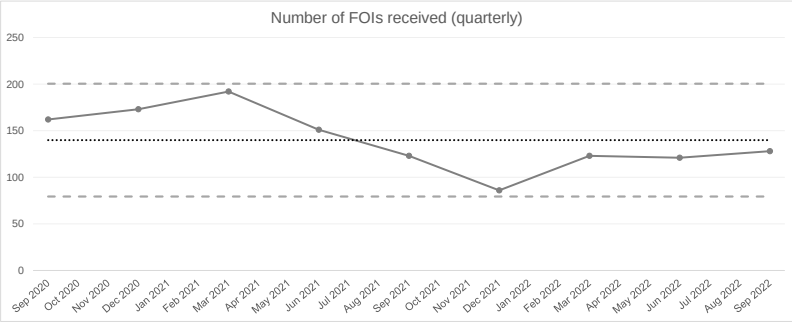
REPORTING MONTH : SEPTEMBER 2022



Sep 2022	36
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Sep 2022	200
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Sep 2022	128
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant

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Data Analysis:

Number of incidents reported and investigated: This indicator is showing common cause variation with recent months being relatively close to the mean.
Number of Patient SARS: This indicator is currently showing common cause variation after a run of eight points above the mean. A high number of Patient SARS were seen in March 2022 (405), which is above the upper control limit.

Challenges:
Sufficient resources to manage FoIs, chasing responses alongside other IG priorities.
Engagement and sufficient resources within the service areas to provide FoI responses alongside other priorities.

Key Risks:
Not meeting statutory responsibilities.
Intervention from the regulator (ICO)

Actions:
Develop FoI handbook to speed process of applying exemptions and developing providing response templates.
Establish key contacts within service areas that can support with responses.
Explore the need for additional resource within the IG team to support the FoI process.

Mitigations:

Finance Performance Report : Sep-2022

Executive Summary

Trust Strategic Goals:

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

Purpose of the Report:

To provide the Board with an integrated overview of Finance Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

Financial Position – September 2022 (Month 6)

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 adjusted deficit of £3.3m against a planned deficit of £0.4m for September. The Trust is £2.9m adversely adrift of plan. The I&E variance to plan position has stabilised and remains at exactly the same level as that reported last month, although there are some significant changes at individual reported line level.

The largest adverse variance relates to pay at £5.1m. Pay expenditure this month is £5m higher than the average of the previous five months. This is primarily attributable to the payment of the 22/23 pay award plus backpay to most staff groups other than junior doctors who have a separate three-year deal. The majority of the pay award is met by additional income through our contracts with ICSs and NHSE, although national calculations of the percentage uplift to contracts with commissioners to cover the pay award have left an underlying cost pressure with many providers including the Trust. We have assessed a £2.1m annual pressure for the Trust, meaning that the £1m pressure for the year to date is contributing to the reported deficit position. This issue has been escalated nationally, and we are awaiting a response from the national team at NHSE. Premium rate pressures linked to increased annual leave and high sickness levels also continuing to contribute to the adverse position.

Other notable variances include a drugs overspend of £0.6m (£1.9m relating to out of tariff drugs with compensating additional income from NHSE), an overspend on other costs of £1.4m, an underspend on clinical supplies and services of £4.6m, and the CIP position is behind plan by £2.1m. 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 £5.1m for the year to date on covid costs compared to a plan of £3.7m; therefore we are £1.4m 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. This position remains under discussion with Care Groups. 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.

The position is also now materially impacted by the cost of the unfunded mobile CT scanner that the Board agreed to continue to support because of the safety impact associated with our diagnostic waiting times. Discussions continue through NHSE to access national Community Diagnostic funding, but this still remains unconfirmed. This uncertainty is likely to continue into November as the national team work to address the pay award funding gap from developmental reserves such as this. The scanner is a fully serviced scanner at a cost of £1.4m for the full financial year; at month 6 this is adversely impacting our position by £0.7m.

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	75,296	37,647	39,595	1,948	79,378
Clinical commissioning groups	528,330	264,165	264,018	-147	520,604
Local authorities	4,873	2,424	2,436	12	4,740
Non-NHS: private patients	514	257	162	-95	324
Non-NHS: other	1,185	593	812	219	1,998
Operating Income from Patient Care Activities	**610,198**	**305,086**	**307,023**	**1,937**	**607,044**
Research and development	1,765	883	1,257	374	2,805
Education and training	22,544	11,239	12,859	1,620	23,046
Other income	49,130	24,637	22,111	-2,526	45,102
Other Operating Income	**73,439**	**36,759**	**36,227**	**-532**	**70,953**
Employee Expenses	-448,418	-222,910	-228,034	-5,124	-438,317
Drugs Costs	-61,934	-31,094	-31,694	-600	-64,927
Supplies and Services - Clinical	-72,840	-36,878	-32,229	4,649	-62,055
Depreciation	-18,291	-9,146	-9,146	0	-18,291
Amortisation	-1,521	-761	-761	0	-1,521
CIP	7,912	2,069	0	-2,069	7,912
Other Costs	-70,459	-34,481	-35,921	-1,440	-83,190
Total Operating Expenditure	**-665,551**	**-333,200**	**-337,784**	**-4,584**	**-660,389**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**8,645**	**5,466**	**-3,179**	**17,608**
Finance income	30	15	283	268	507
Finance expense	-975	-488	-490	-2	-975
PDC dividends payable/refundable	-8,014	-4,007	-4,007	0	-8,013
NET FINANCE COSTS	**9,127**	**4,165**	**1,252**	**-2,913**	**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**	**4,165**	**1,252**	**-2,913**	**9,127**
Remove Donated Asset Income	-9,607	-4,804	-4,803	1	-9,607
Remove Donated Asset Depreciation	452	226	226	0	452
Remove Donated Asset Amortisation	28	14	14	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**	**-399**	**-3,311**	**-2912**	**0**

3. Cost Improvement programme

The core efficiency programme requirement for 2022/23 is £15.7m. 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 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. These requirements have been fully delivered and transacted. The table below details the full programme.

2022/23 Cost Improvement Programme - September									
		September 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	£1,302	£570	£732	£1,562	£1,453	£1,349	£212	£0
2. Acute, Emergency and Elderly Medicine (Scarborough)	£1,404	£606	£606	£0	£828	£576	£828	£0	£0
3. Surgery	£3,008	£1,299	£452	£846	£2,282	£726	£1,783	£499	£0
4. Cancer and Support Services	£2,552	£1,102	£600	£502	£1,837	£715	£1,516	£0	£321
5. Family Health	£1,595	£688	£763	-£74	£1,972	-£378	£1,471	£0	£501
6. Specialised Medicine	£1,639	£708	£594	£113	£1,631	£8	£1,525	£106	£0
7. Corporate Functions									
Chief Exec	£65	£28	£75	-£47	£77	-£11	£77	£0	£0
Chief Nurse Team	£164	£71	£40	£31	£72	£92	£72	£0	£0
Finance	£184	£79	£328	-£249	£499	-£316	£499	£0	£0
Medical Governance	£15	£6	£0	£6	£0	£15	£0	£0	£0
Ops Management	£101	£44	£50	-£6	£50	£51	£50	£0	£0
Corporate CIP	£16,890	£8,445	£8,496	-£51	£19,896	-£3,006	£18,352	£379	£1,164
DIS	£289	£125	£67	£58	£219	£70	£219	£0	£0
Workforce & OD	£314	£136	£158	-£22	£575	-£261	£575	£0	£0
				£0					
Sub total	**£31,234**	**£14,638**	**£12,799**	**£1,840**	**£31,499**	**-£265**	**£28,317**	**£1,195**	**£1,987**
YTHFM LLP	£1,123	£485	£254	£230	£849	£274	£671	£159	£19
Group Total	**£32,357**	**£15,123**	**£13,053**	**£2,070**	**£32,348**	**£8**	**£28,988**	**£1,354**	**£2,006**

Delivery in month 6 has improved but remains behind plan in terms of the core programme delivery. Total plans have now been identified to deliver the total programme of £32.4m, and of this sum £29.0m (90%) is identified as low risk.

Productivity and Efficiency Reviews will be held with Care Groups in October/November. These sessions will be chaired by the Chief Executive.

Getting It Right First Time (GIRFT) Update

Planning work has been completed with Urology to deliver an external GIRFT review on 21 October 2022.

On 9 November 2022 there will be a GIRFT session to review the High Volume Low Complexity (HVLC) procedures across the ICS led by Professor Briggs from the National Team.

Work has been progressing with CG1 and CG2 to ensure data templates are completed for upcoming Emergency Medicine and Acute and General Medicine GIRFT visits which are scheduled for 16 November 2022. These will be joint reviews with clinical teams from across all sites to ensure learning and insights can be shared as part of the GIRFT review process.

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 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, but no funding identified yet.	Continuing in operation. NHSE and ICS aware. Causing £0.7m pressure on our plan. ICS CDH team are submitting national case for support, working with the Trust. No timeline information available, expect November update.
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 intervention and to support discharge.	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 CG2 for covering expenditure non-recurrently using temporary 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 general use after the Jubilee bank holiday weekend to limit expenditure but has occasionally deployed when under real exceptional pressure.

5. ERF

ERF has been confirmed as not recoverable i.e. there we be no clawback by NHSE for under performance, for quarters one and two. This secures ERF income in plan through to September. This is fully reflected in the reported position for the period to date.

We have heard informally that the arrangements for the first half of the year may be extended to the second half of the year, but we still await formal confirmation.

6. Current Cash Position

September cash balance showed a £13.7m favourable variance to plan; this is mainly due to debtors which is £6m behind plan with a £5.6m Health Education England invoice being paid in September. We have also drawn down PDC in September in readiness to pay capital invoices which fall due in October. 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	46,473	49,160	41,182	34,713	36,376	33,648	33,599	36,273	39,964	53,435
Actual	51,793	45,722	39,382	40,651	45,200	48,410						

With NHSE confirming that no ERF will be clawed back for quarters one and two we have been able to forecast income with greater certainty over the first half of the year, but we await confirmation of how ERF will operate for the second half of the year. 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 6 Planned Spend £000s	Mth 6 Actual Spend £000s	Variance £000s
86,513	26,478	23,752	(2,726)

The capital programme for month 6 overall is £2.7m behind plan, this is due to the Community Stadium lease of £8m not being finalised which is partially offset by other leases running ahead of plan. If we remove the impact of IFRS 16 figures the capital programme is £1.2m (7%) ahead of plan, mainly due to the progress with the Scarborough UEC scheme.

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 the work with Care Groups and Corporate Teams has identified plans equal to the full value of the required programme. Notably most of the 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.	ERF has been confirmed as non-refundable for the first half of the financial year. This has significantly reduced the risk in this regard. We have heard informally that the arrangements in the first half of the year may be extended into the second half of the year, but formal confirmation of this position is still awaited.
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 is progressing 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.

Risk Issue	Comments	Mitigation/Management	Current Update
Winter funding pressures	The plan removes the Trust's typical winter contingency that would normally allow further investments to be made at peak activity times.	Full knowledge has been shared to ensure that the ICB and regional teams are aware that 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.	Early information has been shared that suggests £250m will be released nationally for additional winter capacity. We expect to be working with ICS colleagues on this programme in the coming month. The Trust expects at least £1.7m from this fund although confirmation is not yet available. Finalisation of the supported schemes is currently being agreed with the ICB.
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 receding and we do not expect material clawback or further savings requirements from the ICB.
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 of the York ED scheme overspend is now clear and the programme has been adjusted accordingly. This has placed significant pressure on the Trust's capital programme.

9. Income and Expenditure Forecast

As we are now six months into the financial year we have updated our I&E forecast tool to assess our likely year end outcome. The tool takes current trends, adjusted for non-recurrent issues and new expected issues, and extrapolates forward to March 2023.

The current assessment is summarised in the table below.

	Forecast Outturn 22/23 (£000)
Clinical Income	615,526
Non-Clinical Income	76,760
Expenditure	-683,159
Surplus/(deficit)	9,127
NHSE Adjustments	-9,127
NHSE Adjusted Position	0

Key assumptions that been made in the forecast include:

- Additional income is received to cover the £1.4m cost of the CT scanner
- All ERF income is received.
- Covid in the envelope expenditure returns to plan for the final six months of the year.
- The remaining CIP left to achieve will have a 36% impact on run rate.
- Staff car parking charging is reintroduced in Q4.

This forecast has formed the basis of our forecast submission to NHSE/ICB for M6.

Recommendation:

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

Author(s): Graham Lamb, Deputy Finance Director

Director Sponsor: Andrew Bertram, Finance Director

Date: Oct-2022

TRUST BOARD REPORT : September-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

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	75,296	37,647	39,595	1,948	79,378
Clinical commissioning groups	528,330	264,165	264,018	-147	520,604
Local authorities	4,873	2,424	2,436	12	4,740
Non-NHS: private patients	514	257	162	-95	324
Non-NHS: other	1,185	593	812	219	1,998
Operating Income from Patient Care Activities	**610,198**	**305,086**	**307,023**	**1,937**	**607,044**
Research and development	1,765	883	1,257	374	2,805
Education and training	22,544	11,239	12,859	1,620	23,046
Other income	49,130	24,637	22,111	-2,526	45,102
Other Operating Income	**73,439**	**36,759**	**36,227**	**-532**	**70,953**
Employee Expenses	-448,418	-222,910	-228,034	-5,124	-438,317
Drugs Costs	-61,934	-31,094	-31,694	-600	-64,927
Supplies and Services - Clinical	-72,840	-36,878	-32,229	4,649	-62,055
Depreciation	-18,291	-9,146	-9,146	0	-18,291
Amortisation	-1,521	-761	-761	0	-1,521
CIP	7,912	2,069	0	-2,069	7,912
Other Costs	-70,459	-34,481	-35,921	-1,440	-83,190
Total Operating Expenditure	**-665,551**	**-333,200**	**-337,784**	**-4,584**	**-660,389**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**8,645**	**5,466**	**-3,179**	**17,608**
Finance income	30	15	283	268	507
Finance expense	-975	-488	-490	-2	-975
PDC dividends payable/refundable	-8,014	-4,007	-4,007	0	-8,013
NET FINANCE COSTS	**9,127**	**4,165**	**1,252**	**-2,913**	**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**	**4,165**	**1,252**	**-2,913**	**9,127**
Remove Donated Asset Income	-9,607	-4,804	-4,803	1	-9,607
Remove Donated Asset Depreciation	452	226	226	0	452
Remove Donated Asset Amortisation	28	14	14	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**	**-399**	**-3,311**	**-2912**	**0**

Month 6 Summary Position

The table opposite and the graphs on the following pages show the plan for the whole of 2022/23. The Board of Directors approved the final plan at their meeting in June which presented a balanced I&E position. For the period ending September 2022, the Trust is reporting an adjusted I&E deficit of £3.311m against a planned deficit of £0.399m.

Income is £1.405m ahead of plan, primarily linked to excluded drugs and devices, research and development, and education and training income being ahead of plan; partially offset by other income being behind plan.

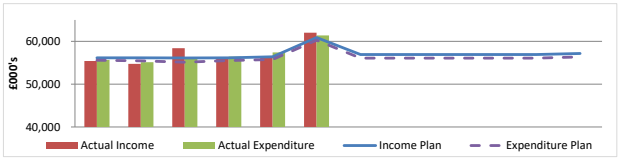
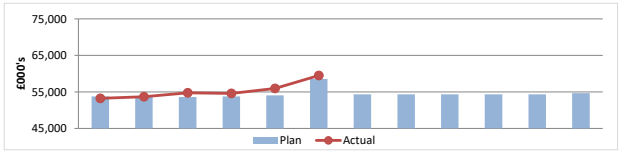
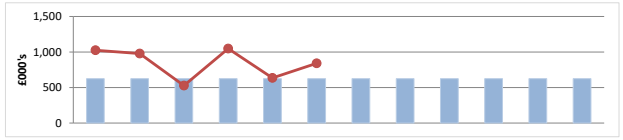
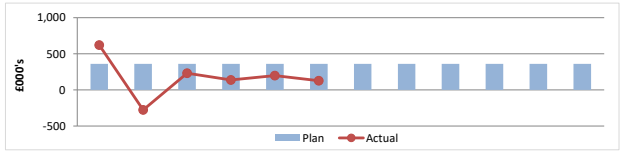
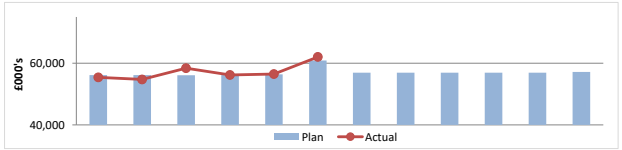
Operational expenditure is £4.584m ahead of plan. There is a shortfall in delivery against the CIP target, and pay, drug, and other non-pay spend is ahead of plan; but these are being partially offset by clinical supplies and services spend being behind plan.

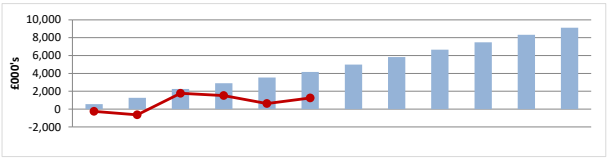
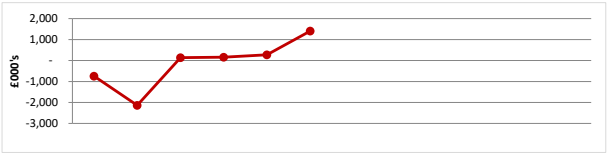
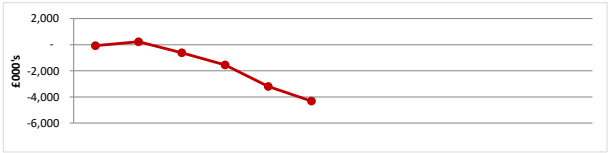
Matters of Concern and Risks to Escalate	Major Actions Undertaken and Work in Progress
1. The Trust is £2.9m behind its I&E plan. 2. Delivery of the 2.4% cost out efficiency programme is currently behind plan. 3. Risk of retaining ERF Funding through delivery of 104% activity levels, with activity currently below this level. 4. Managing the £3.5m Covid spend reduction proposed with the ICB is currently behind plan, with only £1.5m identified to date. 5. CT scanner which is key to the Trust's diagnostic recovery work is still on hire at an annual cost of £1.4m, but no funding stream yet agreed with the NHSE/I or the ICS.	1. The Corporate Efficiency Team has restarted its full support programme; full CIP reporting will recommence, and CIP panel meetings will be reconvened with the CEO. 2. A full 104% activity plan has been devised. The BBC programme picks up elective recovery as a specific work stream. 3. Work is underway with the CGs and YTHFM to look for Covid spend reduction opportunities, and formal monitoring in now in place. 4. Discussions continue with the ICS on finding a funding stream for the CT scanner.
Positive Updates and Assurance	**Decisions Made and Decisions Required of the Board**
1. Care Groups and Corporate Teams have identified efficiency plans equating to 100% of the overall required programme, with notably 90% of plans being categorised as low risk. 2. NHSE/I have confirmed that there will be no clawback or ERF for H1; with the possibility that it also will be for H2, although this is still subject to confirmation.	1. A final balance I&E plan for 2022/23 has now been approved by the Board, and submitted to the ICS and NHSE/I. The table opposite is based on the agreed final plan, whereas for M1 and M2 the previously agreed draft plan was in use.

TRUST BOARD REPORT : September-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

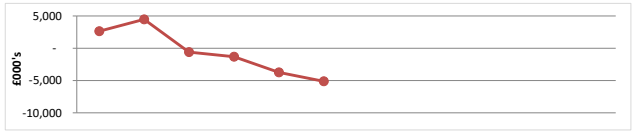
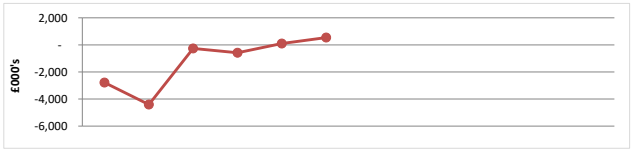
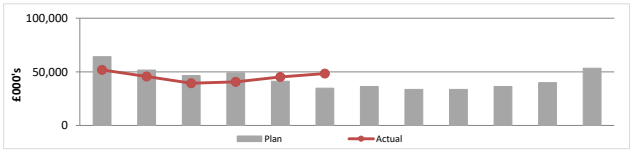
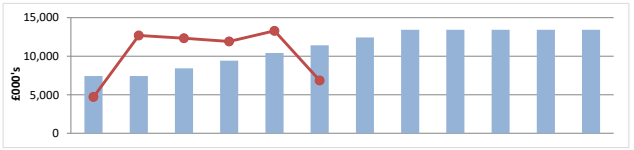
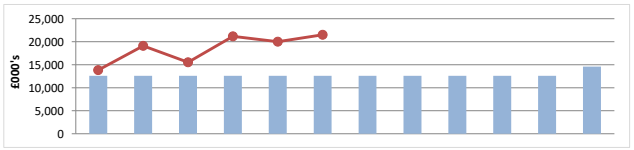
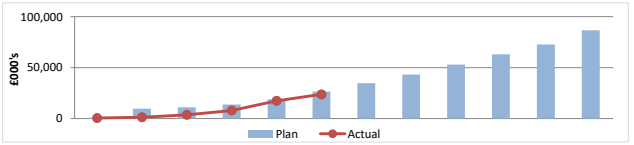
Sep-22	METRIC:	PLAN:	
£1,252	6.01 Income and Expenditure	£4,165	
£59,495	6.02 Operational Expenditure against Plan (exc. COVID)	£58,534	
£841	6.03 COVID-19 'Inside the Envelope' Expenditure	£624	
	Monthly % Covid Spend of Operational Spend:	1.4%	
£128	6.04 COVID-19 'Outside the Envelope' Expenditure	£360	
£62,027	6.05 Income against plan	£60,894	

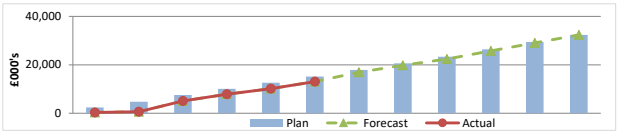
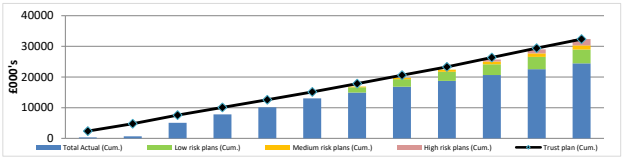
	METRIC:	PLAN:	
£1,252	6.06 Cumulative net actual Income and Expenditure surplus/(deficit)	£4,165	
-£2,913	6.07 Cumulative net Income and Expenditure surplus/(deficit) variance to plan	£0	
£1,405	6.08 Cumulative Income Variance to Plan	£0	
-£4,318	6.09 Cumulative Expenditure Variance to Plan	£0	

TRUST BOARD REPORT : September-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Sep-22	METRIC:	PLAN:	
-£5,124	6.10 Cumulative Pay Expenditure Variance to Plan	£0	
£540	6.11 Cumulative Non-pay Expenditure Variance to Plan	£0	
£48,410	6.12 Cash Position	£34,713	
£6,853	6.13 Debtors	£11,424	
£21,504	6.14 Creditors	£12,605	
£23,752	6.15 Capital	£26,478	

	METRIC:	PLAN:	
£13,055	6.16 Efficiency programme - delivery against plan and forecast delivery	£15,124	
	Delivery ytd:		
	Recurrent £6,449		
	Non Recurrent £6,606		
£32,357	6.17 Efficiency programme - planning position full year	£32,357	

Planning (Gap)/Surplus

	September £'000	EOY £'000	Comments
Target	**15,123**	**32,357**	
PLANS			
Low Risk	14,187	28,996	
Medium Risk		1,354	Medium Risk Plans being reviewed re delivery in year.
High Risk		2,006	High Risk Plans being reviewed re risk status and if deliverable in-year.
Total Plans	14,187	32,357	
Planning (Gap)/Surplus	**-936**	**0**	
Actions			**New Plans** - continue to work with CG's to identify u/spends; opportunities presented in Model Health System (more likely medium/longer term)

TRUST BOARD REPORT : September-2022

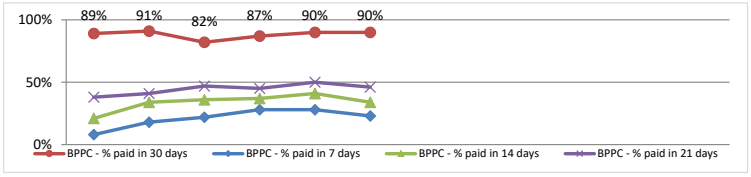
SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Sep-22	METRIC:	PLAN:
£0	6.2 Capital Service Cover	£0
£0	6.21 Liquid Ratio	£0
£0	6.22 I&E Margin	£0
£0	6.23 I&E Margin Variance from Plan	£0
£1,715	6.24 Agency Spend against Agency Cap	£1,324

BPPC Performance

Within 30 days		Within 7 days
90%	6.25 BPPC - % paid in 30 days	23%
	6.26 BPPC - % paid in 7 days	
Within 14 days	6.27 BPPC - % paid in 14 days	Within 21 days
34%		46%
	6.28 BPPC - % paid in 21 days	



Highlights for the Board to Note:

	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Capital Service Cover (20%)				
Liquidity (20%)				
I&E Margin (20%)				
I&E Margin Variance From Plan (20%)				
Agency variation from Plan (20%)				
Overall Use of Resources Rating				

Other Financial Issues:

Metrics 6.2 through 6.23 are not being actively reviewed by NHSE/I following the operation of the emergency financial regime. When normal operation resumes it is expected these will remain key assessment metrics. 6.24 showing our agency spend against plan remains a live assessment metric and, for the year to date we have used more agency staff than planned.

6.24 showing our agency spend against the newly announced NHSEI target for 22/23, which remains a live assessment metric and, for the year to date we have used more agency staff than target.

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

Research & Development Performance Report : Sep-2022

Executive Summary

Trust Strategic Goals:

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

Purpose of the Report:

To provide the Board with an integrated overview of Research Development Performance within the Trust

Executive Summary:

Key discussion points for the Board are:

Our key outcomes in the last month are as follows:

•We have recruited 2019 patients into clinical trials so far this financial year, against a target of 3506, so numbers have improved now the holiday season is over
•We have submitted one grant for funding in the month of Sept, as follows:

£84K to NIHR- To build a regional network / partnership based at the Multi Morbidity Hub at Scarborough to investigate the needs of our population in terms of liver disease and what strengths we have from a research perspective. There will be an additional funding call in two years' time that this partnership will be expected to bid into to support liver research in the region

•We are the first site in Y&H to recruit to the Harmonie vaccine study under Dr Dominic Smith. The study is looking at RSV (Respiratory Syncytial Virus) that is one of the leading causes of hospitalisation in all infants worldwide and affects 90% of children before the age of two. In recent months, there has been a resurgence of RSV following the easing of COVID-19 public health measures. That we hope this study can prevent. For further information please go here:
https://local.nihr.ac.uk/news/first-regional-participants-into-study-against-leading-cause-of-infant-hospitalisation-enrolled-at-york-hospital/31605
•We have also put an expression of interest in for a GSK funded Covid Booster vaccine study to start next year
•We are still in the process of recruiting Professor James Turvill to the Clinical Director of Research role, after Dr David Yates has decided to stand down after holding the post for three years
•We have recruited the new CG6 research lead after Dr Rob Ellis's departure, the post has been taken by Dr Pouya Alaghband
•The Annual Celebration of Research event being held on 21st November is now sold out, with 200 tickets being requested.

Recommendation:

The Board is asked to receive the report and note any actions being taken.

Author(s): Lydia Harris Head of R&D

Director Sponsor: Polly McMeekin Director of WOD
Date: Oct-2022

TRUST BOARD REPORT : September 2022

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022-23	493	442	225	229	158	286							2019
2021-22	77	166	127	1060	648	469	383	411	374	396	179	293	4583
2020-21	615	597	440	461	421	331	259	484	293	513	201	145	4760
2019-20	334	275	284	298	348	220	464	615	477	426	365	166	4272

Breakdown as of end September 22

Care Groups	Accruals Running Total 22/23
CG1 Total	178
CG2 Total	163
CG3 Total	279
CG4 Total	112
CG5 Total	8
CG6 Total	59
RP's Total	187
Cross Trust Studies Total	1033
ACCRUAL TOTALS	2019

Accruals Still Required	1487
Trials Open to Recruitment	93

Non-Commercial Studies 22/23 - Breakdown by Study Design (does not add to 100% as does not include commercial studies)

Study Design	% of all open studies	% of total 22/23 accruals to date	NIHR ABF Weighting
Interventional	34%	10%	*Weighted 11*
Observational	53%	68%	*Weighted 3.5*
Large Interventional	4%	5%	*Variable weighting by study*
Large Observational	4%	16%	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	5%
Non Commercial	95%

If you would like a breakdown of Accruals in each CG, please contact Angela.jackson2@york.nhs.uk

You may notice a difference in our accrual target this year, we have been informed by NIHR that our target for this year is 3506 patients into clinical trials, which is excellent news

APPENDIX : National Benchmarked Centiles

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : SEPTEMBER 2022

Centiles from the Public View website have been provided where available (these are not available for all indicators in the TPR).

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisations. If York and Scarborough Hospitals NHS Foundation Trust's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than the Trust. The colour shading is intended to be a visual representation of ranking of the Trust (red indicates most organisations are performing better, green indicates the Trust is performing better than many organisations. Amber shows that the Trust is in the mid range. Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 20/10/2022
* Indicates the benchmarked centiles are from varying time periods to the data presented in the TPR and should be taken as indicative for this reason
^ Indicates the benchmarked centiles use a variation in methodology to the TPR and should be taken as indicative for this reason

			Local Data (TPR)			National Benchmarked Centile		
TPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Acute Flow and Elective Recovery	UEC	Proportion of patients discharged before 5pm (70%)	Sep-22	63.3%	70%	85	26/120	Sep-22
	UEC	ED: Median Time to Initial Assessment (Minutes)	Sep-22	15	18	18	95/116	*Aug 22
	RTT	RTT Total Waiting List	Sep-22	47289	42445	33	114/169	*Aug 22
	RTT	RTT Waits over 104 weeks for incomplete pathways	Sep-22	0	0	35	110/169	*Aug 22
	RTT	RTT Waits over 78 weeks for incomplete pathways	Sep-22	518	233	19	137/169	*Aug 22
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Sep-22	3	45 (12-month)	5	130/137	*Jul-22
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Sep-22	9	117 (12-month)	17	114/137	*Jul-22
	Patient Experience	Trust Complaints	Sep-22	58	No Target	23	162/210	*Q4 21/22

Report to:	Board of Directors
Date of Meeting:	2nd November 2022
Subject:	Board Priority – People Recovery 2022-23 Update
Director Sponsor:	Polly McMeekin – Director of Workforce and OD
Author:	Polly McMeekin – Director of Workforce and OD

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:

Workforce recovery is one of the four Trust priorities. The Operational Plan approved earlier in the year detailed four components to the workforce recovery:

- Culture Change
- Working Life - (Fix the basics)
- Recruitment
- Workforce Planning

This report provides an update as to these actions. These are detailed in Annex A.

Recommendation:

To note the update report.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Board of Directors	June	To present to public board.

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	Complete
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. Launch of a Trust Leadership framework & 360 Leadership feedback tool	Director of Workforce and OD	Gail Dunning	December 2022	On track – Detail shared with People and Culture Committee (Nov)
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 – part of the Retention & Attraction workstream
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	Strategy shared and on October Board agenda
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 - External Gap Analysis complete. Head of ED&I appointed. WRES &WDES action plans developed.
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	Delayed but new space now identified and approved at October Exec Committee.
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	Bike storage in place from late Nov. Car Parking criteria etc due to be implemented by April 2023.
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	Potential delay. Work continues to identify a solution for lockers and BC being drafted for showers / changing.

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	Progressing but delayed to December completion.
2.7 Deliver transparent and equitable local medical pay agreements.	Director of Workforce and OD	Lydia Larcum	December 2022	Seeking new Medical Director input. Meeting arranged prior to her commencement to move this forward.

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	Open days and recruitment events have been reintroduced.
3.2 Re-establish consultant recruitment events	Medical Director	Care Group Directors	September 2022	Open events yet to occur.
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 – achieved. New RLW announced Sept 2022.	Proposal for funding this considered at Exec Comm in October. Reliant on uptake of Pension Recycling. Expressions of Interest being sought – deadline 2nd Nov.

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	Complete
3.6 Review and update recruitment packs	Director of Workforce and OD	Lydia Larcum	March 2023	On track – work continuing to develop packs. HYMS & Research 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 Retention & Attraction workstream. New starters fairs begin Nov 22
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. 40 have arrived. Further 36 offered and anticipated to start in Q4. Plan for 130 during 23/24 (including potentially 75 from Kerala).
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 – nursing inpatients completed, AHP planned. Medical pending new Managing Director.
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 – projected to spend £2,687,511 by March 2022.

4.3 Explore opportunities to increase research options in job plans (all professions) as part of annual job planning	Medical Director	Care Group Directors	December 2022	Awaiting new Medical Director input.
4.4 Further development of alternative clinical roles e.g. ACPs/SCPs/PAs etc.	Director of Workforce and OD	Will Thornton	November 2022	Complete – new roles developed in Learning Disabilities, Critical Care & Anaesthetics, plus new Lead for AP role in pipeline
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. Lack of approval of the eRoster business case a set back.
4.6 Undertake and embed Safer Nursing Care Tool (SCNT) every 6 months to ensure establishments remain appropriate	Chief Nurse	Emma George	March 2023	Completed June. Will rerun every 6 months.
4.7 Development of a retention strategy for nursing and midwifery through collaboration and engagement	Chief Nurse	Emma George	September 2022	Detailed in various improvement plans rather than one strategy.
4.8 Development of a nursing workforce dashboard for Care Groups and triangulating impact on patient quality indicators	Chief Nurse/ James Hawkins	Emma George	December 2022	Potential delay. Progressing but prioritised alongside other DIS commitments.

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Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Nursing Workforce Report
Director Sponsor:	Heather McNair, Chief Nurse
Author:	Emma George, Assistant Chief 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:

To provide information and assurance to the resource committee on how the Trust has responded to provide the safest and effective nurse staffing levels during August 2022. This will include the requirement to submit the safer staffing metrics using Care Hours per Patient Day (CHPPD). Provide assurance that nursing establishments have been reviewed utilising best practice guidance and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce are in place.

Recommendation:
To receive the report.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

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**

1. Introduction and Background

This report provides the monthly Nurse and Midwifery Staffing data to describe the key workforce data and complies with the National Quality Board (NQB), 2016 guidance and the NHS England, Operational Productivity and Performance report, 2019, Care Hours Per Patient Day (CHPPD) requirements for reporting. This report identifies the wards that reported less than an average of 80% against their planned registered and non-registered staffing levels.

2. Considerations

The Trust has complied with the submission of CHPPD data and the August 2022 submission is attached in Appendix 1. This shows an improvement from July 2022, mainly in HCA fill rate on both day and night fill rates. A 2% improvement is also seen in RN night fill rate this month.

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	78%	84%	21%	-	95%	114%	3%	-
CG2	87%	92%	10%	-	92%	98%	76%	-
CG3	79%	85%	-	-	85%	101%	-	-
CG4	77%	80%	-	-	103%	82%	-	-
CG5	58%	77%	-	-	75%	94%	-	-
CG6	-	-	-	-	-	-	-	-
Total	77%	86%	28%	-	88%	104%	50%	-

The table (2) below details the overview of the organisation and highlights all the adult inpatient wards so is slightly different in figures as maternity are not included in the table below.

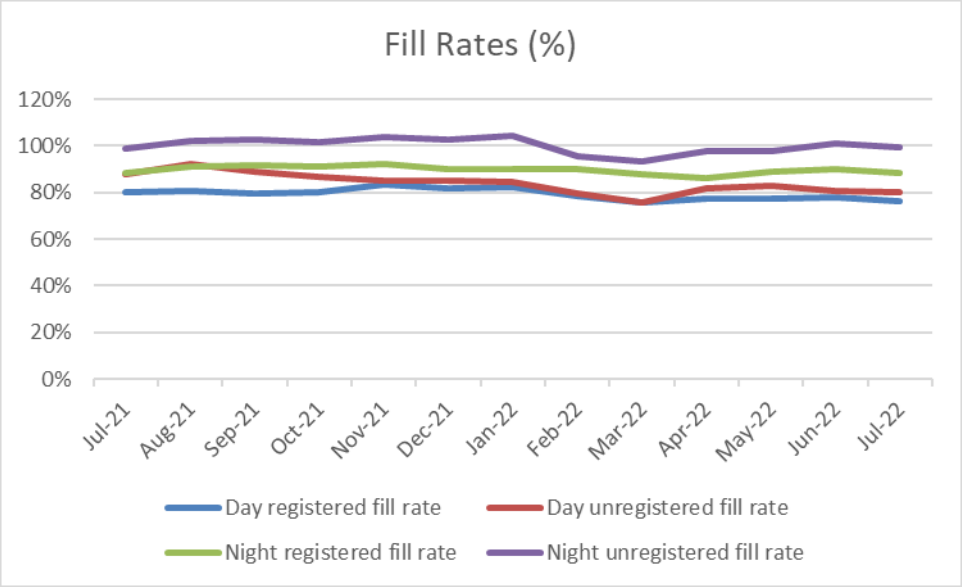
Table 2

	Fill Rate Type	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Fill Rate % (Actual Hours/Planned Hours)	Day registered fill rate	81%	79%	80%	83%	82%	82%	79%	76%	77%	77%	78%	76%	76%
	Day unregistered fill rate	92%	89%	87%	85%	85%	85%	80%	76%	82%	83%	81%	80%	83%
	Night registered fill rate	91%	92%	91%	92%	90%	90%	90%	88%	86%	89%	90%	89%	87%
	Night unregistered fill rate	102%	103%	102%	104%	103%	104%	96%	93%	97%	98%	101%	99%	101%

The average day fill rate in August 2022 for Registered Nurses was 76% this remains the same and for Non – Registered Nurses, 83%, which indicates an improvement since March. The night fill rate has improved and above 80% for both registered and non-registered nurses.

The table identifies the fill rates since July 2021, splitting day and night, registered and unregistered. The graph below indicates that above 80% was achieved for the night shifts since June 2021 but there continues to be a concern in relation to the day shift for the registered workforce.

Table 3



3. Current Position/Issues

Nurse Vacancies

Table 4 shows the current RN predictions, indicating the progress made and the impact as we reduce current leavers.

Model 130 international recruits in FY 23/24												
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Establishment	948.88	948.88	948.88	948.88	948.88	948.88	948.88	948.88	948.88	948.88	948.88	948.88
In post (RNs + 14 INs currently on band 4 positions + 18 known NQs not yet on ESR)	810.71	857.72	880.33	894.94	902.63	910.32	918.01	924.74	931.47	938.2	944.93	951.66
Projected leavers		5.33	5.33	5.33	5.33	5.33	5.33	5.33	5.33	5.33	5.33	5.33
Projected International Recruits		31.16	14.76	14.76	9.84	9.84	9.84	8.88	8.88	8.88	8.88	8.88
Projected UK qualified starters		3.18	3.18	3.18	3.18	3.18	3.18	3.18	3.18	3.18	3.18	3.18
Projected NQs/direct apprenticeships	36	18	10	2								
Vacancies	-138.17	-91.16	-68.55	-53.94	-46.25	-38.56	-30.87	-24.14	-17.41	-10.68	-3.95	2.78

There has been a slight deterioration in RN leavers figures, the table indicates all the starters, including NA who are topping up to RN, international nurses, and PRNs

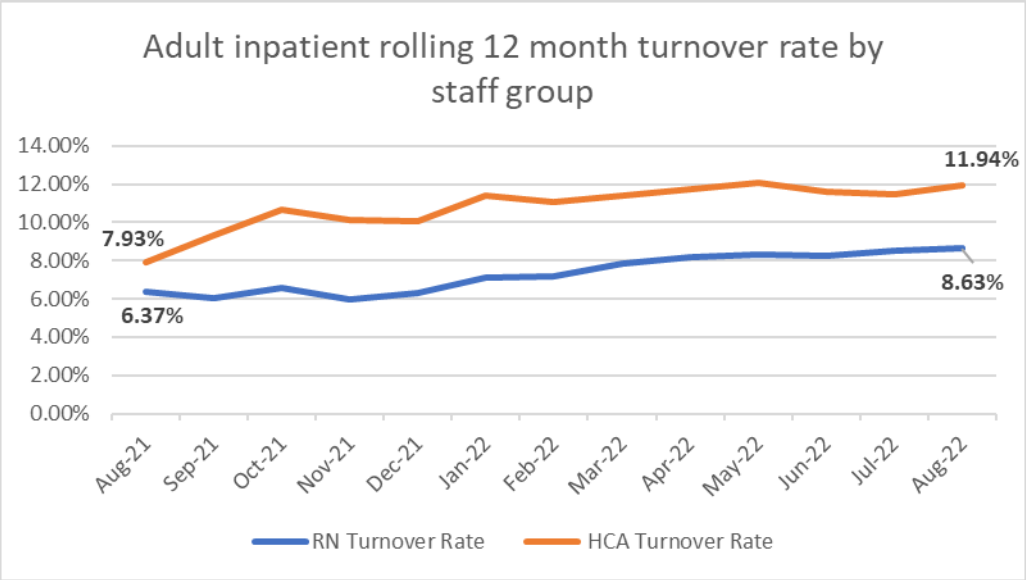


Table 5 HCA Vacancy Levels Trust wide August and predicted 2022/23

Band 2/3	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Establishment	679.53	679.53	679.53	679.53	679.53	679.53	679.53
In post	607.43	626.43	645.43	664.43	683.43	702.43	721.43
Projected leavers		6	6	6	6	6	6
Projected New Starters		25	25	25	25	25	25
Vacancies	-72.1	-53.1	-34.1	-15.1	3.9	22.9	41.9

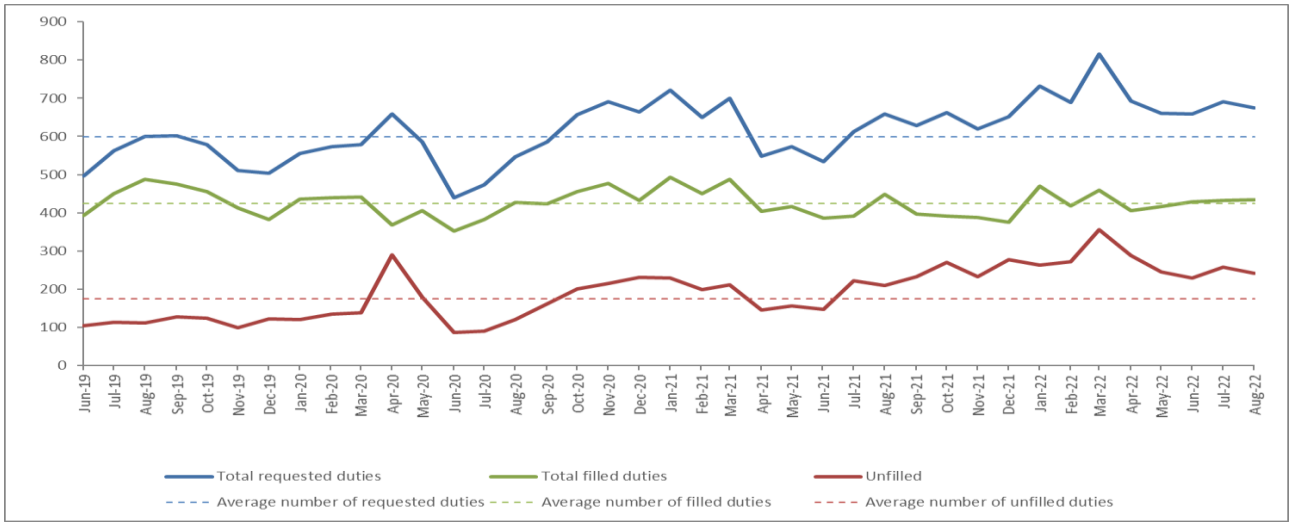
Table 5 details the current HCA position for adult inpatient wards for the Trust, this is a new format of presenting describing the establishments, projected starters, and leavers per month on average. Unfortunately, there has been a deterioration in the leavers this month and therefore the positive position for HCA is now January 2023. Detailed work continues through the HCARRG as to the recruitment process and streamlining this further. NHSE direct support is on going and there is a site visit in October to look at our current processes.

Temporary Staffing

NHSEI have contacted all Trusts detailing additional funding that would be allocated to support with in-year inflationary pressures and that receipt of those funds would be contingent on ensuring appropriate spend controls, of which agency expenditure was one.
They have seen expenditure begin to increase and NHSEI will be re-establishing oversight measures to support the organisation to maintain a sharp focus on reducing these costs. From 1 September 2022, we will be taking the following actions:

NHSEI advised that we remain in the top 3 / 4 organisations in the region for off framework use. They have proposed some supportive measures today which we await more information around but include direct support from their national agency team. There will

be a review of our current processes and practice around agency use in October 2022. NHSE are attending the organisation in October.



The graph above 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, 12,000 requested across the organisation for both RN and HCA.

The Trust continues to report a significant unmet need in relation to temporary staffing requests for registered and unregistered nurses (table 6). In August 2022, 39% of all shift requests were unfilled a deterioration of 1% equating to 403 shifts.

Table 6

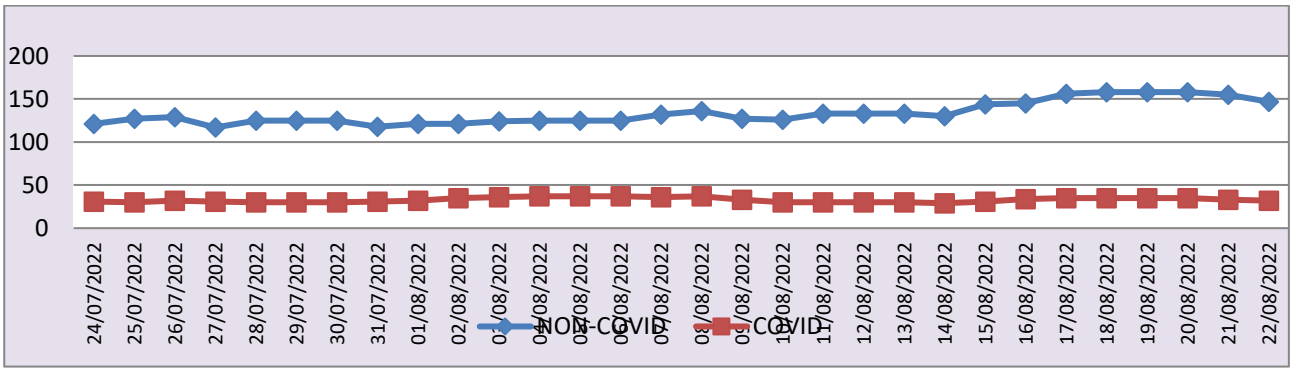
Month	01/08/2022

	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	6136	6320	12456	225	1370	1595	13%	3565	2514	6079	49%	62%	2346	2436	4782	38%
York	3930	4370	8300	225	1034	1259	15%	2192	1687	3879	47%	62%	1513	1649	3162	38%
Scarborough	2206	1950	4156	0	336	336	8%	1373	827	2200	53%	61%	833	787	1620	39%

Impact of sickness absence

Over the past 2 months sickness has increased having an impact on the nursing workforce and exacerbating the fill rates on wards due to the recent increase in COVID 19 prevalence.

Nursing and Midwifery sickness figures



Sickness remains a challenge, with an increase in COVID sickness also impacting and the current guidance to isolate, this is constantly impacting nurse staffing levels, work is commencing to offer further support to Care Groups to monitor sickness and ensure all HR processes are in place.

4. Summary

How we report our vacancy figures has been through the financial ledgers, but it has been agreed that ESR is a more accurate form of presenting accurate figures. Currently we are focusing on the adult inpatient wards and therefore our current figures are reflected in the table. As a result of this focus the figures have changed and the leaver rate is 5.33 WTE for RN and 5.45 WTE for HCA.

Care Groups need relevant and appropriate data that is available for them to articulate their requirements, a dashboard is being produced to correlate the current workforce and impact on quality of care.

The well-being and support we offer our workforce is paramount, with pastoral care being central to the work undertaken such as new roles and the PNAs, we now have 5 of these roles and we are seeing the impact of this already. 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.

5. Next Steps

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 and is now embedded. 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 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, 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.

Red Flags

- The red flag system has been relaunched and these are used to escalate and articulate the concerns related nurse staffing levels. The National Institute of Clinical Excellence (NICE 2014), highlighted 6 Red Flags to be considered which they believe impacted upon delivering safe patient care. Red Flag review has streamlined from 19 to 11 – more meaningful categories requiring narrative,
- Escalation process for raising and mitigation improved inclusive of email alert to matrons/senior nurses.
- Review of tasks streamlined from 42 tasks to 8
- Professional judgement review escalation process improved and made simpler to follow
- Review of census periods and compliance
- Review of accessibility for each department – rectified when access concerns found

In response the Red Flags have been reviewed and streamlined to 11 Red Flags overall and broken down into 3 categories

- Fundamentals of Care – 6 Flags
- Staffing Concerns – 4 Flags
- Enhanced Care – 1 Flag

After review, the Red Flag will either be closed, mitigated or left open using the professional Judgment of the assessor and an acknowledgement of the actions will be recorded on Safecare as a professional Judgement. Each month any open Red Flags will be investigated within care Group alongside Nurse Sensitive Indicators to provide assurances at board level that patients did not come to harm. There will be an suit of the use of red flags and adherence w/c 10 October to see how this is supporting decision making for senior nurses.

Establishment Review

A review of all ward establishments has been completed. Care Group teams have reviewed the previous establishments and was presented to the executive committee in September 2022. Due to the immense changes during the pandemic and the complexities of these changes to ward establishment this has been a complex process. The main finding of this establishment review is that there is a requirement for £15,770,503 investment but £3m is a care group budget contribution. The investment required is **£12,742,235** to the adult inpatient wards, including the inpatient community units that were not factored into the previous review and the changes that have occurred as a result of the pandemic that will be detailed in this report. This equates to **134.43** WTE Registered Nurses, **204.26** WTE Health Care Assistants and **115** WTE Patient Services Operatives, a role that will be introduced across the organisation and is described later in the report. The paper was supported but further work has now commenced to look at the ward areas that require the funding in a priority order, benchmark across the ICS and then represent this to the board to continue to discuss investment and ongoing reviews

Patients Services Operative (PSO) Role

This role was first introduced in Care Group One to support the ward teams with various tasks that were not getting completed by the nursing teams. These included, cleaning

equipment, preparing bed spaces efficiently for the next patient, stocking and tidying and most importantly providing beverages out of mealtimes and supporting nutritional needs for patients, including the completing of menus. The job description is multifaceted, and the role is popular. There is an expectation that out of the establishment review this role will be embedded and rolled out across the organisation. There is a requirement to recruit **115 WTE** and a recruitment plan has already been enacted. This role will help support the cleaning agenda from an IPC perspective, the fluid and nutrition for patients and a clear career progression for our workforce to HCA and then to Registered Nurse through our successful apprenticeship programme. A further recruitment event is being held in October 2022 with support from Indeed and NHSE

Safer Nursing Care Audit

The audit provides organisational level metrics to monitor impact on the quality of patient care and outcomes and gives a defined measure of patient acuity and dependency. It supports all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources. Included are staffing multipliers to support professional judgement and it provides accurate data collection methodology. As an organisation we undertook this audit across all the adult inpatient wards, this has supported the decision making in this review. The SNCT will be rerun in winter (Jan/Feb 2023) also to offer a rounded result of both summer and winter acuity and dependency. The SNCT is also changing in 2023 to include another level 1C which will also capture patients under a DOLs, enhanced supervision and high risk of falls which will offer a more accurate dependency result.

Retention

Nursing and midwifery retention self-assessment tool

This tool enables organisations to undertake a self- assessment against the seven elements of the NHS people promise plus key elements that support staff to deliver high quality care, enhancing job satisfaction and supporting the retention of nurses and midwives. Organisations are encouraged to use the information gathered in the dashboard to develop and implement their local evidence-based retention improvement plans. These headings are

- **Health and well being**
- **Autonomy and shared profession**
- **Leadership and teamwork**
- **Professional Development**
- **Pride and meaningful recognition**
- **Flexible working**
- **Excellence in care**

There has been an assessment of the tool produced by NHSE that we have completed and a gap analysis to inform our retention plans and align the work we are already undertaking and a work plan to be undertaken to consider the gaps. This will form the retention action plan for nursing in the coming months.

Date: 10 October 2022

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Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Workforce Race Equality Standard (WRES) Annual Report
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion and WRES Expert

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 is for assurance and has been shared with the People and Culture Committee for information and discussion. It sets out the Trust's 2022 WRES data, gives an overview on progress of the actions taken in 2021. It also incorporates an action plan for 2022-2023 to address the working experiences and career opportunities of Black and Ethnic Minority (BME) colleagues.

The WRES data was required to be submitted to NHS England (NHSE) by 31 August 2022 along with an Annual Report. The action plans are required to be approved and uploaded to the Trust's website by the 31 October 2022, the Annual Report will be uploaded at this stage. As the October Trust Board meeting was deferred until November 2022, there will be a slight delay in obtaining approval.

The Fairness Forum and Staff Network members were asked to comment on the draft action plan. 2022 is the first year that action plans are required to be submitted to the National WRES team to enable them to provide feedback about them and the extent to which they relate to the Trust's specific data and the evidence-based likelihood of improving outcomes.

As advised by the National Equality and Inclusion team; The Trust's WRES Expert should be professional supported and provided with pastoral support with this challenging role.

The National WRES team requested that Trust's did not include the BME data for bank and agency staff for this year as they would be included in the Bank WRES that is due to be implemented.

Comparison of the 2021 and 2022 data has shown that Metrics 3, 5, 7 and 8 have deteriorated and metrics 2, 4, 6 and 9 have remained static. Metric 1 has seen a mixture of change. Metric 9 has seen a positive change in terms non-voting Board members but has remained static for voting Board members. A statistical analysis has been used of 0.5% and a positive, negative and static movement have been highlighted in green, red and yellow. The data for Metrics 5-8 are taken from the Staff Survey so the Trust's data has been compared to our benchmark group's average.

Responsibility at a senior level is required to ensure that the Trust makes a significant improvement to improve the work experiences and career progression of our BME colleagues.

Recommendation:

The Board of Directors is asked to note the content of this WRES Annual Report, approve the Action Plan and provide their support for its implementation.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

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	2 November 2022	

NHS Workforce Race Equality Standard, 2022

1. Introduction and Background

The Workforce Race Equality Standard (WRES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust is required to comply with. Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at improving the experiences of BME colleagues. The data is required to be submitted to NHS England (NHSE) by 31 August 2022, this deadline was achieved. An action plan is to be drawn up and submitted to NHSE by 31 October 2022. The National WRES team has also requested that action plans are submitted to them for review and advice, this will be an annual requirement from this year.

The WRES covers 9 Metrics regarding the career progression and work experiences of BME colleagues. The data is collected for the period of 1 April 2021-31 March 2022 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey, with a snapshot of the data as at 31 March 2022. The Staff Survey data is from the 2021 Staff Survey.

This report provides an analysis of the 2022 data for the 9 Metrics covering the last three years, progress on the 2021 action plan and the action plan for 2022. For the purposes of the WRES the term BME is defined as non-white, which means that staff from white minority groups are not included. Given this it is important to note that any wider inclusion work within the Trust must consider the needs of white minority colleagues.

Bank workers were not included in this year's data and reporting as NHSE are developing a Bank WRES (BWRES,) due to colleagues on the Bank's unique experiences, they will be included in this analysis once it is implemented.

The Head of Equality, Diversity and Inclusion (EDI), the Fairness Forum and Trust colleagues have contributed to the production of the action plan. The Head of EDI will be attending the Race Equality Network (REN) to discuss the data and action plan with members. Combined Freedom to Speak Up and WRES roadshows will also be delivered.

Considerations

Due to the Head of EDI commencing their role mid-August 2022 the presentation of the data analysis, staff engagement and co-production of the action plan has been carried out within a short timescale. The process will differ slightly within the next reporting period in 2023. An annual report will be presented before the data is submitted via the online portal by 31 August 2023 deadline. Wider staff engagement will take place to co-create the action plan prior to the deadline and submitted for approval before 31 October 2023.

North East, Yorkshire and Humberside Region, EDI support provided a data pack, 'WRES and Workforce Disability Equality Standard (WDES) guidance' that was referred to in creating the action plan. Their information session was also attended. The WRES team have suggested that Trust's that employ WRES Experts should

have an interest in their personal development and ensure they are utilised as a major resource. The following was suggested:

- Enable WRES Experts to support organisations outside their own, including Arm's Length Bodies (ALBs) and professional bodies. (Not all Trusts have a WRES Expert so might call on others for guidance)
- Check-ins and pastoral support for WRES Experts – there is considerable psychological weathering due to the types of conversations that WRES Experts have had to have around race, racism and so forth (e.g. they could also be affected by racial trauma)
- While we have WRES Experts, they have not been adequately welcomed, respected or their role understood by their organisations
- Clinical and non-clinical WRES experts to be engaged differently

The WRES Experts are several NHS colleagues in a variety of bands and roles that were recruited by the National WRES Team and trained in the standard by Inspiring Hope. The programme was designed to have a Board level sponsor as well as a colleague (Expert) that could support, advise and influence the workforce race equality agenda. They did not hold responsibility for its implementation. There are currently four cohorts, with York and Scarborough's WRES Expert being part of Cohort 3, which was the first cohort to do a professional qualification in Workforce Race Equality.

Support for the Experts has been self-managed, personally and through peer support. More recently support has been provided through the North East Yorkshire and Humberside Regional EDI Team and now the national WRES team.

The National Team are preparing a new cohort of WRES Experts for training. A development programme is being created for existing WRES Experts and Trust's may want to consider supporting the professional development of their existing and new WRES Experts.

2. Current Position/Issues

2022 Data Analysis

This analysis has used a method which highlights the positive, negative and static changes in the data. Positive is in green, negative is in red and a figure below 0.5% shows little statistical movement, therefore considered static and is highlighted in yellow. Statistically significant movement is +/- .0.5%.

Total White Staff Headcount & Percentage (for 2022)	Total BME Staff Headcount & Percentage (for 2022)	Total Staff Trust Headcount and Percentage (for 2022)	Total Headcount and Percentage of Staff Not Stated (for 2022)
7,503 (84.1%)	1,116 (12.5%)	8,922 (100%)	303 (3.4%)

Metric 1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

2020 Total BME	2021 Total BME	2022 Total BME
Nonclinical BME • Bands 1-4 = 2.85% • Bands 5-7 = 0.74% • Bands 8-9 = 0.04% • VSM = 0% **Clinical** • Bands 1-4 = 1.04% • Bands 5-7 = 6.07% • Bands 8-9 = 0.12% • VSM = 0% • Consultants = 1.73% • Career Grades = 1.58% • M&D Trainees = 2.75%	**Nonclinical BME** • Bands 1-4 = 1.72% • Bands 5-7 = 1.11% • Bands 8-9 = 0.11% • VSM = 0% **Clinical** • Bands 1-4 = 2.84% • Bands 5-7 = 5.01% • Bands 8-9 = 0.1% • VSM = 0.01% • Consultants = 1.29% • Career Grades = 1.01% • M&D Trainees = 3.22%	**Nonclinical BME** • Bands 1-4 = 3.31% • Bands 5-7 = 0.98% • Bands 8-9 = 0.1% • VSM = 0.03% **Clinical** • Bands 1-4 = 1.21% • Bands 5-7 = 8.84% • Bands 8-9 = 0.13% • VSM = 0% • Consultants = 1.81% • Career Grades = 1.74% • M&D Trainees = 3.26%

In 2022 there has been a positive statistical improvement in non-clinical bands 1-4, but in bands 5-9 there has been a deterioration in the recruitment of BME colleagues in post. Whilst there has been a positive increase in the number of non-clinical colleagues at VM level, this is only 0.03% and is below 0.5% so is considered static.

There has been a deterioration in the percentage of clinical BME colleagues in bands 1-4 but a significant increase in bands 5-7, this might be attributed to the international nurse recruitment. 2022 saw an increase in the number of clinical colleagues in bands 8-9, it is important that there is a continuous increase year on year. There are no clinical BME colleagues at VSM level, but the Trust has seen an increase at Consultant and Career Grade level.

From this analysis it shows that BME non-clinical colleagues are unlikely to progress within the Trust above band 7. This is reflected throughout the NHS. NHS England has set a target of 19% BME representation across all pay bands throughout the NHS.

'NHS England, February 2021, *Workforce Race Equality Standard, 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups.'*

In 2021 the Trust created an action plan, as requested by NHS England, to address its Race Disparity Ratios, this plan still needs to be addressed and has been incorporated into the WRES action plan.

Metric	Description	2020 Total BME	2021 Total BME	2022 Total BME
2	**Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts**	1.76	2.61 ↑	2.60 ↔

Metric 2 compares the relative likelihood of White colleagues being appointed from shortlisting compared to that of BME colleagues being appointed from shortlisting across all posts. The relative likelihood focuses on a figure of 1 being parity. As you can see from the above figures, the Trust is making little positive statistical movement which shows that our BME colleagues are adversely impacted with the Trust's shortlisting process.

In 2021 the Trust had an action plan for the Implementation of the 6 Key Actions on the Overhaul of Recruitment and Promotion. This plan should still be carried out and is incorporated as an action the accompanying plan.

Metric	Description	2020 Total BME	2021 Total BME	2022 Total BME
3	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process**	0	0.51 	1 

There has been a negative statistical increase of above 0.5% but the relative likelihood of BME colleagues entering the disciplinary process compared to white colleagues is the same. It is important that experiences do not deteriorate any further.

Metric	Description	2020 Total BME	2021 Total BME	2022 Total BME
4	**Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff**	0.86	1.06 	1.07

There has been no statistical change with Metric 4, but the figure is slowly increasing above the level of parity.

Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
26.5%	23.6%	25.5% 	22.5%	28.0% 	25%

After seeing a positive change in 2020, 2021 has seen a significant deterioration with the number of BME colleagues experiencing unwanted behaviour from those who use our services, this figure is high and is only 0.8% below the Staff Survey benchmark group average.

Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
30%	24.2%	31%	24.8%	31.4%	25.1%

There has been a slight deterioration with this figure in 2021 and although there is no significant statistical movement it is still high and is above the Staff Survey benchmark group average of 28.5%.

The Trust is currently experiencing a recruitment and retention problem and if our BME colleagues continued to experience harassment, bullying or abuse this will only have a negative impact on this problem. Therefore, it is imperative that the Trust continues to address this.

Metric 7 Percentage believing that the Trust provides equal opportunities for career progression or promotion

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
49.2%	57.1%	46.7%	55.6%	41.9%	56.8%

2020 and 2021 Staff Survey results have seen a consistent deterioration of this Metric with only 41.9% of BME colleagues believing that the Trust provides equal opportunities for carer progression or promotion. The fact that Metrics 1 and 2 demonstrate that there is an issue with promotion supports this belief. Our Staff Survey benchmark group average is 44.6%.

Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
16.1%	5%	16.0%	6.3%	20.3%	6.1%

The 2021 Staff Survey results have seen a significant deterioration of this figure by 4.3%. The national figures for BME colleagues experiencing discrimination within admin and clerical, AHPs, nursing and medical and dental roles are all higher than their white counterparts with nursing being the highest. This is referenced in the aforementioned report. The Trust figure is above the Staff Survey benchmark group average figure which is 17.3%.

The CEO's Listening Exercise is also reflective of this experience and is addressed within the accompanying action plan to demonstrate that the Trust is listening and takes the experiences of its BME colleague's seriously.

Metric	Description	2020 Total BME	2021 Total BME	2022 Total BME
9	**BME Board Members**	0	0 ↔	1 ↑
	Percentage difference between the organisations' Board voting membership and its overall workforce			6.25%
	Voting Board Members	0	0 ↔	0 ↔
	Non-voting Members	0	0 ↔	1 ↑

The percentage of Board members by ethnicity compared to its BME workforce is 6.25%. The aim of this metric is for the Board to reflect its BME workforce, which is currently at 12.5%. This should be an opportunity to create diversity of thought, equal opportunities, diverse representation and inclusion.

In the 2021 WRES report, previously mentioned, within North East and Yorkshire 12.2% of the workforce is made up of BME colleagues. The Boards are 87.7% white, 8.2% BME and 4% have an ESR declaration status of Unknown. There is a lower proportion of BME people on Boards compared to the proportion of BME colleagues.

Progress Against the 2021 Action Plan

The responsibility for the Equality Action Plan 2021 was held with several colleagues within Workforce, overseeing the whole action plan whilst carrying out their substantive roles.

The action plan covered the WRES and Workforce Disability Equality Standard (WDES) and was very extensive. It covered several areas aimed at improving BME colleague's experiences. With any action plan an improvement in experiences and therefore data needs to be monitored on a year on year basis which will provide a true reflection of improvement. There have been different levels of progress with the 2021 action plan; for the following reasons:

- Absenteeism
- Staff Network members response
- Some actions not aligned with anyone specifically
- Postponement of the intervention

There has been progress with some of the actions, but this has not been the case throughout. The pilot of the Reciprocal Mentoring Programme has been implemented and reviewed, with a plan to continue rolling this out throughout the Trust. Policies have/are being reviewed to be more inclusive, the Staff Networks have been engaged with and the CEO has conducted a Listening Exercise and there has been a review of the Leaver's questionnaire. There should still be a 'push' forwards where there has been a lack of response from colleagues and it is hoped that the Head of EDI can influence and support colleagues where necessary.

Some of the 2021 actions have been incorporated into the 2022/23 action plan to ensure they are implemented. On this occasion, the WRES and WDES action plans have been drawn up separately as less progress has been made with the WRES, so it needs to be very focused. Colleagues who hold responsibility for an area of work are encouraged to ensure that EDI is threaded throughout and take responsibility for consulting data and listening to colleague's lived experiences to improve outcomes.

2022-2023 Action Plan

This year's action plan focuses on the Metrics that have deteriorated and those where the data remains high, so experiences are negative. The National advice is not to necessarily focus on all 9 Metrics but on those that require addressing the most. In saying this there will naturally be other organisational interventions that might have a positive impact on experiences and therefore the data. It is imperative that a deep dive into the data is carried out to ensure there is a better understanding of experiences. This will be intrinsic to some of the actions.

The National WRES Team have provided a template action plan, but it is not mandatory to use this, although it will be in the future. 2022 is the first year where they have requested that Trusts submit their action plans for analysis. They will then provide feedback about the action plans regarding the extent to which they relate to the Trust's specific data, and the evidence-based likelihood of improving outcomes.

1. Summary

- The Trust needs improve the experiences of its BME colleagues, there has been inadequate improvement of its data.
- The impact of BME colleagues work experiences and career progression will not create a healthy and sustainable workforce if they continue to be negative.
- The financial cost to the organisation of not 'getting this right' will be significant.
- The experiences of BME colleagues may impact on patient care
- Negative outcomes will affect our Well-led review, especially as the National WRES team have been working with the CQC.

2. Next Steps

The data was submitted by the deadline of 31 August 2022. The Trust's action plan will be submitted by the deadline of 31 October 2022 and will be published on the Trust's website.

The Trust Board is asked to review the data and sign off and support the action plan for implementation.

Appendix 1 – WRES Action Plan 2022-2023

Date: October 2022

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
Executive Lead: Polly McMeekin, Director of Workforce and Organisational Development
York and Scarborough Teaching Hospitals NHS Foundation Trust

APPENDIX 1

Metric 1: Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
To increase self-declaration of ethnicity and dispel myths as to why the Trust collects this data. Increase percentage of staff in post who share their ethnicity status by a minimum of 3% in 2023	Evaluate communication methods used to disseminate information to staff on self-declaration and re-launch Self Service and the ESR app.	Deputy Head of Resourcing, Digital and Insights	Generate quarterly reports from ESR, workforce to evaluate if communications are being effective. Establish ways to aid communication. March 2023		
	Trust Managers to analyse local data and encourage colleagues via local meetings.	HR Business Partners and EDI Workstream	Local quarterly reports provided to the EDI workstream. May 2023		

1

Not Started	On Track	Completed	Overdue

	Identify perceptions and barriers around self-declaration to feed into Myth Busting Guide	Head of EDI, EDI Workstream and the Staff Networks	Information obtained to aid completion of a Myth Busting Guide. March 2023		
	Launch an Equality Monitoring Myth Busting Guide to dispel myths about sharing ethnicity status	Head of EDI and the Staff Networks	Production and dissemination of a Myth Busting Guide to support self-declaration. April 2023		

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
Executive Lead: Polly McMeekin, Director of Workforce and Organisational Development
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Increase the relative likelihood of BME staff being appointed from shortlisting for clinical and non-clinical staff in Bands 8-9. This figure has slightly deteriorated for Non-clinical bands and slightly increased for clinical bands. In 2022 Non-clinical bands 8-9 = 0.1% Clinical bands 8-9 = 0.13%. Increase by 2% for non-clinical and clinical.	Continue to implement the action plan for 6 key actions on the overhaul of recruitment and promotion	Recruitment Manager	Review and continue to implement the Trust's Action Plan. August 2023		
	Training – unconscious bias and cultural competence	Head of EDI	Bespoke and specific training implemented in Quarter 1/2.	This action will require financial support if delivered by an external consultant(s.) Employers Network for Equality and Inclusion (ENEI) can deliver this, which requires membership then delivery costs. Membership does include access to free resources, information, webinars and round table discussions. Previously used by the Head of EDI and NHS Employers are members.	

Not Started	On Track	Completed	Overdue

Apart from at VSM level, bands 8-9 have the lowest percentage of BME colleagues in post. Focusing on bands 8-9 will support the Trust's talent pipeline into a VSM position. The relative likelihood in 2021 was 2.61 and in 2022 it was 2.60.	Continue to implement the 2021 Race Disparity Ratios action plan.	Workforce and Head of EDI	Review progress to determine action required. February 2023		
	Interview Skills preparation.	Recruitment Manager	Determine what support can be made available for colleagues to support them in applying for jobs. Date TBC.		
	Shadowing or participate in senior leader stakeholder events.	Executive Director/Deputy Director of Workforce & OD	Opportunities to be communicated through REN. From 2023		

	ODIL to promote the Coaching and Mentoring opportunities available for all colleagues within the Trust to REN and the International Nurses.	Head of ODIL	ODIL to attend a REN meeting and IN induction to promote the opportunities available. 2023		

Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Reduce the percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public. There has been a negative increase in this metric from 25.5% in 2020 to 28% in 2021.	Create a statistical comparison of data – reported through the 2020 Staff Survey, Datix and FTSU. Determine what action is required to address the findings.	Head of EDI, FTSU Champion, Datix Manager, Staff Engagement Project Lead	This action will enable the Trust to identify if there are any differences in colleagues reporting their experiences. It will also enable the Trust to determine what		

The benchmark group average is 28.8%. Decrease this percentage by 3.5%.			action is required. Quarterly reports to be provided from January 2023.		
	Engagement through the Staff Networks to find out what colleagues lived experiences are.	Head of EDI and Staff Network Chairs	Update the EDI Workstream on the findings to enable them to incorporate actions into local plans. April 2023.		

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
Executive Lead: Polly McMeekin, Director of Workforce and Organisational Development
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 6 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
Reduce the percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. There has been little statistical movement with this metric but the Trust figure of 31.4% is higher than the benchmark group average of 28.5% Decrease this figure by 3.5%.	The Trust's Behaviour Framework was launched in 2022.	Head of Employee Relations & Engagement	Evidence - communication methods used to launch the BF July 2022		
	Develop a Microaggressions poster with all Staff Networks for communicating throughout the Trust.	Head of EDI and the Staff Networks	Raised awareness of everyday incivilities that cause unwanted behaviour. February 2023		
	Review how the Trust's Behavioural Framework has been incorporated into Corporate and Local Induction as well as relevant training.	Workforce and Organisational Development	Dissemination of the Trust's BF increases understanding of the behaviours expected to		

Not Started	On Track	Completed	Overdue

			support our values. June 2023		
	A cultural celebration for colleagues in Scarborough to share aspects of our ethnically diverse colleague's culture, UK colleague's culture to aid integration and breakdown barriers. Run by the Internationally recruited nurses.	Internationally recruited nurses, Hospitality and the Stay and Thrive Committee	Scarborough Festival of Culture implemented at the Scarborough Beach Huts September 2022	Programme: • Career Progression & Cultural Ambassador briefing • African Culture day • Philippines Culture day • British & rest of the world • India, Pakistan and Nepal Culture day • Family Day & Beach Party • Canteen – dishes from around the world	
	For all of metric 4 - review the Trust's processes for addressing experiences of bullying and harassment. (As per the Listening to Employee Voice: Our way forward action plan)	Head of Employee Relations & Engagement	Launch of new Harassment and Bullying Policy 31 March 2023		

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
Executive Lead: Polly McMeekin, Director of Workforce and Organisational Development
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 7 Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

Objective	Actions / Targets		Measurement & Completion Date	Progress/Comment	Status
Increase colleague's experiences and perceptions about the Trust providing equal opportunities for career progression or promotion. The Trust has seen a deterioration of this metric over a 3-year period. The figure in 2021 was 41.9% which is below the benchmark group average of 44.6%. Increase this figure by 3%.	Explore colleague's experiences through the REN Staff Network encouraging other colleagues to attend	REN Staff Network Chair and Head of EDI	Colleagues will have been able to share their lived experiences with the Staff Network Chair. This will feed into wider work. April 2023	Invite colleagues who are not members of the network.	
	Continue to roll out the Trust's Reciprocal Mentoring Programme.	Head of ODIL	Colleagues will have the opportunity to share their lived experiences with senior leaders and obtain career	Pilot has been implemented and a refreshed proposal presented to Trust Board.	

Not Started	On Track	Completed	Overdue

			support and advice. Spring 2023		
	Explore working with our International Nurses to help them align their overseas qualifications with UK qualifications, as per the Trust's Listening Exercise with the CEO.	International Nurse Recruitment	IN Team will have worked with colleagues to align their current qualifications with UK qualifications to enable them to have an increased understanding. Date TBC		
	Promote the NHS Leadership Academy's programmes throughout the year through REN.	Head of ODIL and Head of EDI	Courses promoted throughout the Trust 2022/23	Head of EDI started to promote these in October 2022.	
	Explore the implementation of targeted development programmes for:	Head of EDI	Implementation of a programme supporting BME	Contact North East London Foundation Trust to obtain information about their band 2-8 leadership development programme.	

	BME Non-clinical, bands 1-4 and Clinical, bands 5-7		colleagues with their development for advancement. June 2023	Arden and Gem Commissioning Support Unit (CSU) are currently running cohort 1 of a BME Leadership Programme targeted at all BME colleagues. Run by an academic and WRES Expert. It is envisaged that resources and/or finance will be required to support this action.	

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
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York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager, team leader or colleague

Objective	Actions / Targets		Measurement & Completion Date	Progress/Comment	Status
The data for this metric has seen a significant deterioration from 16% in 2020 to 20.3% in 2021, this is above the benchmark group average of 17.3%. Decrease this figure by 5%.	Implement a Schwartz Round or panel discussion, open to all staff to attend – subject around people's lived experience of race discrimination	Head of EDI and REN Staff Network	Ethnically diverse colleagues from REN and the wider Trust are invited to be part of a panel to share experiences to raise awareness. June 2023		
	Race Conversations, development programme for managers		A date will need to be determined. The action should be implemented once it is felt	The recommended external consultant is Dave Ashton Consultancy who has worked with the NHS Leadership Academy, the Head of EDI and many other Trusts for a number of years and is well versed on the topic of race and possesses the skills to navigate	

Not Started	On Track	Completed	Overdue

			that its reception would be welcomed.	conversations and situations with managers at all levels.	
	Implement a Buddy System for the international nurses	International Nurse Team	A successful buddying system will be implemented to support the International Nurses. TBC		

Workforce Race Equality Standard (WRES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
Executive Lead: Polly McMeekin, Director of Workforce and Organisational Development
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 9 Percentage difference between the organisations board voting membership and its overall workforce

Objective	Actions / Targets		Measurement & Completion Date	Progress/Comment	Status
Commence a year on year approach to increase BME representation at Board level by 1%.	Review of VSM recruitment processes within the Trust	Head of EDI, Foundation Trust Secretary and the Recruitment Manager	Process reviewed and advice given. February 2023	Search methods may need widening.	
	Learn from Trusts who have been identified as one of the top ten best performing Trusts for this metric	Head of EDI	February 2023		

Notes

Many of the actions will impact on other WRES metrics, this should hopefully have a more holistic improvement.

The Trust previously submitted action plans to NHS England (NHSE) on the 'Implementation of the 6 key actions on the overhaul or recruitment and promotion' and the Race Disparity Ratios. The recommendation is that progress against the action plans are reviewed.

Not Started	On Track	Completed	Overdue

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Workforce Disability Equality Standard (WDES) Annual Report
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion and WRES Expert

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 is for assurance and has been shared with the People and Culture Committee for information and discussion. It sets out the Trust's 2022 WDES data, gives an overview on the progress of the 2021 action plan. It also incorporates an action plan for 2022-2023 to address the working experiences and career opportunities of Disabled colleagues.

The WDES data was required to be submitted to NHS England (NHSE) by 31 August 2022 and then uploaded to the Trust's website. The action plans are required to be approved and uploaded to the Trust's website by the 31 October 2022. As the October Trust Board meeting was deferred until November 2022, there will be a slight delay in obtaining approval.

The Fairness Forum and Staff Network members were asked to comment on the draft action plan.

Comparison of the 2021 and 2022 data has shown that there has been good improvement within Metric 1 regarding Disabled staff in post. This could possibly be attributed to the increase in disability declaration rates. Metrics 2, 3, 4c, 5 and 6 have improved, 4b, 4d, 7 and 8 have deteriorated and 4a, 9 and 10 have remained static with

1 Board Member declaring themselves as Disabled. A statistical analysis has been used of 0.5% and a positive, negative and static movement have been highlighted in green, red and yellow. The data for Metrics 5-9 are taken from the Staff Survey so the Trust's data has been compared to our benchmark group's average

Many disabilities are hidden and should be taken into consideration when reading this report.

Responsibility at a senior level is required to ensure the Trust makes a significant improvement to improve the work experiences and career progression of our Disabled colleagues.

Recommendation:

The Board of Directors is asked to note the content of this WDES Annual Report, approve the Action Plan and provide their support for its implementation.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

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	2 November 2022	

NHS Workforce Disability Equality Standard, 2022

1. Introduction and Background

The Workforce Disability Equality Standard (WDES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust is required to comply with. Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at improving the experiences of Disabled colleagues. The data is required to be submitted to NHS England (NHSE) by 31 August 2022, this deadline was achieved. An action plan is to be drawn up and submitted to NHSE by 31 October 2022.

The WDES covers 10 Metrics regarding the career progression and work experiences of Disabled colleagues. The data is collected for the period of 1 April 2021-31 March 2022 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey, with a snapshot of the data as at 31 March 2021. The Staff Survey data is from the 2021 Staff Survey.

This report provides an analysis of the 2022 data for the 10 Metrics covering the last three years, progress on the 2021 action plan and the action plan for 2022.

The Head of Equality, Diversity and Inclusion (EDI), the Fairness Forum and Trust colleagues have contributed to the production of the action plan. The Head of EDI will be attending the Enable Network to discuss the data and action plan with members. Combined Freedom to Speak Up and WDES roadshows will also be delivered.

Considerations

Due to the Head of Equality, Diversity, and Inclusion (EDI) commencing their role mid-August 2022 the presentation of the data analysis, staff engagement and co-production of the action plan has been carried out within a short timescale. The process will differ slightly within the next reporting period in 2023. An Annual Report will be presented before the data is submitted via the online portal by 31 August 2023 deadline. Wider staff engagement will take place to co-create the action plan prior to the deadline and submitted for approval before 31 October 2023.

North East, Yorkshire and Humberside Region, EDI support provided a data pack, 'WRES and WDES guidance' that was referred to in creating the action plan. Their information session was also attended.

2. Current Position/Issues

2022 Data Analysis

This analysis has used a method which highlights the positive, negative and static changes in the data. Positive is in green, negative is in red and a figure below 0.5% shows little statistical movement, therefore considered static and is highlighted in yellow. Statistically significant movement is +/- .0.5%.

Total Disabled Staff Headcount & Percentage (for 2022)	Total Non-Disabled Staff Headcount & Percentage (for 2022)	Total Trust Staff Headcount and Percentage (for 2022)	Total Headcount and Percentage of Staff Not Stated (for 2022)
420 (4.08%)	7,869 (76.4%)	10,300 (100%)	2,011 (19.52%)

According to the 'WDES Implementation team, May 2022, Workforce Disability Equality Standard 2021 data analysis report for NHS Trusts and foundation Trusts', there has been an increase of Disabled people in the total workforce, which is now 3.7%. Our declaration rate has increased to 4.08%.

Metric 1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

2020 Total Disabled	2021 Total Disabled	2022 Total Disabled
Non-clinical Disabled • Bands 1-4 = 3.1% • Bands 5-7 = 2.3% • Bands 8a - 8b = 2.4% • Bands 8c – 9 & VSM = 3.1% **Clinical** • Bands 1 - 4 = 3.1% • Bands 5 - 7 = 2.78% • Bands 8a – 8b = 1.13% • Bands 8c – 9 & VSM = 0% • M&D Consultants = 0.75% • M&D Career Grades = 2.61% • M&D Trainee Grades = 2.64%	**Non-clinical Disabled** • Bands 1-4 = 3.5% • Bands 5-7 = 2.9% • Bands 8a - 8b = 3.4% • Bands 8c – 9 & VSM = 2.6% **Clinical** • Bands 1 - 4 = 3.3% • Bands 5 - 7 = 3.2% • Bands 8a – 8b = 1.5% • Bands 8c – 9 & VSM = 0% • M&D Consultants = 0.7% • M&D Career Grades = 1.7% • M&D Trainee Grades = 2.3%	**Non-clinical Disabled** • Bands 1-4 = 4.5% • Bands 5-7 = 4.7% • Bands 8a - 8b = 5.5% • Bands 8c – 9 & VSM = 3.6% **Clinical** • Bands 1 - 4 = 3.9% • Bands 5 - 7 = 4.6% • Bands 8a – 8b = 2.1% • Bands 8c – 9 & VSM = 0% • M&D Consultants = 0.7% • M&D Career Grades = 2% • M&D Trainee Grades= 2.2%

2022 has seen a positive statistical improvement in all non-clinical bands and clinical bands 1-8b. Movement has remained static from band 8c and above, this could be related to the perceptions about sharing a disability status or understanding about what is considered a disability. Also, according to the above report, 59% of Trusts have fewer disabled colleagues in senior positions (bands 8c and above including medical consultants and Board members).

Metric	Description	2020 Total Disabled	2021 Total Disabled	2022 Total Disabled

2	**Relative likelihood of Disabled staff being appointed from shortlisting compared to non-Disabled staff**	8.79 of overall workforce	6.27 of overall workforce	1.87 of overall workforce

The relative likelihood of Disabled colleagues being appointed from shortlisting has significantly improved since 2021 and the data shows that the Trust is reaching the level of parity compared with non-disabled colleagues. The Trust is a Disability Confident Employer and if more applicants have felt comfortable in disclosing their status, they will have been shortlisted which will have put them in an equal position to be appointed. This is potentially why there has been an increase within Metric 1 above.

Metric 3	Description	2020 Total Disabled	2021 Total Disabled	2022 Total Disabled
	Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	1.61 of overall shortlisted who revealed a disability	1.40 of overall shortlisted who revealed a disability	1.35 of overall shortlisted who revealed a disability status

Metric 3 has seen a positive decrease in Disabled people entering the capability process due to performance and if there is a year on year progress, parity should be reached.

Metric 4a Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in the last 12 months

Metric 4b Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months

Metric 4c Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

Metric 4d Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months

Metric	2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
4a	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
	31.2%	21.9%	30.9%	20.2%	31.2%	23.2%

4b	17.7%	10.5%	18.2%	10.9%	19.4%	9.4%
4c	27.3%	17.2%	29.7%	16.2%	28.8%	17.8%
4d	49.0%	45.7%	48.7%	43.1%	45.0%	41.6%

Whilst it is positive that there has been a decrease in the harassment, bullying or abuse that Disabled colleagues have experienced from colleagues, there has been an increase from managers and in either Disabled colleagues or other colleagues reporting it. Overall, the percentage for this type of negative behaviour remains high.

Staff Survey Comparison

Metric 4a - Statistically there has been little change over 2 years, 31.2% is still below the benchmark group average of 32.4%

Metric 4b - This figure is above the benchmark group average of 18.0%.

Metric 4c - This has seen a decrease from 29.7% in 2020 to 28.8% in 2021 but is still above the benchmark group average of 26.6% which is equates to a negative experience.

Metric 4d - This metric has seen a deterioration from 48.7% in 2020 to 45% in 2021 and is below the benchmark group average of 47%.

Metric 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
50.5%	57.9%	49.3%	56.5%	52.1%	56.9%

Metric 5 has seen a positive increase and is above the percentage it was at in 2020.

Metric 6 Percentage of Disabled staff compared to non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
25.6%	22.1%	27.7% ↑	21.9%	26.9% ↓	18.9%

There has been a positive decrease in Metric 6 and whilst some Trusts have found that colleagues have experienced 'presenteeism' throughout the pandemic because of the perceived pressure to support their teams, it has also been noted that enabling colleagues to work from home has supported them in balancing any health needs they need to be taken into consideration. Anecdotal evidence throughout the NHS suggests that colleagues that have been provided with the necessary equipment to work from home have overcome barriers they faced.

Metric 7 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
34.4%	46.9%	33.3% ↓	46.3%	30.6% ↓	39.6%

This metric has seen a year on year deterioration since 2020 and is addressed in the action plan, the figure is below the Staff Survey benchmark group average of 32.6%.

Metric 8 Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

2020 (2019 Staff Survey)	2021 (2020 Staff Survey)	2022 (2021 Staff Survey)
Disabled	**Disabled**	**Disabled**
77.7%	77.1% ↓	74.4% ↓

Metric 8 has also seen a year on year deterioration since 2020 and is addressed in the action plan. It needs to be ascertained from colleagues whether they felt reasonable adjustments were made during the pandemic to enable them to work from home, but not whilst on work premises. This is still above the Staff Survey benchmark group Average of 70.9% which is commendable, but anecdotal

examples regarding the problems experienced means the organisation should review its process.

Metric 9 The staff engagement score for Disabled staff, compared to non-Disabled staff

2020 (2019 Staff Survey)		2021 (2020 Staff Survey)		2022 (2021 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
6.5%	7%	6.4%	7%	6.2%	6.7%

The staff engagement score for Disabled staff has remained static for the past two years, hopefully wider Trust work regarding the Staff Survey will have an impact on this.

Metric	Description	2020 Total Disabled	2021 Total Disabled	2022 Total Disabled
10	**Disabled Board Members**	0 out of 12 board members	0 out of 15 board members	1 out of 16 board members
	Percentage difference between the organisations' Board voting membership and its overall workforce	(0%)	(0%)	(6.25%) 
	Voting Board Members	0	0	0
	Non-voting Members	0	0	1 

The percentage of Board members by Disability compared to its non-disabled workforce is 6.25%. The aim of this metric is for the Board to reflect its Disabled workforce, which is currently at 4.08%.

Progress Against the 2021 Action Plan

The responsibility for the Equality Action Plan 2021 was held with several colleagues within Workforce whilst carrying out their substantive roles.

The action plan covered both the WRES and WDES as several actions overlapped, the plan was quite extensive. National guidance is that where Trusts decide to have one action plan they should ensure that issues and actions are not conflated.

With any action plan an improvement in experiences and therefore data needs to be monitored on a year on year basis which will provide a true reflection of

improvement. There have been different levels of progress with the 2021 action plan; for the following reasons:

- Absenteeism
- Staff Network members response
- Some actions not aligned with anyone specifically
- Postponement of the intervention

There has been progress with some of the actions, but this has not been the case throughout. Workforce colleagues have reviewed policies, the leavers questionnaire and engaged with the Staff Networks. The Trust has also continued with its development of an Open and Just Culture. Colleagues have held discussions with the Staff Networks about sharing their disability status, this is likely to have had an impact in the increase in declaration rates.

Some of the actions have been carried forward to the 2022/23 action plan to ensure they are implemented and the WRES and WDES action plans have been drawn up separately. Colleagues who hold responsibility for an area of work need to ensure that EDI is threaded throughout and take responsibility for consulting data to improve experiences.

2022-2023 Action Plan

This year's action plan focuses on the Metrics that have deteriorated and those where the data remains high, so experiences are negative. The National advice is not to necessarily focus on all Metrics but on those that require addressing the most. In saying this there will naturally be other organisational interventions that might have a positive impact on experiences and therefore the data. It is imperative that a deep dive into the data is carried out to ensure there is a better understanding of experiences. This will be intrinsic to some of the actions.

1. Summary

- Overall, the Trust has made good progress with disability equality, which can be seen in the improvements of the 2022 data. Given this it is important that we continue to progress and do not become complacent.
- There are Metrics that still require focus and these have been addressed in the action plan.
- The experiences of Disabled colleagues may impact on patient care
- Negative outcomes will affect our Well-led review, so it is important that we consider the needs of our Disabled workforce.

2. Next Steps

The data was submitted by the deadline of 31 August 2022. The Trust's action plan will be submitted by the deadline of 31 October 2022 and will be published on the Trust's website.

The Trust Board is asked to review the data and sign off and support the action plan for implementation.

Appendix 1 - WDES Action Plan

Date: October 2022

Workforce Disability Equality Standard (WDES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
York and Scarborough Teaching Hospitals NHS Foundation Trust

APPENDIX 1

Metric 1: Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
To increase self-declaration of disability and long-term health conditions and dispel myths as to why we collect this data. Increase percentage of staff in post who share their disability status by a minimum of 2% in 2023	Evaluate communication methods used to disseminate information to staff on self-declaration and re-launch Self Service and the ESR app.	Deputy Head of Resourcing, Digital and Insights	Generate quarterly reports from ESR, workforce to evaluate if communications are being effective. Establish ways to aid communication. March 2023		
	Trust Managers to analyse local data and encourage colleagues via local meetings.	HR Business Partners and EDI Workstream	Local quarterly reports provided to the EDI workstream. March 2023		

Not Started	On Track	Completed	Overdue

	Identify perceptions and barriers around self-declaration to feed into Myth Busting Guide	Head of EDI, EDI Workstream and the Staff Networks	Information obtained to aid completion of a Myth Busting Guide April 2023		
	Work towards Disability Confident Level 3.	Workforce Lead	Level 3 achieved, or requirements established to achieve the next level. Date TBC		
	Launch an Equality Monitoring Myth Busting Guide to dispel myths about sharing disability status	Head of EDI and the Staff Networks	Production and dissemination of a Myth Busting Guide to support self-declaration. May 2023		

Workforce Disability Equality Standard (WDES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 4a: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Reduce the percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public. Statistically there has been little change over 2 years and whilst 31.2% is below the benchmark group average of 32.4% this figure is still high. Aim to reduce this figure by 2%.	Create a statistical comparison of data – reported through the 2022 Staff Survey, Datix and FTSU. Determine what action is required to address the findings.	Head of EDI, FTSU Guardian, Datix Manager, Staff Engagement Project Lead	This action will enable the Trust to identify if there are any differences in colleagues reporting their experiences. It will also enable the Trust to determine what action is required. Quarterly reports to be provided from April/May 2023		

Not Started	On Track	Completed	Overdue

Workforce Disability Equality Standard (WDES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 4b: % of staff experiencing harassment, bullying or abuse from managers in the last 12 months
Metric 4c: Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/ Comments	Status
Metric 4b - Reduce the number of staff experiencing harassment, bullying, or abuse from managers. The last 12 months has seen a slight increase from 18.2% in 2020 to 19.4% in 2021. This figure is above the benchmark group average of 18.0%. Aim to reduce this figure by 2%.	Embed a culture of civility and respect through communication and training.	Head of EDI and the Enable Staff Network	Reduction of B&H complaints through HR, FTSU and data in the Staff Survey. May 2023	• Develop a RESPECT Charter through the Enable Staff network and launch within the Trust. • Include the Charter in corporate or local the induction of all new starters. • Implement a variety of disability awareness training to increase colleague's knowledge and skills (this will require funding and resources.)	

Not Started	On Track	Completed	Overdue

	For all of metric 4 - review the Trust's processes for addressing experiences of bullying and harassment. (As per the Listening to Employee Voice: Our way forward action plan)	Head of Employee Relations & Engagement	Launch of new Harassment and Bullying Policy 31 March 2023		

Metric 4c - Reduce the percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. This has seen a decrease from 29.7% in 2020 to 28.8% in 2021 but is still above the benchmark group average of 26.6%. Aim to reduce this figure by 3%.	The Trust's Behaviour Framework was launched in 2022.	Head of Employee Relations & Engagement.	Evidence communication methods used to launch the BF July 2022.		

	Develop a Microaggressions poster with all Staff Networks for communicating throughout the Trust.	Head of EDI and the Staff Networks.	Raise awareness of everyday incivilities that cause unwanted behaviour. April 2023		

Workforce Disability Equality Standard (WDES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 4d: % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Metric 4d - Ensure all staff are aware of the behaviour expected and how to report bullying and harassment / unwanted behaviour should it occur. This metric has seen a deterioration from 48.7% in 2020 to 45% in 2021 and is above the benchmark group average of 47%. Implement an action to see a 2% positive change in 2023.	Workforce and FTSU to provide quarterly figures on complaints to the EDI Workstream.	Workforce / FTSU Guardian	Data to compare with 2023 Staff Survey Results and to pinpoint areas of focus July 2023		
	General Allyship/Bystander training implemented in the Trust.	Head of EDI	TBC	Financial resources required to implement this.	

Not Started	On Track	Completed	Overdue

Workforce Disability Equality Standard (WDES)
DRAFT Action Plan, 2022-2023

Author: Virginia Golding, Head of Equality, Diversity and Inclusion, Workforce
York and Scarborough Teaching Hospitals NHS Foundation Trust

Metric 7 Percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
The percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work has seen a continuous deterioration, and the figure is below the benchmark group average of 32.6%. 34.4% in 2019 33.3% in 2020 30.6% in 2021 Aim to reduce this figure by 2%.	Re-introduce the Celebration of Achievement Awards for 2022.	Director of Communications	Awards will focus on valuing colleagues contribution, hopefully will impact on all colleagues.	Correlation will be difficult to prove.	
	Introduce an Equality, Diversity and Inclusion Category in the Celebration of Achievement Awards for 2023.	Director of Communications	New category introduced in 2023 demonstrating the value of diversity and inclusion.	Discussed with the Director of Communications on 27/9/22.	
	Enable Staff Network Chair to discuss this metric with members to ascertain	Enable Staff Network Chair	Engage with staff to delve into the data.		

9

Not Started	On Track	Completed	Overdue

	actions required for improvement. Feedback to the Head of EDI and EDI Workstream.		Improvement actions considered for implementation. March 2023		

Metric 8 Percentage of Disabled saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This metric has deteriorated, in 2020 it was 77.1% and in 2021 it was 74.4%. This is still above the benchmark	Previous Enable Staff Network discussions identified issues with the IT process. Review the process with a view to identifying the blockages and creating a new streamlined process.	IT, Head of EDI and Enable Staff Network	New process in place and communicated to staff, Staff Networks and managers. A positive increase in 2023 data. April 2023	Head of EDI met with Matthew Chappell on 272022 to identify the issues.	

group average of 70.9% which is commendable but anecdotal examples regarding the problems experienced means the organisation should review its process.	Implement a Health Passport to ensure that staff's reasonable adjustments are communicated and met.	Workforce Lead	A Health Passport co-produced with staff, piloted and launched. Date TBC	Almost ready to launch, waiting for IT solution.	

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Perinatal Clinical Quality Surveillance Update
Director Sponsor:	Heather McNair
Author:	Sue Glendenning - Director of Midwifery Sarah Gallagher – Quality and Governance Lead

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 CQC continue to request monthly assurance around Tendable and MEWS compliance on Ward G2. Compliance with this request has been low due to challenges in providing this information to the CQC in respect of capacity in the senior leadership team, a plan has been worked up to ensure this is provided in the coming months.

There were 13-unit closures at York in September, a slight decrease on August 2022 however still higher than in previous months.

Progress against compliance with all 10 safety actions for Maternity Incentive Scheme (formally CNST) is currently challenged due to compliance with the Saving Babies Lives Care Bundle to include carbon monoxide monitoring at 36 weeks and not consistently scanning high risk pregnancies within 3 days, mandatory training compliance and the lack of chair for the Maternity Voice's Partnership, these discussions will form part of the Maternity Transformation Board with the inaugural meeting planned on 6th October. This may mean that the Trust will not meet the MIS requirements for 2022-23 and therefore will not be eligible to recover the contribution to the incentive scheme.

Work continues towards the Seven Immediate and Essential Actions from the Ockenden report published in December 2020. To be fully compliant, the Trust is reliant on Maternity Voices Partnership collaboration, the formation of working relationships with the newly formed Integrated Care System and the implementation of Maternal Medicine Networks.

Concerns remain in relation to cross- site being able to evidence multi-disciplinary handovers, ward rounds, medical training and PROMPT training compliance.

Recommendation:
The Board of Directors are asked to receive for information and assurance.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

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

Perinatal Clinical Quality Surveillance Report – October 2022

1. Introduction and Background

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. The report aims to provide assurance, mitigations and any gaps in assurance surrounding any identified issues, themes, and trends to demonstrate working towards an embedded culture of continuous improvement.

The NHS Maternity Incentive Scheme (MIS previously 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, the submission date is 5 January 2023. Due to increased pressure on workforce the maternity service cannot always assure that the labour ward coordinator will be super nummary for 100% of the shift and a vacancy for the Coast and Country MVP could affect compliance with MIS and may result in the Trust not being eligible to reclaim the contribution to the scheme for 2022-23.

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 seven Immediate and Essential Actions (IEA) in the Ockenden Report with a total of 49 standards to be addressed. The final Ockenden Report was published on 30 March 2022 with a further 92 safety recommendations. The Trust is awaiting National steer around action planning and is aware the publication of the East Kent Report, expected this month, will guide these plans. Focus is to remain on the existing Ockenden action planning until this is published with a review planned in October of all ongoing Ockenden audit within our maternity services which will be reported in November's report.

Maternity services were notified by NHS England on the 21st September that there no longer is a target date for services to deliver the midwifery continuity of care model and a safe workforce is now the key priority.

During September, the updates required for the CQC around Tendable and MEWS were provided for Ward G2. The Ward Manager is being supported to undertake this work and actions will be overseen by the Associate Director of Midwifery until our Inpatient Matron is in post.

There is a plan to review the current Women's Health Clinical Governance monthly forum Terms of Reference by the Quality and Governance Lead to ensure correct attendance

and quoracy and ensure appropriate rigour, challenge and escalation. The Director of Midwifery and Associate Director of Midwifery both new in to post on the 5th September 2022 will be attending this meeting going forward for oversight and assurance.

The minimum data set as required NHSE/I required for the perinatal clinical quality surveillance report can be found in Appendix A.

2. Current Position/Issues

2.1 Moderate Harm & Serious Incidents

Moderate harm is any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Over the course of the reporting period there were four incidents reported as moderate harm, three at York and one at Scarborough. Two of the reported incidents were related to high acuity on the wards and decreased staffing to safely manage this. The other two incidents were related to clinical care; both incidents were discussed at the weekly Maternity Case Review meeting and at the Trust Quality and Safety meeting, local and individual learning was identified in both cases and actions agreed to reduce the risk of reoccurrence and the learning will be shared at specialty governance.

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

2.2 Healthcare Safety Investigation Branch Reports (HSIB)

HSIB is a national quality improvement programme which aims to reduce the number of babies who die or are left severely disabled because of incidents occurring during term labour. They investigate any intrapartum stillbirths, early neonatal deaths, potential severe brain injuries diagnosed in the first seven days of life and maternal deaths of women who are pregnant or who die within 42 days of the end of pregnancy.

There was one incident reported to HSIB in September 2022, an unexpected admission to SCBU for cooling at a Tertiary Centre, this was also declared as a Serious Incident following discussion at the Trust Quality and Safety meeting. It was confirmed that there was no harm caused to the baby following an MRI however the case reported to HSIB who agreed to investigate following discussion with the family.

One draft HSIB report has been received into the Trust and is currently undergoing review by the contributors for factual accuracy.

2.3 Perinatal Mortality Review Tool (Appendix B)

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 made 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.

A summary of the PMRT activity is detailed in Appendix B.

The project plan in relation to stillbirths is identified in Appendix D.

2.4 Unit diverts and closures

In September, there were 13-unit closures at York in Scarborough and no closures at Scarborough. High acuity, inadequate midwifery staffing, insufficient bed space on the postnatal ward were the common themes for unit closures and diverts.

The Maternity Service is undertaking an urgent piece of work around the process of closures, diverts, the escalation process, support from the on-call team and the wider LMS and ICS.

2.5 Training Compliance (Appendix C)

The training figures for both Scarborough and York sites are included in Appendix C. Maternity Services are looking to standardise reporting, reporting on August data for York September data for Scarborough as is reliant on administrative capacity to complete this work Compliance for mandatory training levels for maternity and medical staff across both sites is variable which the service acknowledges needs to be addressed. With Scarborough medical staff a slight increase in compliance has been noted since the last report regarding noncompliance but still reporting on May reds, the Clinical Director is aware and supporting with an improvement plan.

2.6 Safe Staffing

The vacancy rates for midwives is 1.89% (1.13 WTE) at Scarborough site and 14.77% (16.11 WTE) on the York site, this is an increase on last month. Maternity services are welcoming 15 WTE midwives to commence in post from mid-October, the majority are newly qualified. There are significant gaps in the roster across the service, incentives have been agreed with varied levels of uptake, for a short period of time double pay has been supported from the Trust Board to support safe staffing, there has been an increase in uptake and a boost in morale noted.

There is momentum to progress scrub nursing for obstetric theatres to release midwives from scrubbing in theatres and support the core integrated teams on labour ward and this work is critical. This is an urgent piece of work for York given the acute workforce shortages but there will be a theatre scrub model and recruitment programme that is developed across both sites and this Trust wide model is a priority.

The recruitment and retention midwives have developed a robust preceptorship plan for the newly qualified midwives to include a full 2 weeks induction, preceptorship period with

a designated line manager, rotation through the service, WhatsApp group for support, four monthly time out with updates and peer support and reflection throughout the year long period. The preceptorship midwives will also wear a different coloured uniform so they can be easily identifiable and the MDT will recognise they are new and require support and guidance and are been welcomes into the Trust on a Band 4 contract until they receive their PIN.

Maternity have welcomed our first International midwife who is settling in well and has already received positive feedback from our women and families.

There is work on going to manage staff absence with supportive conversations in line with the sickness and absence policy and timely supportive return to work in interviews. The recruitment and retention midwives will support staff back to work if this is requested by line managers and individual staff.

The service is looking to strengthen the twice daily staffing huddles which will link into the ongoing work around the escalation policy, supporting the band 7's to have robust oversight of their rosters for the next 24 to 48 hours and encouragement of the use of eroster as a live tool to enable a status at a glance picture for the service.

The Director of Midwifery is reviewing how appraisals are conducted and by who with plans to align members of staff to the area that they are working to support clarity regarding line management. Specialist Midwives will also continue to conduct appraisals and there will be a clear plan for the unregistered workforce. The Director of Midwifery and Associate Director of Midwifery will support to ensure as many staff as possible receive an appraisal in this reporting period, however, acknowledge the current compliance is low.

To continue to support the safe care of women and babies at York, G2 and G3 wards remain merged since the summer 2022. This does have an impact of flow across the unit and is enabling a review of process to include triage, pediatrician reviews, timings of labour ward and post-natal ward rounds, this will require an MDT approach to move forward with a different approach.

The Midwifery Leadership Team is fragile and both the Director of Midwifery and Associate Director of Midwifery are trying to manage the many asks alongside supporting a safe service. The Lead Matron / DHoM commences in post on the 10th October joining from Mid Yorkshire Trust and the Inpatient Matron commences in post on the 17th October, an internal promotion from G2. Recruitments are planned for the Antenatal / Community Matron on the 7th October.

2.7 Service User Feedback

The York MVP Chair has been recruited and a meeting is planned for October, the Coast and Country Chair has recently resigned. Collaborative working with the MVP remains a risk in terms of MIS and Ockendon compliance.

The new Associate Director of Midwifery is speaking to women who received care and the feedback she has received has been that women have had positive experiences despite the challenges we are facing.

The service is working with the communication Team to develop a questionnaire to receive immediate feedback on discharge which we hope will improve patient experience and reduce on complaints.

The Care Group continues to reframe the process for managing complaints and building on the confidence of the Band 7's to manage these situations at point of contact, to ensure a timely response and a better experience for patients and families.

We are waiting to hear who our Patient Safety Partner will be in line with the Patient Safety Strategy and Ockendon.

2.8 Staff Survey

It has been difficult to progress all the work required following the staff survey with the staffing challenges. However, a listening event was held in Scarborough in July, a Trust wide WebEx meeting in July and a York specific listening event is being arranged, this was cancelled due to a surge in covid cases later in July.

The feedback from the listening event in Scarborough was delayed as the plan was to feedback to both sites, this feedback has now been fed back to the Ward Managers and the Director of Midwifery and Workforce Lead are now planning to feedback to the Scarborough team.

Key themes were identified to include but not exhaustive staffing, breaks, visible leadership at all levels, lack of understanding of the pressures and feeling like the poor relation, CoC and Triage., inequitable cover from specialist midwives. Some solutions were discussed at the time of the listening event and some are progressing with plans to include local managers and teams in understanding solutions as we progress further.

The annual staff survey is live at the beginning of October, all staff will be encouraged to complete.

2.9 Safety Champions Feedback

The Chief Nurse and the Non-Executive Director continue to do monthly walkabouts across both sites. Feedback from these walkabouts is provided to the ward managers to improve the working and surrounding environment however this requires strengthening to include the ward to board approach, it is evident that not all staff are included in this feedback.

Themes from the September walkabout were a lack of visible leadership at Scarborough, staff feeling like there is poor communication and working environment. These issues will

be picked up by the Senior Leadership team as part of the cultural transformation work this is ongoing and in direct conversations with the ward managers and teams.

3. Summary

The teams continue to work under significant pressure and above and beyond to ensure a safe service and should be recognised for this. Maternity service are unprecedented times and the acuity and complexity of the women we care for is increasing.

4. Next Steps

The new senior maternity leadership is evolving and there are gaps on posts which is affecting local leadership and visibility.

Our focus is to concentrate on the Key Lines of Enquiry working in collaboration with the Corporate Governance team to prepare, plan and understand for the upcoming CQC inspection.

Date: 06 October 2022

Monthly Oversight of Perinatal Clinical Quality Minimum Data Set - Appendix A

York and Scarborough Teaching Hospitals NHS Foundation Trust

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

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

	2021				2022						
	Sep	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun	Jul	Aug
Number of reviews completed using the Perinatal Mortality Review Tool	2	5	0	0	1	1	0	4	0	1	0
Number of cases notified to MBRRACE	1	2	2	4	0	1	2	2	1	1	3
Number of cases referred to HSIB as per eligibility criteria	1	1	1	0	0	0	1	0	1	0	3
Number of received HSIB final reports	1	0	0	1	0	0	0	2	0	1	0
Number of incidents with a harm rating of Moderate or above	1	2	1	1	0	1	4	5	1	1	3
Number of Maternity Unit Diverts						11	4 SGH 4 YDH	0 SGH 2 YDH	1 SGH 3 YDH	1 SGH 8 YDH	SGH 0 YDH 7
Number of Maternity Unit closures	4	10	4	2	5	0	0	0	2	11	14
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	0	1	0	2 (CQC)	1 (CQC)	0	2 (CQC)	1 (CQC)	1 (CQC)	1(CQC)
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0
Continuity of Carer											
Percentage of Continuity of Carer bookings	38%	40%	31%	37%	40%	40%	37%	34%	35%	paused	Paused
Of those booked for Continuity of Carer - Black, Asian and mixed ethnicity backgrounds	44%	38%	22%	29%	60%	14%	28%	2%	64%	paused	Paused
Of those booked for Continuity of Carer - Postcode for top decile for deprivation	84%	91%	94%	73%	94%	83%	92%	8%	90%	paused	Paused
Intrapartum Continutiy of Carer received - Overall	17%	15%	16%	8%	25%	19%	25%	25%	19%	paused	Paused
Intrapartum Continutiy of Carer received - Scarborough	43%	43%	42%	28%	25%	19%	24%	25%		paused	Paused
Intrapartum Continutiy of Carer received - York	4%	6%	5%	0.42%	0%	3%	11%	0.00%	11.00%	paused	Paused
Intrapartum Continutiy of Carer received - Black, Asian and mixed ethnicity backgrounds	9%	7%	14%	14%	25%	0%	0%	0%	8%	paused	Paused
Intrapartum Continutiy of Carer received - Postcode for top decile for deprivation	42%	37%	23%	20%	19%	9%	15%	23%	50%	paused	Paused
Safe Staffing											
1 to 1 care in Labour - Scarborough	94%	99%	95%	94%	98%	96%	95%	98%	100%	100%	99%
1 to 1 care in Labour - York	95%	93%	97%	96%	96%	97%	94%	100%	100%	100%	100%
L/W Co-ordinator supernumary % - Scarborough	98%	99%	100%	100%	97%	92%	84%	95%	99%	94%	73%
L/W Co-ordinator supernumary % - York	95%	93%	87%	99%		100%	100%	100%	100%	76%	90%
Vacancy Rate - Scarborough (including maternity leaves)						5%	3%	4.60%	1.55%	0.15%	
Vacancy Rate - York (including maternity leaves)						18%	15%	13%	12%	13.75%	

2021 Staff Survey: Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work (Reported annually)	
2021 Staff Survey: Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to receive treatment (Reported annually)	
2022 Staff Survey: Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

PMRT – Appendix C

PMRT Summary from Q1 and Q2 2022

Quarter 1

Four reports were completed and sent within quarter one, 2 intrapartum stillbirth and 2 antenatal.

The under use of translation services has been identified as a cause for concern within one of the reviews. There has been a considerable amount of work done with regards to translation services within the service including the introduction of tablets for translation within the unit and portable phones ordered for each area to enable the use of language line. The success of the implementation of these will be audited in the coming months.

Smoking cessation support was also identified to be an area for improvement in two of the cases.

The reintroduction of face to face training is also enabling better engagement with staff when delivering teaching and facilitating discussion and feedback more easily. Care of women in labour and the significance of monitoring of this on a partogram is being highlighted within these sessions.

Quarter 2

There were two reports completed in quarter two, one antenatal stillbirth and one intrapartum. Although it was felt within both cases that there were no concerns relating to the management of the pregnancy and the outcome, there were coincidental findings which have enabled learning. With relation to a delay in assessment on arrival to the unit, new triage guidance is being published to

reflect the urgency of attendees and the basis on which they should be prioritised. This should enable staff to manage their workload and prepare for expected patients accordingly.

The lack of smoking cessation being offered has also been highlighted and subsequently the importance of this has been widely shared to staff, particularly the incorporation of the entire family unit and offering services to people within the home. The compliance with smoking e-learning is also being reviewed by the admin team and staff that are not compliant will be followed up and supported to complete.

It was also noted that in both of these cases the Kleihauer test was not conducted. Following on from a conversation with a senior lab technician it appears it may have been a new member of staff that did not carry these out as it is known by staff within the lab that this is a required test on all stillbirths. They have assured us that they will endeavour to make all new starters aware of this process due to the clinical importance in the review into the loss.

Training Compliance – Appendix C

Midwifery Staff – York (September figures not available at the time of writing)

	Frequency	January	February	March	April	May	June	July	August
Neonatal Life Support	Annual	77	73	74	87	92	93	92	92
Infant Feeding	Annual	77	75	66	64	81	84	91	94
Professional Midwifery Advocate	Annual	84	84	85	86	89	92	94	97
Perinatal Mental Health	Annual	90	91	89	90	92	94	93	95
Public Health	Annual	20	22	33	44	50	56	56	63
Personalised Care - Year 1 (2021/2022)	3 yrly	20	23	33	44	51	56	60	64
Personalised Care - Year 2 (2023)	3 yrly	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Personalised Care - Year 3 (2024)	3 yrly	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT - Midwives	Annual	64	72	82	91	92	90	92	94
PROMPT - MSW/HCA	Annual	60	54	64	77	77	81	79	79
COVID in pregnancy - Midwives	Annual	84	67	68	N/A	N/A	N/A	N/A	N/A
COVID in pregnancy - MSW/HCA	Annual	80	71	64	N/A	N/A	N/A	N/A	N/A
Antenatal and Newborn screening	Annual	78	70	75	83	84	85	84	85
Learning from Incidents, Complaints & Claims	Annual	27	27	34	46	53	62	68	68
Substance Misuse	3 yrly	89	89	91	90	89	89	88	91
Mentorship	Annual	26	26	33	45	52	60	56	56
Bereavement update	Annual	60	54	49	70	72	76	75	81
e-lfH National Bereavement Care Pathway	One off	21	19	18	18	20	18	18	18
K2 - Intrapartum CTG Assessment	Annual	74	72	69	70	70	69	73	75
K2 - Intrapartum Intermittent Auscultation Assessment	Annual	73	71	66	66	72	72	73	78
K2 - Antenatal CTG Assessment	Annual	73	72	69	73	72	72	74	80
K2 - Full Midwife pathway	Annual	63	60	57	61	66	66	70	72
SBLCB - Supporting a smoke free pregnancy	Annual	71	72	71	68	61	64	65	64
SBLCB - Detection and surveillance of growth restrictions	Annual	81	61	59	61	61	60	62	66
SBLCB - Reduced Fetal Movements	Annual	84	64	64	67	63	63	66	74
SBLCB - Effective continuous fetal monitoring	Annual	81	60	59	62	57	57	59	62
SBLCB - Reducing Pre-term birth	Annual	87	66	66	68	62	63	66	70
Bereavement Workshop - HCAs	One off	80	71	64	69	69	69	61	66
2 day BFI - Midwives/MSWs/HCAs	One off	83	83	83	92	81	82	82	79
SBLCB - Fetal Monitoring (with Rachel McCormack)	Annual	83	87	90	89	91	94	94	94
Intelligent Intermittent Auscultation in Labour	Annual					9	13	19	25
BLS - Midwives	3yrly	90	87	84	77	72	89	92	94

Midwifery Staff Scarborough

		Frequency	January	February	March	April	May	June	July	August	Sept
Face to face training	Neonatal Life Support	Annual	83	77	81	89	87	78	72	68	68
	Infant Feeding	Annual	73	73	83	77	80	71	59	59	69
	Professional Midwifery Advocate	Annual	81	82	87	89	90	79	74	74	77
	Perinatal Mental Health	Annual	91	93	93	96	94	94	91	93	92
	Public Health	Annual	14	26	26	26	36	36	35	34	35
	Personalised Care - Year 1 (2021/2022)	3 yrly	13	23	31	31	33	36	34	32	37
	Personalised Care - Year 2 (2023)	3 yrly	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Personalised Care - Year 3 (2024)	3 yrly	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	PROMPT - Midwives	Annual	74	81	85	88	90	87	68	79	77
	PROMPT - MSW/HCA	Annual	59	71	81	75	70	68	78	78	83
	COVID in pregnancy - Midwives	Annual	57	49	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	COVID in pregnancy - MSW/HCA	Annual	76	76	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Antenatal and Newborn screening	Annual	68	72	65	61	69	63	58	50	53
	Maternal Obesity	3 yrly	90	87	85	85	86	86	86	N/A	N/A
	Learning from Incidents, Complaints & Claims	Annual	16	24	32	35	47	50	48	44	55
	Substance Misuse	3 yrly	86	84	84	89	91	91	92	95	95
	Mentorship	Annual	16	5	19	22	33	36	36	33	44
	Bereavement update	Annual	61	56	45	42	54	53	52	50	52
	e-lfH National Bereavement Care Pathway	One off	12	11	11	13	13	13	13	14	15
	K2 - Intrapartum CTG Assessment	Annual	84	70	70	65	76	80	73	76	76
	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	83	68	59	59	67	72	67	67	69
	K2 - Antenatal CTG Assessment	Annual	80	61	63	64	74	78	73	73	76
	K2 - Full Midwife pathway	Annual	62	49	45	49	67	67	67	62	66
	SBLCB - Supporting a smoke free pregnancy	Annual	65	58	71	64	64	64	68	68	69
	SBLCB - Detection and surveillance of growth restrictions	Annual	67	46	41	50	41	54	59	62	68
	SBLCB - Reduced Fetal Movements	Annual	65	46	53	65	63	68	71	71	74
	SBLCB - Effective continuous fetal monitoring	Annual	71	46	41	50	41	41	52	55	58
	SBLCB - Reducing Pre-term birth	Annual	67	45	51	58	58	62	68	71	70
Ad hoc training	Bereavement Workshop - HCAs	One off	88	82	57	57	75	74	74	72	61
	2 day BFI - Midwives/MSWs/HCAs	One off	96	96	86	88	89	92	92	93	93
	Fetal Monitoring (with Rachel McCormack)	Annual	93	87	97	92	94	91	91	91	89
	BLS - Midwives	3yrly	97	97	90	91	90	87	90	91	95

Medical Staff - York (September figures not available at the time of writing)

Training Attendance	Course	January	February	March	April	May	June	July	August
Face to face	PROMPT	50	53	61	71	90	97	100	87
E-learning	COVID in pregnancy	75	69	70	N/A	N/A	N/A	N/A	N/A
E-learning	Antenatal Screening	13	31	45	45	59	62	61	60
Face to face	Fetal Monitoring (with Rachel McCormack)	75	72	64	71	71	87	89	80
E-learning	Perinatal Mental Health	0	19	36	52	55	60	64	67
E-learning	Personalised Care - Year 1 (2021/2022)	0	16	36	55	65	70	71	67
E-learning	Personalised Care - Year 2 (2023)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	Personalised Care - Year 3 (2024)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	Risk Assesment through pregnancy	0	19	39	61	71	77	79	70
E-learning	Learning from Incidents, Complaints & Claims	0	22	42	48	55	57	64	63
E-learning	SBLCB - Supporting a smoke free pregnancy	75	66	64	55	65	70	71	63
E-learning	SBLCB - Detection and surveillance of growth restrictions	69	56	55	68	68	77	75	73
E-learning	SBLCB - Reduced Fetal Movements	72	59	55	68	74	83	86	80
E-learning	SBLCB - Effective continuous fetal monitoring	69	59	61	81	77	80	79	73
E-learning	SBLCB - Reducing Pre-term birth	72	59	55	71	74	83	86	77
E-learning	K2 - Intrapartum CTG Assessment	72	75	73	74	74	80	75	63
E-learning	K2 - Intrapartum Intermittent Auscultation Assessment	65	66	67	65	65	73	71	63
E-learning	K2 - Antenatal CTG Assessment	72	72	73	74	74	80	79	67
E-learning	K2 - Full Medical Staff pathway	56	56	61	58	55	67	61	57

Medical Staff – Scarborough

Training Attendance	Course	Frequency	Measure	January	February	March	April	May	June	July	August	Sept
Face to face	PROMPT	Annual	% of staff trained	55	60	80	75	70	84	79	48	67
E-learning	COVID in pregnancy	Annual	% of staff trained	60	60	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	Antenatal Screening	One off exl F2 & GP	% of staff trained	10	10	10	0	0	11	37	42	48
Face to face	Fetal Monitoring (with Rachel McCormack)	Annual	% of staff trained	75	75	75	75	55	58	63	37	48
TBC	Perinatal Mental Health	Annual	% of staff trained	0	30	40	35	40	42	58	32	48
E-learning	Personalised Care - Year 1 (2021/2022)	3 yrly	% of staff trained	0	15	25	20	35	37	53	26	48
E-learning	Personalised Care - Year 2 (2023)	3 yrly	% of staff trained	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	Personalised Care - Year 3 (2024)	3 yrly	% of staff trained	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
E-learning	Risk Assesment through pregnancy	Annual	% of staff trained	0	15	20	25	40	42	58	32	52
E-learning	Learning from Incidents, Complaints & Claims	Annual	% of staff trained	0	25	40	40	40	42	58	32	48
E-learning	SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	85	85	80	75	75	68	68	32	48
E-learning	SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	85	85	75	75	80	58	58	32	48
E-learning	SBLCB - Reduced Fetal Movements	Annual	% of staff trained	85	75	85	75	70	63	53	26	43
E-learning	SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	80	80	75	70	70	58	53	26	43
E-learning	SBLCB - Reducing Pre-term birth	Annual	% of staff trained	80	75	75	70	70	58	58	21	38
E-learning	K2 - Intrapartum CTG Assessment	Annual	% of staff trained	75	75	70	60	55	53	53	53	43
E-learning	K2 - Intrapartum Intermittent Auscultation Assessment	Annual	% of staff trained	80	75	65	60	55	53	53	47	43
E-learning	K2 - Antenatal CTG Assessment	Annual	% of staff trained	65	65	65	60	60	63	58	53	48
E-learning	K2 - Full Medical Staff pathway	Annual	% of staff trained	65	65	60	55	55	53	53	53	43

York and Scarborough Teaching Hospitals NHS Foundation Trust

Stillbirth Project Work Plan

Project Leads: Stacey Benzon, Quality and Governance Midwife
Megan Simpson, Quality and Governance Midwife
Louise Spicer, Maternity Quality and Governance Manger

Date	Milestone	Action	RAG Rating
03/10/2022	Present York and Scarborough stillbirth data to the Y&H Region Stillbirth Steering Group to support from the other Trusts in the region	Presentation was well received with constructive suggestions for areas to consider for future workstreams	
04/10/2022	To complete a detailed MDT walkthrough of one stillbirth to identify any good practice or gaps in care. This will include the perspective and experience of the family.	Completed with strong actions because of the exercise	
11/10/2022	Project plan and findings from the Y&H Steering Group and MDT walkthrough to presented at speciality Clinical Governance	Recommendations to include the proposal of a formation of a stillbirth task and finish group to work though the findings of the project so far	Added to the agenda
17/10/2022 or 24/10/2022 (TBC)	Project plan and recommendations to be presented to Trust Quality and Safety Group to provide assurance that work is ongoing to understand the number of stillbirths at the Trust		Date to be confirmed

09/11/2022	Project update to be provided to speciality Clinical Governance meeting		To be added to agenda
08/12/2022	Project update to be provided to speciality Clinical Governance		To be arranged
Jan 2023 (date TBC)	Findings and final action plan to be presented to speciality Clinical Governance		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 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 continues to progress the Board priority work on Acute Flow and Elective Backlogs. The Trust has seen some improvement in the proportion of patients into Same Day Emergency Care and achieved the 104 week long waiter position in September.

However, the Trust remains off plan for the 78 week and Cancer trajectories and has resubmitted updated trajectories as requested by NHSE Regional Team. This is likely to move the Trust into Tier 1 support for Elective Recovery.

The Trust has appointed an interim Improvement Director who commenced in October, with an agreed scope to lead the Elective Recovery Programme. In addition the Improvement Director will support with the system plans on delayed discharges.

Recommendation:
That the Board of Directors notes the updated position.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

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**

Chief Operating Officer's Report

1. Introduction and Background

This report sets the operational update Board of Directors oversight. The operational performance position is provided in the Trust Priorities Report.

2. Considerations

That the Board of Directors notes the updated position.

3. Current Position/Issues

The Executive Board of Directors has approved the changes to the Transformation Programmes to support delivery of the Building Better Care Strategy. These are now based on the organisational priorities, with two discreet programmes 'Urgent and Emergency Care' and 'Elective Care' under the remit of the Chief Operating Officer.

The Trust has appointed an interim Improvement Director for 2 days a week, who commenced 10th October. The Improvement Director will review and rescope the work under the Elective Care Programme. The remit will include surgical capacity (mutual aid, outsourcing and productivity), Outpatients Transformation (including the move to partial booking for services with long waits to first appointment), Diagnostics and Cancer.

The Executive Committee approved the resourcing of the core Programme team, enabling protected resource to deliver on these high priority Programmes.

3.1 Board Priorities: Acute Flow

The Programme Lead has revised the scope for the Urgent and Emergency Care Programme, in alignment with the new Integrated Care System (ICS) Urgent and Emergency Care Programme Board.

The CQC commenced an unannounced visit of the Trust's emergency department, medical areas and Maternity on 11th October.

3.1.1 Discharge Pathways:

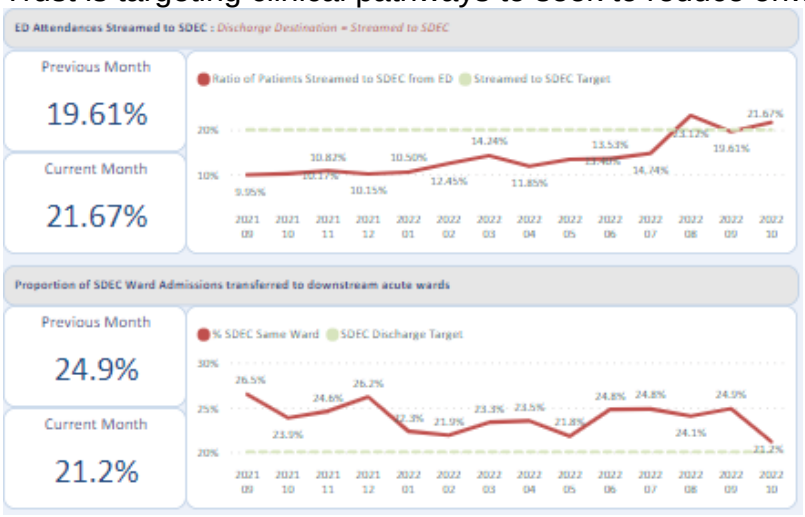
Discharges by 5pm has remaining relatively static in September, at 63.3% against a target for 70%. The Trust continues to work with the York system rapid quality review action plan to reduce system delays. The Trust has increased the capacity of the York Care Unit and supported recruitment days in partnership with the local authority.

3.1.2 Same Day Emergency Care

The opening of the Emergency Assessment Unit and expansion of the opening hours was a Board priority action for 2022/23. The first weeks of the EAU mobilising 24/7 have seen the following improvement data:

- 71% Increase in the total number of patients referred and managed through the EAU each week (From Average of 70 pre-change to 120 currently).
- 50% increase in the proportion of patients directly streamed from the emergency department (from 20% to 30%).
- 63% reduction in the number of medical patients having a Zero LoS outside of the EAU

Across the Trust, the proportion of patients streamed to Same Day Emergency Care (SDEC) is increasing as pathways and opening hours have increased. The Trust is targeting clinical pathways to seek to reduce onward admission from SDEC.



3.2 Board Priorities: Elective Backlogs

The Trust declared 0 104 week waiters at the end of September.

The Trust was required to resubmit trajectories for patients waiting 78 weeks by the end of March and for patients waiting over 62 days on a Cancer pathway. These were submitted to NHSE region on the 11th October and reflect a variance to the Operational Plan.

3.2.1 RTT 78 week position:

The Trust will need to stop 3,857 clocks patients to deliver the RTT 78 week target of zero by the end March at the time of writing the report. The Trust is off trajectory due to a combination of factors including:

- Under delivery of plan for 1st Outpatient Appointments and associated long waits for a 1st Outpatient appointment.
- Reduced Service Level Agreement for theatres
- Delays for routine diagnostics
- Validation and administration of services for some specialities

The Trust has been requesting Mutual Aid through the Tier 2 meetings to support ENT and MaxFax specialities, but this has not been delivered to date. The ICS has secured resource for the administration of Mutual Aid, which will provide support to the Trust. The Trust has also been exploring mechanisms to support extra contractual activity due to limited take up of any 'waiting list initiative'.

On the basis of the recovery plans in place the Trust has resubmitted a non-compliant trajectory. Current plans include returning to planned levels of activity, securing extra contractual activity and outsourcing to the Independent Sector. NHSE region are committed to assisting the Trust to address the shortfall in clock stops.

		Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 78 weeks or more	Submitted as part of 22/23 plan	165	131	97	63	29	0
	Revised - October 2022	772	760	670	657	539	397

The revised trajectories remain high risk for a number of specialities, including ENT, MaxFax, Gynaecology and Orthopaedics for the RTT 78 week position.

3.2.2 Cancer pathway patients waiting over 62 days:

The Trust is off trajectory for the number of patients over 62 days on the Cancer Patient Tracking List. Due to the clinical importance of Cancer, the recent implementation of the Somerset Cancer Information System and offer of the Cancer Intensive Support Team, the Trust has committed to returning to plan by the end of March 22.

The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
	345	306	267	228	189	151

The Cancer targets remain high risk for Colorectal, Skin, Urology and Head and Neck, which are at the greatest variance from their targets.

The variance from target is related to:
- Increased demand
- Diagnostic capacity and
- Administration processes for benign diagnosis.

The Trust is likely to move to Tier 1 intervention for elective recovery as a result of the variance from plan. This will involve weekly progress meetings with the national elective recovery team and mandated Intensive Support Team involvement.

3.3 Productivity

The Trust has resubmitted the Model Hospital data following a data capture review. 78.4% of theatre time was utilised across York, Scarborough and Bridlington Hospitals in September.

The Getting It Right First Time (GIRFT) team will be visiting the Trust in the Autumn to review theatre productivity action plans and opportunities for improvement. The Trust is also engaged in the ICS Collaboration of Acute Providers Theatre Productivity Task and Finish Group.

The Trust continues to operate with a reduced Service Level Agreement (SLA) for Theatres, with -29.1% variance to the SLA due to workforce shortages.

3.4 Back to Basics

The operational management training programme is in development, to be launched in February across the Trust. A series of pre-requisite training will be held in advance including:

- Excellence in Basics (waiting list management, RTT and Cancer operational management).
- Roles and Responsibilities in waiting list management.
- Access Policy application.

The Executive has also approved the reinstating of a professional lead for Patient Administration to address the process issues identified as part of the 'discovery' work in the patient pathways programme. This post will also provide a Trust lead on outpatient recovery actions, including the move to partial booking, the use of the Clinical Assessment Service and streamline booking processes across the Trust.

4. Operational Activity Plan

Current Activity

September 2022	Planned	Actual	% Plan	% 19-20 outturn
Advice and Guidance	3637	3683	101%	167%
Outpatient 1st	17907	13703	77%	101%
Outpatient FU	28797	33806	117%	106%
Day Case	6917	6430	93%	103%
Ordinary Elective	688	560	81%	85%
Non-Elective	6305	5379	85%	98%

The specialities continue to deliver a similar profile of outpatient activity from 2019/20, rather than the increased proportion of 1st outpatients required in in the 2022/23 plan to address waiting list growth and to meet the Elective Recovery Fund expectations.

Weekly outpatient meetings are in place to review this in detail. The Outpatient Transformation Programme Responsible Owner has been requested to offer further support Care Group teams to expedite alternatives to Follow Ups, including Patient Initiated Follow Ups.

The actions required to return to plan will be further discussed at Executive Committee in October.

Date: 12th October 2022

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Building Better Care Programme Summary

Decisions at the September Executive Transformation Committee (ETC)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- The remit of the ETC is extended to include all priority transformation programmes.
- The following changes were approved at the September ETC:
  - The establishment of a Transformation Programme for urgent care (Acute Flow), with associated Programme Board to take forward the urgent and emergency care priority work for the Trust.
  - The Building Better Care Programme Board will be reformed to focus on the Elective Recovery priority, bringing together the work on elective care, outpatient transformation, cancer and Community Diagnostic Centre (CDC).
  - The communications/ branding of Building Better Care will be retained to deliver across the priority programmes.

Decisions at the September Executive Transformation Committee (ETC)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- Recurrent funding for the Programme Team was confirmed to continue to support Acute and Elective Care priorities. In addition, this would enable the re-establishment of a lead for the Patient Administration programme to support enabling working related to patient admin as part of the EPR preparation and provide professional expertise on patient administration to address the significant organisational challenges in outpatients.
  - Project Support Officer (band 4) (fixed term funding to substantive).
  - Project Manager (Band 7) (fixed term funding to substantive).
  - Programme Manager (8b) Elective (fixed term funding to substantive).
  - Programme Manager (8b) Urgent Care (fixed term funding to substantive).
- Project staff to work as part of a professional network with access to a career structure.

Transformation Programmes

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Oversight

- Enterprise Portfolio Management Office (EPMO)
- Executive Transformation Committee (ETC)

Portfolios

- Our People
- Maternity Transformation
- Quality and Safety
- Elective Recovery
- Urgent and Emergency Care
- Electronic Patient Record (EPR)

Programmes and Projects

- Culture Change
- Working Life (Fix the basics)
- Recruitment
- Workforce Planning
- Fundamentals of Care
- Journey to Excellence
- Infection Prevention
- Elective Care
- Outpatients Transformation
- Cancer
- Diagnostics (Community Diagnostic Centre (CDC))
- Diversionary and Alternative Pathways of Care
- Bed Capacity and Discharge
- Patient Administration and Contact Strategy
- EPR Process Readiness

Outline Plan

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Activity	SEP 22	OCT 22	NOV 22	DEC 22	JAN 23	FEB 23	MAR 23
Delivery of current projects in Building Better Care Programme							
Re-scoping Urgent Care (Acute Flow) Programme							
Transition Building Better Care to Acute Flow Programme							
Re-scoping Elective Recovery							
Transition Building Better Care to Elective Recovery Programme							
Reporting on priorities through the ETC							
Establish Our People and Quality and Safety Programmes							
Identification of resources across the ETC Programmes							
Transition of Building Better Care project staff to the PMO							

Programme Summary – September 2022

York and Scarborough Teaching Hospitals NHS Foundation Trust

OVERALL RAG					
SCOPE/ QUALITY	RISK	COST	RESOURCE	TIME	BENEFIT REALISATION

Reason why RAG is not Green	See reasons within Executive Summary. The RAG of the programme has improved following decisions to extend the Transformation work by transitioning the programme into separate Urgent and Emergency Care and Elective Recovery Transformation Programmes.
Executive Summary	In November the Building Better Care Programme will transition into two Transformation Programmes to support the Executive Priorities of Acute Flow and Elective Recovery. The Elective Recovery Programme will include the current Outpatient Transformation, Elective Care, Early Diagnosis & Staging and Community Diagnostic Hub Projects within Building Better Care. The Executive Transformation Committee (ETC) agreed on 21st September to approve the establishment of the Urgent and Emergency Care (UEC) Programme and have appointed Gemma Ellison as the Programme Lead. Existing input from the Executive Committee Priority Actions, 7 Day Service Standards (7DS) Baseline Assessment, 100 Day Challenge and Discharge Report have been included within the scope of the programme as well as other national and ICS level priorities. The 7DS Steering Group, Discharge Steering Group and Building Better Care Urgent and Emergency Care Project Board have been disbanded to create a single UEC Board that will report directly to the Executive Transformation Committee (ETC). Pre-habilitation reported in June that we have exhausted the backlog of patients from the complex abdominal wall service. We have had 2 referrals in September and only saw one new patient. Decision was made 18 July to expand inclusion to colorectal patients. Inclusion criteria is being drafted before linking with surgeons regarding this. No action in August or September. The Senior Operations Managers is taking the operational lead on this project. Currently insufficient data to draft a business case. ICB have requested a Community Diagnostic Centre SFBC for SGH for end of October. This deadline is not reasonable for a variety of reasons, including but not limited to the fact that Shared Agenda have still not shared any capital costings, which as of today would give 3 weeks to complete the SFBC document in its' entirety. The roles and responsibilities changed and now the trust has been informed it will need to do the majority of the work on the case, which was not the position previously. The building design / initial shell is being funded by the council (via levelling up bids) and therefore there is a reputational risk should the SGH CDC SFBC not be approved. Although retaining an amber status this month a risk has been identified within the Early Diagnosis and Staging project impacting endoscopy capacity due to the resignation of a Gastroenterologist at SGH and significant vacancy across SGH. There is also a workforce issue in Patient Access that is impacting FT appointments in the Lung pathway.

Programme Dashboard – September 22

York and Scarborough Teaching Hospitals
NHS Foundation Trust

PROGRAMME METRICS

Projects in Delivery	Red Projects	Amber Projects	Green Projects	Asks/ Escalations Raised	Asks/ Escalations Actioned
8 ↔	2 ↓	6 ↑	0 ↔	14 ↑	14 ↑

PROJECT CHANGE REQUESTS

Raised	SRO Approved	ETC Approved
14 ↑	13 ↔	13 ↔

CHANGE REQUESTS (DIS)

Raised	In Delivery	Completed	On Hold	Closed – BAU/ not delivered	Impact Assessment
24 ↔	3 ↔	7 ↔	3 ↔	2 ↔	9 ↔

URGENT AND EMERGENCY CARE

Measure	M	Y
Average time to initial assessment	↓	↓
Average time in department - admitted	↔	↑
Average time in department - non-admitted	↑	↔
Type 1 – no investigation or significant treatment	↓	↑
ED attendances over 12 hrs split by admitted/ non-admitted	↑	↑
Average time of clinically ready to proceed	↑	↑
ED attendances streamed to SDEC	↓	↑
Proportion of SDEC ward admissions transferred to downstream acute wards	↑	↔
ED attendances admitted to SDEC	↓	↓
Average time of admitted patients ready for transfer	↔	↑
SDEC ward admissions transferred to downstream acute wards	↑	↔
Ward transfers between 10pm and 6am	↓	↓
On day cancellations	↓	↔
SAFER – discharges before 5pm	↑	↔

EARLY DIAGNOSIS AND STAGING

Measure	M	Y
FDS percentage	↓	↓
Early stage diagnosis percentage	↓	↓
Staging completeness	↓	↓

Measure	M	Y
Endo – proportion achieving time to 1st scope, UGI	↑	↔
Endo – proportion achieving time to 1st scope, Colo	↓	↓
Radiology turn around time (to follow)	TBC	TBC

OUTPATIENT TRANSFORMATION

Measure	M	Y
% of 1st appointments seen non face to face	↓	↓
% of cancellations with 24 hours of an appointment	↑	↑
% of GP referrals discharged at 1st appointment	↔	↑

Measure	M	Y
% of follow up appointments seen non face to face	↑	↓
% of outpatient appointments moved to PIFU	↓	6↔h
Overdue FUPB	↑	↓

ELECTIVE CARE

Measure	M	Y
Touch time utilisation	↓	↓
On day cancellations	↓	↓
Number of P2 waiters	↑	↑

Measure	M	Y
On time starts	↑	↔
104 week waiters	↑	↓
MRSA screening	↓	↓

York and Scarborough Teaching Hospitals
NHS Foundation Trust

York & Scarborough Teaching Hospitals
CG1 - Emergency Assessment Unit (EAU) Progress 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 & Key Points

This briefing paper is intended to provide an update to delivery of the Emergency Assessment Unit (EAU) 24 hours per day.

The first weeks of the EAU mobilising 24/7 have seen the following improvement data:

- 71% Increase in the total number of patients referred and managed through the EAU each week (From Average of 70 pre-change to 120 currently).
- 50% increase in the proportion of patients directly streamed from the emergency department (from 20% to 30%).
- 63% reduction in the number of medical patients having a Zero LoS outside of the EAU
- 12% increase in the number of patients managed by EAU who subsequently require an overnight stay

Recommendation

Quality Committee are asked to:

- Note the contents of this paper
- Support the ongoing progress, development and delivery of EAU 24/7
- Note the ongoing risks to delivery and considerations

Authors: Darren Fletcher, General Manager, Donna Jack, Head of Nursing
Care Group sponsor: Jamie Todd – Associate Chief Operating Officer
Date: October 2022

1. Introduction

The York Hospital currently provides Same Day Emergency Care (SDEC) services from Ward G1. This has been relocated from the previous Same Day Emergency Care (SDEC) location of Ward 24 and has combined the Rapid Access Frailty Assessment (RAFA) and SDEC service within one footprint. This move was intended to bring the teams together in one space to jointly deliver an EAU model.

The extended EAU service began on 12 August 2022 created through the conversion of ward 29 into the York Care Unit (YCU) and subsequent release of nursing and HCA resource that was then re-deployed allowing the implementation of a 24/7 EAU service.

2. EAU progress

The development of the EAU 24/7 aligns with our ambitions and priorities within Acute and Emergency care to deliver a sustainable model which increases capacity and capability for patients to receive Same Day Emergency Care, earlier senior clinical assessment and reduce time spent within the Emergency department.

Currently the EAU operates a reduced capacity overnight, taking a maximum of 10 patients in order to support safe patient care whilst continuing to support transfers from ED overnight. The capacity for overnight transfer can increase to 15 however it was agreed through the EAU development group to cap this at 10 in the first initial mobilisation phase.

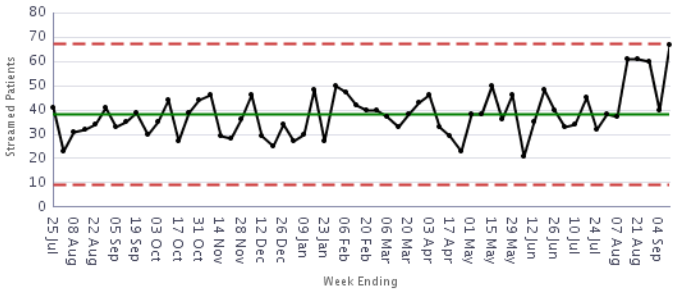
Summarising the improvement data the initial mobilisation has seen the following headline improvement:

- 71% Increase in the total number of patients referred and managed through the EAU each week (From Average of 70 pre-change to 120 currently).
- 50% increase in the proportion of patients directly streamed from the emergency department (from 20% to 30%).
- 63% reduction in the number of medical patients having a Zero LoS outside of the EAU
- 12% increase in the number of patients managed by EAU who subsequently require an overnight stay

Section 3 below gives an analysis and overview of the key metrics being measured in assessing the impact of the 24/7 EAU as part of the ongoing improvement group.

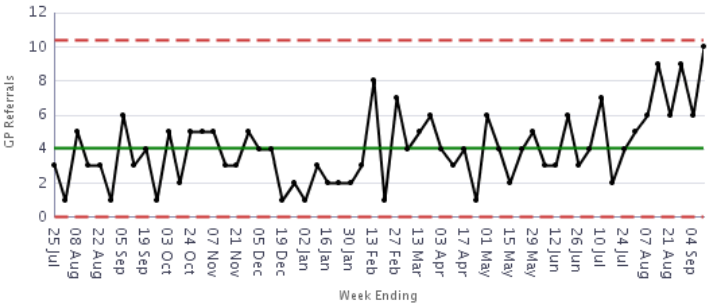
3. Performance Measures

Total number of new patients attending ED and were streamed to EAU



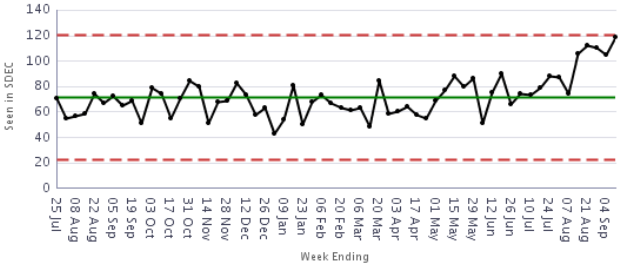
There has been a clear increase in the number of patients streamed to SDEC since August. These data are represented weekly and exclude any planned follow-up patients and include frailty patients (previously RAFA). Patients streamed directly to EAU will reduce time spent in the ED and help to improve flow.

Total number of GP Referrals attending ED who were seen in EAU



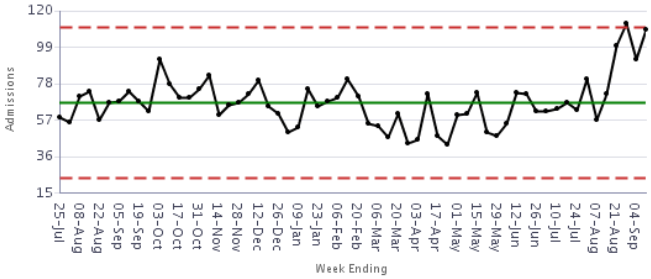
There has been a noted and sustained increase in GP referrals to EAU with 7 consecutive data points above the average. Should be noted that these patients first attended the Emergency department suggesting further work is needed with GPs to support direct admission to EAU.

The total number of patients attending ED who were seen in EAU



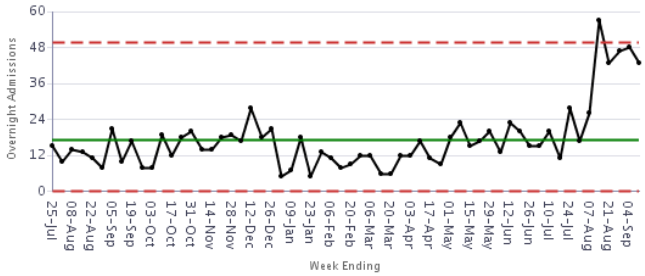
The total number of patients that attended ED and subsequently seen in SDEC has risen considerably from an average of 70 per week to 120 w/e 11th September. These data include elective cases. Non-elective presentations only are displayed below.

The total number of NEL admissions who are seen and treated in EAU



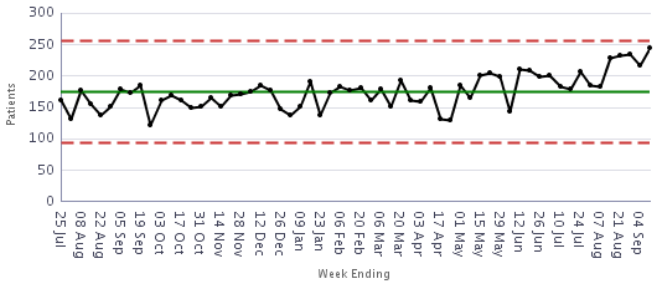
Reviewing data for non-elective admissions only also indicates a considerable increase in numbers from August 22.

Total number non-elective presentations to EAU who are admitted overnight



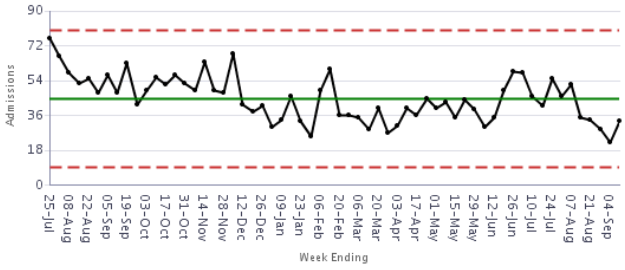
As expected, with increased numbers of acute presentations attending EAU, there will be an associated increase in the need to admit patients from the EAU to the acute bed base. This is not in any way to be viewed as a failure of the service and is indicative of an increase in more acute cases being referred.
These data are representative of patients who are admitted to EAU and have a LOS of 'overnight'. This will therefore include patients who are referred to EAU prior to midnight and discharged after midnight and is therefore not truly indicative of patients requiring admission to the acute bed base from EAU.

The total number of patients first seen on EAU



These data represent the total number of patients for whom the first ward of a spell is on EAU and includes all admission methods. A sustained increase is noted from June with 9 points above the average and a further more considerable increase is noted from August, suggesting an increase from 170 per week to 250 per week.

The total number of non-elective admissions NOT to EAU who are discharged the same day



The number of patients discharged the same day that did not attend EAU has shown a decline. This is a positive reflection on the patients and numbers being seen in EAU resulting in less 0 day LOS on the acute floor. These data exclude deaths.

4. Ongoing Challenges and Next steps

There are a number of ongoing challenges relating to the delivery of the 24/7 model for EAU. They include:

- Overnight Medical Provision
- Weekend Senior Medical Provision after 3pm
- Capacity within EAU
- Nursing workforce availability
- Prolonged unnecessary stay on the EAU - Site flow issues causing delays to transfer off EAU into a bed where required

Within EAU, medical cover continues to be challenging, particularly overnight. Medical cover for frailty patients remains 8am to 6pm weekdays and relies on Locum cover at weekends.

The ED continue to refer patients to the EAU overnight where appropriate even in the absence of an EAU dedicated doctor. With agreement from ED, these patients will have a medical review and clear plan in place prior to transfer to EAU. The unit is currently holding a maximum of 10 patients overnight with this model in place.

Both GIM and Elderly medicine consultants, plus the medical registrar, support the EAU on weekends after 3pm however this provision can be limited dependent upon other pressures on the hospital site and whilst not a barrier to utilisation of the EAU it can place more difficulty in identifying suitable patients to transfer and / or time to medical assessment.

Key next steps for the EAU development group priorities include:

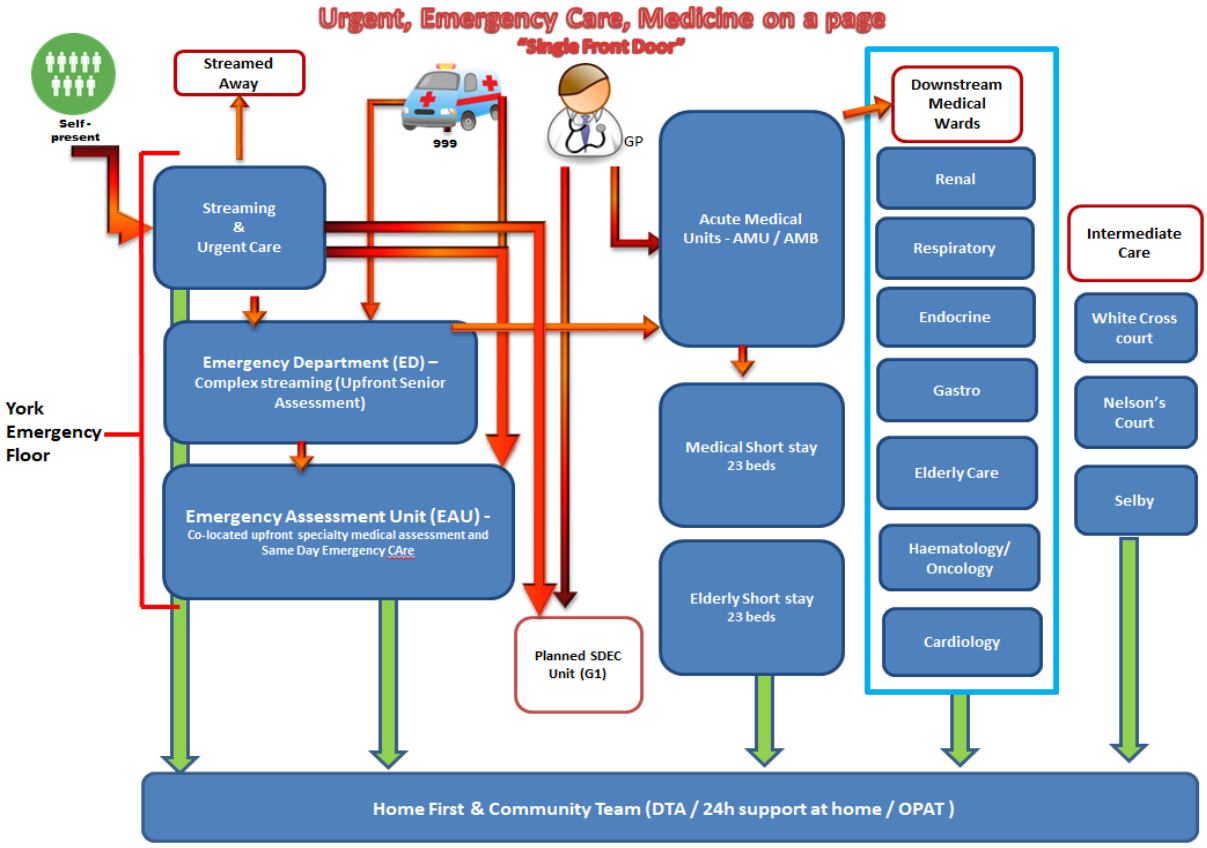
- Separation of the planned and unplanned elements of he SDEC work to free up additional acute EAU capacity
- Increase in overnight capacity from 10 to 15 patients
- Employment of EAU trust grade doctor to support senior decision making and overnight medical provision.
- An advert is due to go live for two additional Acute Physicians and ED will be supporting the consultant input to EAU with 4 PAs per week from the end of October 22.
- Plans developing for the future migration of EAU to a co-located space with the new ED build in support of the future Acute and Emergency Model of Care.

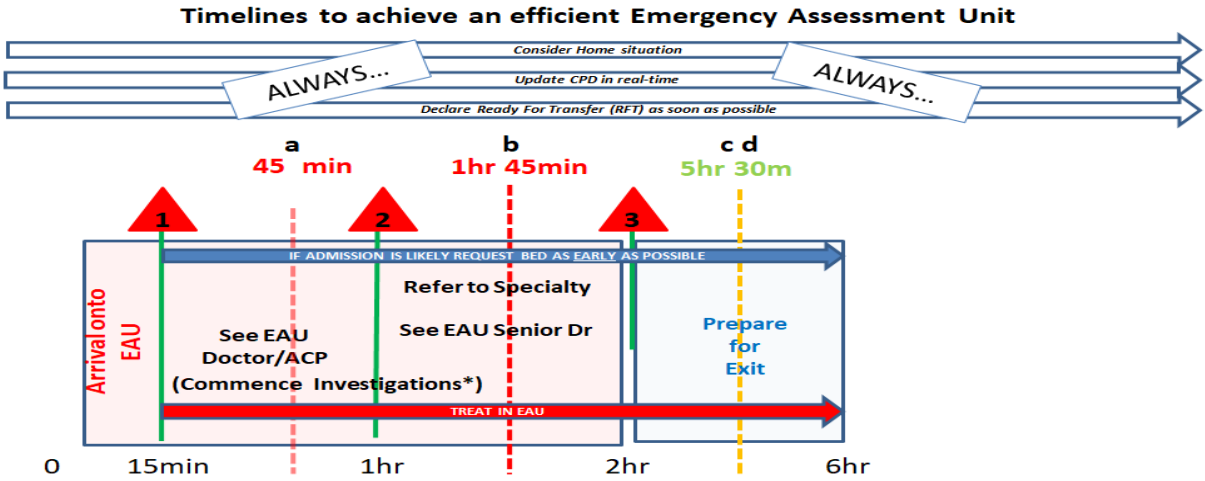
5. Recommendations

- Note the contents of this paper
- Support the ongoing progress, development and delivery of EAU 24/7
- Note the ongoing risks to delivery and considerations

Authors: Darren Fletcher, General Manager, Donna Jack, Head of Nursing
Care Group sponsor: Jamie Todd – Associate Chief Operating Officer
Date: October 2022

Appendix A – EAU Flow Diagram





1 Latest time for inputting onto CPD

2 Latest time for first seen by EAU doctor.

3 Latest time for EAU Decision.

Escalations:

a. If no doctor review , call doctor to notify of timescale
b. If decision not made for patient disposal call doctor to make aware of timescale
c. If patient not yet moved into bed base or discharged home escalate to Nurse/Dr in charge
d. If no bed available, NIC to escalate to Patient Flow manager and duty operations manager.
f. If no transport available escalate to Patient flow manager

Appendix C – EAU Criteria

The following is adopted from National Guidance, Ambulatory Emergency Care Guide: Same Day Emergency Care.

The EAU is designed to provide a rapid specialty assessment and develop the most appropriate plan of care in the most expedient way possible. However it is acknowledged that not all acute patients that present to the organisation will be clinically appropriate for the EAU and therefore the following exclusion criteria is to be applied:

1) Patient has a recorded NEWS score of 5 or more
2) Follows a specialist pathway already in operation (i.e. Stroke/NOF)
3) End of life
4) Infection control issue requiring a side-room e.g. D&V / CDiff
5) Meets the criteria for a specific Ambulatory Care Pathway

If a patient meets any of the above criteria then the patient is to be referred for admission via the normal means directly into either **AMB (Frail older patients 80 and over)** or **AMU (Younger non-frail patients).**

Patients referred by their GP to York Hospital

GPs wishing to have their patients assessed for a possible admission should contact the Trust Bed Management Team in the usual way. The Bed managers will then direct the GP to send patient to the most appropriate location in the hospital (Either specialist pathway, EAU, AMU/AMB) based on the above criteria. Where required the bed manager will transfer the call through to the appropriate medical team to avoid admission or book an appointment for assessment the following day if clinically appropriate.

GP patients attending the EAU will quickly be assessed by the nursing team upon arrival to obtain the patient key observations and determine their suitability for EAU and re-direct where required.

Patients referred by Yorkshire Ambulance Service (YAS) to York Hospital

EAU will accept direct admissions from YAS wishing to have their patients assessed for a possible via a direct line to both the Acute and Frailty service. The lead clinician will then direct YAS to send patient to the most appropriate location in the hospital (Either specialist pathway, EAU, AMU/AMB) based on the above criteria.

YAS patients attending the EAU will quickly be assessed by the nursing team upon arrival to obtain the patient key observations and determine their suitability for EAU and re-direct where required.

Appendix D – EAU Floor Plan

1 Reception

2 SDEC/ GP/ YAS admissions

3 Frailty SDEC

4 Follow-up waiting room

5 Consulting rooms

Capability:

Acute consulting rooms: 4
Follow-up consulting room: 1
Flex treatment room: 1
Trollies: 5 (Medical) & 3 (Frailty)
Chairs: 12 (Medical) & 4 (Frailty)
Follow-up waiting room: 4

York and Scarborough Teaching Hospitals
NHS Foundation Trust

RTT Long Wait & Cancer Backlog Summary Highlights for Meeting

06th October 2022

Action Log

Meeting Date	Action No.	Action / For Info	Detail of Action / Decision / Information	Lead	Status	Comments	Date Completed or Action Signed-off
17.8.22	1	Action	**FIT** Action from the last meeting but not unclear. **ACTION ~ Liz Hill and Simon Cox to discuss and agree the action for FIT outside of the meeting**	Liz Hill/ Simon Cox		*Update 22.9.22 - Confirmation given that a call was planned with Simon Cox pn 23.9.22 to pick up on FIT*	
17.8.22	2	Action	**Theatre Proctivity** To be carried forward to next meeting as ran out of time for Trust update	Michelle Waugh		*Update 22.9.22 - The trust included an update within slide deck for the meeting on 22.9.22* ***Further update to be provided at the next meeting in regards to the Trusts progress against its deliverables*** *Caroline advised communications is expected to go out shortly to Trust MD's in regards to theatre productivity, where this is flagged with in data as underperforming. Caroline offered and the Trust accepted the offer for GIRFT to undertake site visits to review productivity and processes with the Trust and to provide support where this would be valuable. It was agreed focus would be on the areas likely to have the greatest impact and that parties would work together to design a programme*	
1.9.22	3	Action	**Mutual Aid** **Urology** Liz to share with Shaun details of dialogue with NLAG regarding mutual aid for Urology. **ACTION ~ Shaun to follow up with NLAG** The Trust confirmed it had secured insourcing capacity to March 2023 **Head and Neck** Harrogate has offered mutual aid and both Trusts are now agreeing numbers of patients. **ACTION ~ Liz Hill to provide details of numbers of patients to transfer to Harrogate at the next meeting** **ACTION ~ Caroline, Shaun and Lynette to meet to discuss options outside of the ICS** •Max Fax and ENT •Offer from Jim Mackey for Upper GI •T&O High ASA patients Once all MA has been explored the Trust will remodel its trajectories. **ACTION ~ Mel Lilley/Lynette Smith** 22.9.22 - Following the Trust advising that options for working with Nuffied and Ramsey had been explored, however in reality, whilst the Nuffield has engaged in dicussions, capacity is being utilised for private patients. Caroline Wood to explore further with Nuffield nationally, recognising the National discussions with the IS on supporting the NHS.	Liz Hill/Shaun Liz Hill Caroline Wood /Liz Hill/ Shaun Jones Mel Lilley/Lynette Caroline Wood		*Update 22.9.22 - Action complete,* ***however agreement to keep action open as requires further follow-up with NLAG*** *Update 22.9.22 - Theatre days offered to York, however coincids with days when surgeons are not available - Trust advised it is still working through options. In addition, the Trust would like to explore IPT options with Harrogate and a followup meeting is planned.* ***Update to be provided at the next meeting*** *Trust highlighted again concern and support needed with Max Fax and ENT Scheduled for Monday 5th September 2022* *Item to remain open until MA options are fully explored*	
1.9.22	4	Action	**Diagnostics** – Work underway within the Trust to determine if acute demand is impacting on routine work. MRI capacity is an ongoing issue – an action was agreed to further explore what more could be done within the ICS	Anil Vara/Mikki Golodnitski/Kym Hinton		*Update 22.9.22 - update on current work ongoing with regards to utilisation of diagnostic capacity across the ICS and plan to identfy if any capacity can be released to support York.* ***ACTION ~*** *Update on the outcomes of this capacity and demand work to be brought to the next meeting.* ***ACTION ~*** *ICS to explore options to assist York with additional CT/MRI. Shaun to raise at next ICB executive meeting* ***ACTION ~*** *Kim Hinton to share Trust paper with regards to what capacity in needed and associated costs* *MA offer from NLAG for Exdoscopy was noted*	
22.9.22	5	Action	**Text validation** - Caroline advised there could be an opportunity to secure funding and York confirmed its interest.	Caroline Wood/Lynette Smith		*Lynette and Caroline to explore options*	

Update on Position

Trust Update

York and Scarborough Teaching Hospitals
NHS Foundation Trust

- **Trust Improvement Director commencing on Monday 10th October**
  - confirm and challenge on proposed trajectories prior to submission next week
  - Review of high risk specialities to improve delivery
  - Refresh of priority work within the Elective Care Programme (new approach approved 5th October following Gateway Review)

- **September 2022** – All patients were treated as planned and therefore zero 104 week breaches were declared at end September.

- **October 2022** – There are 8 patients who will reach their 104 week breach date during October, 6 of the 8 have a booked TCI in month. The final two patients had booked TCIs on the 4th & 6th of October but contacted the Trust on the 3rd & 5th of October to inform us that they had COVID. The teams are reviewing the guidance regarding the 7 week delay.

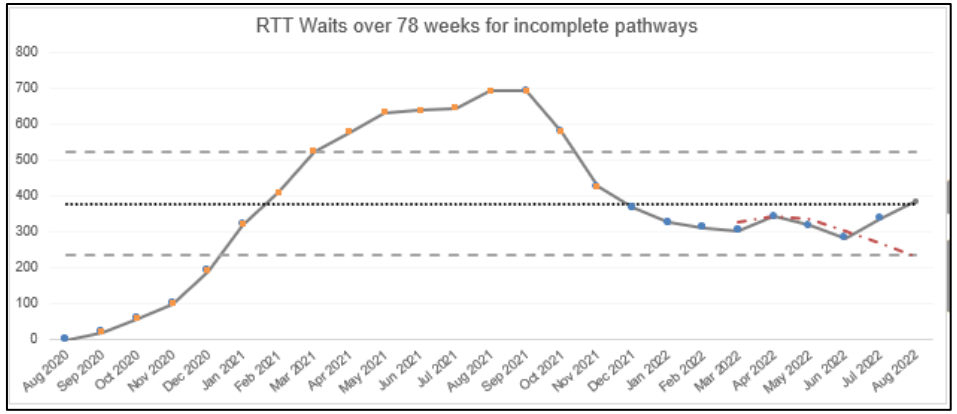
78 Week Waiters – Current position

York and Scarborough Teaching Hospitals
NHS Foundation Trust

As at 05th October 4,085 patients on our RTT TWL have a 78 week breach date before the end of March 2023, a reduction of 387 from 21st September.

The number of patients currently waiting 78+ weeks as at 05th October is 526, an decrease of 1 compared to the position of 527 on 21st September 2022. We are off track to meet monthly trajectory of 165 for end of October.

Specialty	DAY CASE	ELECTIVE (Overnight)	OUTPATIENT	Grand Total	Change from 21/09/22
Anaesthetics	1		3	4	0
Breast	2	3		5	1
Colorectal	5	2	4	11	-1
Dermatology			2	2	2
Ear, Nose And Throat	7	6	29	42	0
Gynaecology	10	18	1	29	0
Maxillofacial Surgery	27	3	189	219	15
Neurology			2	2	0
Ophthalmology	4	1		5	-1
Orthodontics			12	12	2
Plastic Surgery	1		2	3	-8
Trauma And Orthopaedic Surgery	16	26		42	-3
Upper Gi	61	20	7	88	3
Urology	25	35	1	61	-10
Vascular	1			1	1
Grand Total	**160**	**114**	**252**	**526**	1



78 Week Waiters – Current position

York and Scarborough Teaching Hospitals NHS Foundation Trust

Of the 526 patients currently waiting over 78 weeks:

- 274 are on an admitted pathway, 105 of which have a booked TCI date.
- 252 are on a non-admitted pathway, 227 of which have booked appointments.

Admitted Pathways

Specialty	TCI	No TCI	Grand Total	Change from 21/09/22
Anaesthetics	0	1	1	1
Breast	0	5	5	-1
Colorectal	4	3	7	0
Ear, Nose And Throat	11	2	13	1
Gynaecology	15	13	28	1
Maxillofacial Surgery	13	17	30	0
Ophthalmology	2	3	5	-1
Plastic Surgery	0	1	1	-2
Trauma And Orthopaedic Surgery	14	28	42	-3
Upper Gi	29	52	81	5
Urology	16	44	60	-10
Vascular	1	0	1	1
Grand Total	**105**	**169**	**274**	-8

Non-Admitted Pathways

Specialty	Booked OP appt	No booked OP appt	Grand Total	Change from 21/09/22
Anaesthetics	3	0	3	-1
Colorectal	3	1	4	-1
Dermatology	2	0	2	2
Ear, Nose And Throat	21	8	29	-1
Gynaecology	1	0	1	-1
Maxillofacial Surgery	180	9	189	15
Neurology	0	2	2	0
Orthodontics	11	1	12	2
Plastic Surgery	1	1	2	-6
Upper Gi	5	2	7	-2
Urology	0	1	1	0
Grand Total	**227**	**25**	**252**	7

A further 145 patients will tip over to waiting 78+ weeks in the next two weeks, broken down as below:

- 60 are on an admitted pathway, 18 of which have a booked TCI date.
- 85 are on a non-admitted pathway, 70 of which have booked appointments

Risks to Delivery	Actions	Update
Head and Neck Outpatients: capacity and validation.	• Investment in x4 WTE administrators to increase booking and validation capacity in Head and Neck services. Targeted training for the new team on booking, administrative processes and PTL management. • Clinical time out to review follow up pathways. • Protected lists in Theatre SLA review to expedite surgery for long waits in non-admitted pathway. • Delivering 2 – 4 WLI clinics per week currently (approximately). Aiming to increase but lack of take up due to concerns about pension/tax • Exploring support for MaxFax from plastics (internal) • ACOO meeting with Harrogate on 18.8.22 to discuss mutual aid for outpatients and/or day cases	• Additional 3 administrators in place, fourth due to start w/c 10th October • Ongoing discussion/ arrangements on additional payments for consultants to support extra contractual activity – information provided following the national visit under review • Internal support from plastics will commence in November 2022 • Requested support for 56 paediatric grommets, 348 BCC - 67 over 60 weeks. • Mutual aid with Harrogate. No patients transferred yet but further meeting planned for 13/10/22. • Capacity further reduced by sickness absence in ENT, locum cover being sought
Anaesthetic capacity affecting ability to run full SLA.	• SLA review across all specialities. • Exploring options for insourced anaesthetics in addition to the current insourcing arrangements (extension to one insourcing list per day at York until end of March 23, one additional anaesthetist started 15th August, second to start 5th Sept). • Extension of insourcing to end of year – dependent on resources. • Focus on list utilisation and LA provision to offset reduction in GA lists.	• Insourcing contract extended to end March 23 and additional anaesthetic support to support theatre SLA. • Theatre SLA and timetable agreed and implemented • Shortfalls in theatre staffing (ODP) affecting full utilisation
Diagnostic capacity for routine work.	• Capacity and demand analysis capacity identified – focus on increased acute demand and inpatient requests for diagnostics. • ICS considerations of the allocation of additional capacity - pending further analysis from NLaG and Hull. • Ongoing recruitment and retention efforts including consideration of recruitment and retention bonus as have currently have 40wte vacancies for radiographers / radiographer support staff.	• Identification of funding for IS staffed mobile capacity for CT (545 days) and MRI (120 days). • Lead identified for the acute diagnostics impact. • Support to explore IS capacity and Nuffield and Ramsay. • Exploring mutual aid from neighbouring Trust. • Ongoing recruitment actions. • Support to undertake demand management with primary care for NOUS demand inline with national guidance.

Risks to Delivery	Actions	Update
Urology	• Limit cancellations of urology lists (will be managed through SLA review) • Work ongoing to improve utilisation of urology lists – looking to run perfect week in October • Establish stone surgery at Scarborough (affected by radiographer availability) – first list to run in September • Looking to run weekend theatres WLI (subject to staff volunteering)	• Mutual aid - no patients transferred to NLAG yet. • Insourcing capacity approved to March 23 • Hull agreed to take 16 paediatric urology patients, should be offered TCI dates in November and December 2022.
Upper GI/Colorectal	• Limit cancellations of GI lists (will be managed through SLA review) • Additional clinics to reduce non-admitted wait • Weekend waiting list initiatives for clinics and theatres (dependent on staff availability)	• Mutual aid - no patients transferred to NLAG yet, offer of support from Northumbria • Insourcing capacity approved to March 23
Orthopaedics	• Elective hub commenced to protect day case and ordinary electives. Currently not delivering the full SLA due to ongoing anaesthetic capacity issues. • High ASA cases are being managed on York Hospital site for all cases across the Trust using side rooms as no ring-fenced elective beds due to acute capacity/demand. Anaesthetic capacity issues will potentially impact ability to offer this service.	• Plan approved to support three side rooms to manage the long wait high ASAs. • Ramsay hub looking to recruit dedicated team • Partner organisation plans to recruit own Anaesthetic cover 3 month lead in time. • Micro-managing on a case by case basis using Trauma lists where possible. • Cancellations of long waits this week due to operational pressures
Gynaecology	• Use PAs released due to reduction in theatre SLA to backfill with outpatient/CAS recovery clinics. This would provide roughly 3 clinics per week with 8-10 patients per clinic. These would be utilised to triage the long wait outpatient appointments as well as see any F2F patients. • Continue with the micromanagement of theatre lists to ensure patients booked in waiting list order and have the correct pre-operative input.	• Committed to retain locum consultant to support work through OP backlog. • Review job plans on an individual level to ascertain if there are any temporary changes that can be made to accommodate recovery work (i.e. elective section lists moved to registrar run). • Implementation of PIFU/REI to support with reduction in follow up appointments and decommissioning of CAS longer term. • Ongoing discussion/ arrangements on additional payments for consultants to support extra contractual activity – information provided following the national visit under review

Theatre Utilisation Improvement

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Objectives for Theatre Utilisation Improvement Programme:

- Achieve 85% touch time utilisation for all theatre lists – **79.7% achieved in August 2022**
- Reduce cancellations on the day of surgery to less than 5% - **7.4% achieved in August 2022**
- Achieve the BADS target for the 25 highest volume day case procedures – **information to be provided on 20/10/22**

Action Plan:

Action	Owner	Timescale
Re-establish fortnightly production meeting for each specialty	TACC General Manager	Completed
Refresh theatres dashboard to ensure that the internal reporting is consistent with model hospital	Lead Dashboard Developer	End of September 2022. Now delayed until mid-October 22
Monthly clinical review of patients cancelled on the day of surgery	TACC GM & Lead Anaesthetist for Pre-assessment	October 2022
Review of booking processes to ensure 48 – 72 hour phone call to patients prior to admission for surgery	Waiting List Team Manager	October 2022
Establish 'perfect week' for urology theatres to test improvement work	ACOO CG3	November 2022
Consistently ensure the York Day Unit is open until 10pm	Associate Chief Nurse CG3	November 2022
Introduce text message reminders for elective and day case patients	ACOO CG3	January 2023

Cancer Position

Cancer PTL

Somerset Cancer Registry is now live for tracking patients from Day 0. This has increased the overall size of our PTL but has enabled full visibility of referrals. We are off trajectory for the end of September 2022; latest declared position as at w/e 02nd October is 335 which equates to 13.1% past day 62, against trajectory of 153 for end October.

Cancer Site	0-62 Days	63-104 Days	105+ Days	Total waiters on PTL this week	% of waiters past day 62
Breast	177	0	2	179	1.1%
Colorectal	779	102	12	893	12.8%
Gynaecology	147	7	1	155	5.2%
Haematology	13	1	2	16	18.8%
Head and Neck	261	37	10	308	15.3%
Lung	56	6	2	64	12.5%
Other	14	0	0	14	0.0%
RDC	20	0	0	20	0.0%
Skin	357	77	6	440	18.9%
Upper GI	146	28	7	181	19.3%
Urology	257	29	6	292	12.0%
Grand Total	**2227**	**287**	**48**	**2562**	**13.1%**

Trends over the past 4 weeks are shown below, almost 60% of our long waiters are either Colorectal or Skin so these two specialties are detailed in the table.

Week ending	Long waiters and total PTL size	Share past Day 62	Colorectal past Day 62	Skin past Day 62
11th Sept	283 of 2,307	12.3%	104	63
18th Sept	301 of 2,493	12.1%	93	72
25th Sept	335 of 2,493	13.4%	111	90
2nd Oct	335 of 2,562	13.1%	114	83

Cancer 62 waits – Cancer site Concerns

York and Scarborough Teaching Hospitals

Cancer Site	Current Issues	Update
Colorectal	• Increased demand: 30% rise on 2019 position. • Extended waits for endoscopy. • Inability to implement FIT +ve pathway as referral pathway with primary care not agreed. • Reduction in theatre capacity as a result of workforce challenges. • Significant wait for oncology services delaying first treatment.	• Escalation of ongoing discussions with cancer alliance and primary care regarding FIT +ve pathway. • Escalation of imaging demand and capacity issues with ICB and regional team. • Opening of endoscopy room 6 in October 2022 to increase core capacity (workforce dependent). • Implementation of 28D PTL management and benign diagnosis communication in Pathway Navigator role • Escalation of oncology capacity to cancer alliance and mutual aid discussions being arranged for October 2022
Gynaecological	• Increased demand: 42% rise on 2019 position. • Capacity shortfall for outpatient appointment and increased number of ASIs. • Reduction in theatre capacity as a result of workforce challenges. • Extended waits for CT & MRI. • Significant wait for oncology services delaying first treatment. • Delays in histology turnaround times due to workforce challenges.	• Escalation of imaging demand and capacity issues with ICB and regional team. • Escalation of oncology capacity to cancer alliance and mutual aid discussions. • Ongoing prioritisation of theatre capacity for cancer and long wait patients. • Pathway Navigator undertaking 28D PTL management and communication of benign diagnosis.
Skin	• Capacity shortfall for outpatient appointments and increased number of ASIs. • Shortfalls in consultant workforce. • Delays in histology turnaround times due to workforce challenges.	• Super Saturday clinics commencing in September. • Skin cancer lead nurse and PA increased capacity • Pioneer insourcing being explored to support Saturday and Sunday sessions. • Recruiting a Pathway Navigator and recruitment drive for Consultants. • DOS reviewed and updated. Letter sent to list conditions that will no longer be accepted that can be managed by GPs or in a community service. • Pushing to go live with partial booking so we can carve out FT capacity
Urological	• Increased demand; May 2022 saw 223 FT referrals received (24% rise on May 2019). • Extended waits for CT & MRI. • Significant wait for oncology services delaying first treatment.	• Pathway analyser completed, resulted in need to increase Post MDT clinic provision which has been highlighted as a significant contributor to performance on 28 day and 62 day targets. This should be in place from end of Sept/early Oct. • Escalation of imaging demand and capacity issues with ICB and regional team. • Escalation of oncology capacity to cancer alliance and mutual aid discussions. • Ongoing prioritisation of theatre capacity for cancer and long wait patients. • Implementation of 28D PTL management and benign diagnosis communication in Pathway Navigator role

Risks to Delivery	Identified mitigations	Next steps/ Support
Diagnostic turnaround times	• Capacity and demand analysis capacity identified – focus on increased acute demand and inpatient requests for diagnostics • ICS considerations of the allocation of additional capacity - pending further analysis from NLAG and Hull • Ongoing recruitment and retention efforts including consideration of recruitment and retention bonus as have currently have 40wte vacancies for radiographers / radiographer support staff.	• Identification of funding for IS staffed mobile capacity for CT (545 days) and MRI (120 days) and endoscopy insourcing of staff. • Support to explore IS capacity and Nuffield and Ramsay for imaging. • Exploring mutual aid from neighbouring Trust. • Ongoing recruitment actions. • Support to undertake waiting list management review of long waiters and acute demand for imaging. • Support to undertake demand management with primary care for NOUS demand in line with national guidance.
Administration - letters and identification of fast track diagnosis	• Implementation of Cancer Information System – Somerset (enable clinicians to review progress against timed pathways and identify fast track patients from their work list)	• SCR now live for tracking patients from Day 0. This has increased the overall size of our PTL but has enabled full visibility of referrals. It has been identified that Hull track from first appointment (with NLAG tracking from day 0) and this is to be discussed at the Cancer Alliance Network meeting to agree on tracking methodology so all Trusts in the ICS are aligned. • Work on CPD to be completed by January 2023 to enable clinicians to identify patients on a FT pathway through their NOTIFY in order for them to be able to better prioritise FT patients. • CGs asked to implement standard letters for benign diagnosis (only used in Skin at present) and to use Pathway Navigators to communicate benign diagnosis
Oncology Provision	• Exploration of locum capacity • Promoting overseas recruitment, exploring opportunities through the East Coast Recruitment Team • Offering to support training opportunities- .i.e. CESAR • Review and development of alternative roles - .i.e. Physician Associate/Advanced Clinical Practitioners • Upskilling nursing team and providing more nurse led clinics – Oral SACT service being developed, Metastatic Cancer Nursing Service being developed	• Support to undertake an alliance wide review of oncology workforce models • Ongoing support from alliance of funding alternative roles • In the short-term exploring mutual aid support from neighbouring Trusts and reinvigorating the ICB workforce strategy. Reviewing strategies taken in neighbouring ICB's .i.e. WY ICB's networked model
Workforce	• Dermatology vacancies have increased. Potential to impact ability to manage skin cancer referrals. • Concerns that other Trusts surrounding the geographical location are stopping routine referrals – we may see more referrals into an already very stretched service.	• Recruitment campaign underway. • Prioritising FT and NPU. • Review of DOS completed to increase the number of services that are excluded in line with other Trusts policies. Shared with ICS awaiting further PCN conversations to push forward.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Emergency Planning Resilience and Response (EPRR) – Annual Self Assessment
Director Sponsor:	Chief Operating Officer – Melanie Liley
Author:	Emergency Planning Manager – Richard Chadwick

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 Emergency Preparedness, Resilience and Response Core Standards Annual Self-Assessment has been completed. The Trust is declaring a "partially" compliant rating as it does not meet fully 10 out of the 64 applicable standards. The reduction in the overall compliance rating is as a result of the Trust's continued focus on the response to COVID-19 that has inhibited staff's availability to plan and participate in Emergency Planning and Business Continuity activity. This reduction in compliance rating is a common occurrence amongst Acute Trusts regionally and nationally.

The 10 partial or non-compliant standards are in the following areas:

- **Duty to Maintain Plans.** Further work is required to develop and implement Trust plans for countermeasures, evacuation and mass casualty incidents.
- **Training and Exercising.** There is a requirement to re-start the Trust Training Programme to test and exercise the Trust Emergency and Business Continuity plans.
- **Warning and Informing.** There is a requirement to complete the integration of the Communications team into the Trust and ICB command and control structure.

Recommendation:

The Committee is requested to:

- To approve the report and assurance rating of “partial” compliance with the NHS England EPRR Core Standards.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting)

No ☒ Yes ☐

EPRR CORE STANDARDS – ANNUAL SELF ASSESSMENT

1. Introduction and Background

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

On an annual basis, The NHS England Core Standards for EPRR set out the minimum standards that NHS organisations and providers of NHS funded care must meet. The Trust is required to undertake an annual self-assessment against these standards and provide assurance to NHS England that robust and resilient EPRR arrangements are in place and maintained within the Trust. In 2016/17 and in 2017/18 the Trust reported that it was "partially" compliant with these standards – meaning it only fully met 77-88% of the core standards. In 2018/19, 2019/20 and 2021/22 the grading improved to "substantially" compliant – meaning that it complied 89% to 99% of standards.

Following this year's self-assessment process, the Trust is declaring a "partially" compliant rating as it does not meet fully 10 out of the 64 applicable standards. The reduction in the overall compliance rating is as a result of the Trust's continued focus on the response to COVID-19 that has inhibited staff's availability to plan and participate in Emergency Planning and Business Continuity activity. This reduction in compliance rating is a common occurrence amongst Acute Trusts regionally and nationally.

The Committee is requested to note this compliance rating. The action plan is at Appendix 2 to this report and sets out the key actions required to regain the Trust's compliance with these standards and when they will be addressed over the next 12 months.

2. Significant EPRR Issues of Note in the Last 12 Months

2.1 Integrated Care Board

In July the Integrated Care Board (ICB) was established and the Civil Contingencies Act 2004 was amended to add the ICB as a Category 1 responder. This altered the command and control, passage of information and reporting pathways resulting in amendments to the Trust Incident Response Plan. Future EPRR work will now be more closely coordinated with ICB Acute Provider colleagues and will benefit from support and guidance from the ICB and the Local Healthcare Resilience Partnership.

2.2 EPRR Portfolio

The scale and scope of the EPRR portfolio has increased significantly over the last 24 months as follows:

- An aging estate, staff shortages and climate change are resulting in an increasing frequency of business continuity incidents. In this period alone there have been incidents such as: clinical equipment shortages, avian flu outbreaks, IT outages, power outages, periods of heatwave, flooding and the discovery of an unexploded shell at a hospital site.
- An increasing number of incidences are occurring where SILVER Command has had to be stood up to coordinate pan Trust responses to an incident. This requires the Emergency Planning Manager to coordinate.

- The cost of living crisis will increase the risk of power outages and industrial unrest over the next 6 months adding to the numbers of likely incidents.
- National and regional data collection requirements that were imposed through COVID-19 and winter escalation are enduring. This is leading to a continual requirement for an EPRR member of staff to be present in the Trust to submit daily reports and returns.
- Resilience planning for the winter period is increasing in scope and complexity requiring planning to commence earlier in the year and to collaborate with the ICB.

Consideration is being given to strengthen the EPRR portfolio to continue to respond to this increase in activity and the continuing need to respond to COVID-19 and winter operational pressures.

2.3 The Impact of COVID-19 Response on Delivery of EPRR Core Standards

Last year's EPRR Core Standards Self-Assessment report to the Board of Directors highlighted the focus on COVID-19 and operational pressures prevented staff from being released to participate in emergency planning and business continuity activity. This was acknowledged at a national level and resulted in the removal of the Training Domain within the self-assessment; this enabled the Trust to report a Substantial Compliance grading.

This year the Training Domain has been reintroduced; however, the ability of the Trust to conduct collective training and exercising beyond only the most essential topics remains constrained by staff availability to be released from frontline duties. This has resulted in a reduction in the overall Trust compliance grading.

2.4 Individual Training

Essential individual training has been conducted this year. The Chemical, Biological, Radiological and Nuclear response capability has been reinforced on both sites with the training of additional Powered Respirator Protective Suit operators and non-clinical staff in the erection of the collective decontamination tent. Trust On Call Manager induction training continues for those new to the rota and all 1st and 2nd On Call Managers are now participating in the Principles of Public Health Command Programme at both a tactical and strategic level.

2.5 Adverse Weather Plan

The Trust endured a significant heatwave in the summer with unprecedented temperatures recorded on the wards on both sites. The levels of heat resulted in mobile AC units being deployed into clinical areas where risk assessment allowed; this was the first time this measure has been required in the Trust. A comprehensive lesson learnt report was submitted to the Executive Committee with the main recommendations to explore the introduction of automated temperature recording and to establish formal risk assessment processes for the deployment of mobile AC units. The Trust Sustainability WG and the Ventilation Steering Group continue to lead on the more formal mitigation of adverse heat on wards through capital works programmes.

3. Governance and Leadership Arrangements for EPRR

The work reported last year to establish Governance and Leadership Arrangements for EPRR is close to completion. The Emergency Planning Steering Group has successfully established the Infectious Disease, CBRN and Business Continuity Working Groups and they have met regularly throughout the year. The Major Incident Working Group is yet to

meet, and it is expected that a volunteer Senior Clinician in the Trust will be appointed as the chair in the very near future.

4. Plans for EPRR 2022/23

4.1 Re-establish EPRR Collective Training in the Trust

Opportunities to conduct individual and collective training in emergency planning and business continuity have not been available over the last 18 months due to the pandemic response. Skill fade will be present in most teams, there will be new starters within the Trust and most plans have been adapted from the COVID-19 response lessons learnt. The priority for 2023 is to re-start the cycle of progressive individual and collective training after the winter operational pressures have abated.

The conduct of a LIVEX in 2024 is currently being explored. Discussions with Regional EPRR and the ICB continue to identify the scope of a LIVEX to practice the partial and full evacuation of a hospital site. The scope is likely to include practical activity at an operational level in addition to tactical and strategic table topping of the regional response. Significant preparatory work will need to be carried out next year to deliver the exercise in 2024.

4.2 Plans and Policies for Development

All Trust EPRR plans and policies have been updated other than 2 which still require development, consultation, implementation, dissemination and training as a matter of priority. They are:

- **Mass Casualty Response.** The Trust is mandated to have plans, on the declaration of a Mass Casualty Major Incident, to make available 10% of the adult acute and general beds within 6 hours increasing to 20% after 12 hours and to double Level 3 ITU capacity for 96 hours. In addition, a response of this nature will require the immediate creation of space in ED to receive casualties. Significant work has been completed to identify the Scarborough Hospital response and this was validated with a tabletop exercise in preparation for the Armed Forces Day celebrations. Further work is required in 2023 to identify the York Hospital response and explore how Trust wide capabilities such as Theatres and Critical Care are integrated into site plans. The Major Incident WG will complete this work started by the Emergency Planning Manager by October 2023.

- **Evacuation Plan.** The Trust currently has a draft Evacuation Plan that has been developed from the identification of best practice across the NHS. Collaboration with Regional EPRR is ongoing to develop a Patient Evacuation Dispersal Matrix across the North East and Yorkshire. Consultation is now required with Regional EPRR, the ICB, Yorkshire Ambulance Service and Local Authorities to identify resources that could be made available in the event of a requirement to evacuate a site. It is planned that this consultation will conclude prior to the LIVEX 2024 event as described in paragraph 4.1 to allow validation of the Trust concept.

4.3 Communications Integration into Trust Command and Control Structure

The Communications Team have been integrated into the Trust Command and Control structure since it was established. The establishment of the ICB now necessitates a review to understand how the ICB Communications Team link to the Trust Communications Team. This is key to solving the identified issue of how a small team provide an enduring capability

to any incident response 24/7 for a number of days. It is expected that this work, led by the Director of Communications, will be completed in early 2023.

4.4 Mass Vaccination Countermeasures

The revision of the EPRR Core Standards has recently introduced the requirement for the Trust to have arrangements in place to support an incident requiring countermeasures or a mass countermeasures deployment. The Trust does have in place plans to provide countermeasures to staff as demonstrated by the vaccination programmes for COVID-19 and Flu, however it does not have a plan in place to deliver mass countermeasures to the public. Prior to the pandemic this work was being coordinated by North Yorkshire Council and now needs to be restarted to integrate Acute Trusts into a regional plan. The ICB have indicated that they will raise the requirement with North Yorkshire Council and the Trust will be engaged in this planning.

4.5 Individual Portfolios for Responder Training

Recent enquiries into the Grenfell fire and the Manchester Arena bombing identified the requirement for On Call managers to be trained to a standard as laid out in the recently issued Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR). This training has been recently completed for Trust Executives undertaking a 2nd On Call duty and is in progress for Operational Managers who act as 1st On Calls.

The document also set out the requirement for the achievement and recording of competence and training by healthcare managers with portfolios of evidence that would be auditable following participation in any incident. Work will be completed by the Emergency Planning Manager, when Regional EPRR have determined the scope and layout of the portfolios, to develop a process for portfolio completion. This will be included in the Trust IRP at Annex A – Command and Control.

5. Conclusion

Routine EPRR work continues to be subjected to disruption, in the same manner as other specialities, as the Trust responds to COVID-19 and increased operational pressure over the winter. The “Living with COVID” initiative is providing the space for routine work to be restarted and any future strengthening of the EPRR portfolio in 2023 will provide the resources to complete all outstanding actions identified in this self-assessment.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.
2. EPRR Core Standards Assurance – Action Plan 2022-2023.

Date: 01 November 2022

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

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

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

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

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

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

Signed by the organisation's Accountable Emergency Officer

01/11/2022

Date signed

02/11/2022	02/11/2022	01/06/2023
Date of Board/governing body meeting	Date presented at Public Board	Date to be published in organisations Annual Report

Appendix 2 EPRR Core Standards Assurance – Action Plan 2022/23

Ref	Domain	Standard	Detail	Self assessment RAG	Action to be taken	Lead	By When
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	**Non-Compliant**	The EPM is to liaise with the EPRR lead for the ICB and determine when the NYCC work will recommence. If the restart is not imminent then EPM to seek guidance from Regional EPRR.	EPM	Dec 22
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	**Partially Compliant**	Draft of Mass Casualty Plan to be completed incorporating YTH and Trust wide plans prior to tabletop validation and EPSG endorsement.	MI WG	Oct 23
16	**Duty to maintain plans**	**Evacuation and Shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	**Partially Compliant**	EPM to engage stakeholders to validate the plan and to arrange testing and validation.	EPM	Oct 23
22	**Training and Exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	**Partially Compliant**	Trust training plan to be written and distributed. Exercising of EPRR plans to recommence.	EPM	Aug 23

23	**Training and Exercising**	**EPRR Exercising and Testing Programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	**Partially Compliant**	Exercising and testing programme to be recommenced in accordance with the Trust training plan.	EPM	Aug 23
24	**Training and Exercising**	**Responder Training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	**Non-Compliant**	EPM awaits Regional EPRR direction on format of personal development portfolio and then to write the process into policy (Annex A – Command and Control to the Trust IRP).	EPM	Mar 23
34	**Warning and Informing**	**Incident Communications Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	**Partially Compliant**	Review and refresh of the plan and action cards in light of system changes.	Dir of Comms	Jul 23
35	**Warning and Informing**	**Communications with Partners and Stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	**Partially Compliant**	Review the plan to ensure operational communications can be supported and that lines of communication are clear and up to date.	Dir of Comms	Mar 23
36	**Warning and Informing**	**Media Strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media.	**Partially Compliant**	To refresh the list of appropriate spokespeople and to provide media training for those new in role.	Dir of Comms	Mar 23

48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	**Non-Compliant**	BRONZE Command BC Leads are to recommence BC training with their departments as per the Trust Training Plan	BC Leads	Jan 23

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Corporate Communications and Engagement Strategy
Director Sponsor:	Lucy Brown, Director of Communications
Author:	Lucy Brown, Director of Communications

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 strategy sets out how the trust's communications and engagement activities will be planned and delivered over the next two years to align with the trust's priorities and how resources will be prioritised to best inform, involve and inspire our audiences.

It outlines how we will build on current strengths and good practice and how we will demonstrate effectiveness, as well as identifying areas for growth, development and innovation in the support that is offered.

The strategy covers York and Scarborough Teaching Hospitals NHS Foundation Trust group, including its estates and facilities partner YTHFM.

Recommendation:

The Board is asked to approve the strategy.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Executive Committee	**19 October 2022**	**Approved**

Communications and engagement strategy October 2022 - October 2024

1. Context:

The organisation is facing a number of challenges which influence our communications priorities and directly impact how we deliver them.

Since early 2020 virtually all communications activity has been focused on managing the pandemic. Now that we are 'living with covid'. We are adjusting to what business as usual looks like for communications whilst continuing to manage covid-related issues.

The trust is facing difficulties in a number of areas: staff recruitment, retention and engagement, performance against key access targets and quality standards, ageing estate and infrastructure, and a squeezed funding position in response to covid recovery. National and local media interest in the NHS is significant, and the wider political and economic landscape also impacts on our trust.

Externally, we have ongoing challenges with levels of trust in certain parts of our community, and our current position with backlogs, performance and quality will be contributing to this.

There have been significant changes in how health and social care is structured with the creation of Integrated Care Systems, and what this means for communications and engagement is still being developed.

Inevitably all of this is having a profound effect on our people. We know, not just anecdotally but through CQC feedback, staff survey results, and our largescale staff engagement work Our Voice, Our Future, that morale is low, engagement is poor, and how we communicate needs to improve.

In reality we are communicating more than ever with our staff, yet we regularly hear that they do not feel informed about what's happening. We know that high levels of staff engagement lead to improved outcome for patients, so it is important we address this and understand what we need to do to make this better.

We need to respond to the fact that working practices have also changed. With the growth of hybrid working, on top of a very complex set of working practices for our workforce with hugely varied roles and working patterns, and our large geographical footprint. Face to face communication is often the preferred way to receive information, but this is clearly challenging in an organisation like ours. The shift in some groups to communicate through greater use of digital technology following the pandemic is an opportunity we need to build on, but at the same time ensure no one is left behind.

We need to refresh our communications strategy to respond to the trust's priorities in order to engage our communities and staff in delivering our strategy of Building Better Care Together.

2. Trust priorities:

The trust has identified four priority areas in order to deliver a step change in performance.

They are:

- Our People
- Quality and Safety
- Acute Flow

- Elective Recovery

Our communications strategy reflects these priorities, with the key objectives and actions designed to support their delivery.

This strategy complements and supports a number of wider trust strategies and plans:

- Workforce and Organisational Development strategy
- Building Better Care
- Membership strategy
- Quality Strategy (in particular patient and public involvement)
- Quality Improvement strategy

3. Communications principles:

All of our communications are based on core principles which are rooted in the organisation's values and behaviours.

Kindness:

- We seek to recognise colleagues who live our values and tell their stories.
- We use our expertise and experience to provide support to colleagues who need it, and are fair and objective in doing so, recognising different views.
- Staff should be first to find out about changes that affect them.

Openness:

- We keep staff informed with honest, timely and relevant information.
- We are open to feedback.
- We create and promote opportunities for leadership visibility.
- We use multiple channels (different people have different needs which may vary over time) and aim to meet accessible information standards and accessibility best practice.
- We use inclusive language and imagery, supporting and promoting diversity.
- We use clear, simple language and avoid jargon.

Excellence:

- We celebrate success at every level.
- Our communications activity is evidence-based and follows best practice, learning from other organisations in and out of the NHS and using feedback to develop.
- We are ambitious and innovative in our approach, always seeking to learn from the best.
- We look for opportunities where we can stand out from the crowd as an employer, both internally (for retention) and externally (for recruitment).

4. Scope: The role of the communications team

'Communication' in its broadest sense underpins everything we do, and is often cited as a key factor in the success or failure of a project. It is positive that there has been a shift over time towards recognition of the importance of communications as an essential corporate business function alongside other such as finance, HR, digital and governance, but in order to manage this effectively we need to be clear on what is in the remit of the communications team, and what we would expect of leaders and managers and their operational teams. It is everyone's business, and we need to be clear on expectations, roles, and responsibilities in order to best support this.

The communications team will support making sure there is this clarity, and equip staff with the principles, content and the skills they need.

5. Strategic communications approach:

Our communications approach will have the following aims:

Our people at the heart of our communications:
Communications should be story-led, people-centred, with a human voice. It should reflect our values and behaviours, describing not just what people are doing but how they are doing it.

Supporting an engaged and informed workforce:
Working with staff to move from being passive receivers of information to active participants/contributors to the organisation. We must empower managers to support communication, and to help us understand what is and isn't working and where we need to focus efforts. We need to move away from the broadcast/command and control style of communications used during covid into a two-way approach that encourages engagement and helps teams to reconnect with each other and the organisation.

Right message, right channel, right time, right audience:
Ensure all staff have the information they need, when they need it, and that communications activity is planned, strategic and evidence-led. We will look to package activity into themes and take a planned approach to creating clear, simple campaigns, working in partnership with care groups, corporate directorates and project teams.

Be proactive and shape the narrative:
We must be brave in our communications style and be bold in celebrating success but honest about our challenges. We must aim to be ahead of the story instead of behind it playing catch up.

Show, don't tell:
Continuous sharing - internally and externally - of case studies, examples, evidence of improvement, the work in practice and what's been achieved. Word of mouth, through trusted influencers and experts, works best and lets the work speak for itself.

Champion our brand:
We will support the development, promotion and protection of our brand, and actively seek to reinforce it and enhance our reputation both as an employer and as a provider of care to our communities.

Be a trusted voice in the community:
Through strong partnership working and stakeholder engagement, working with patients and public, members and governors, and being a trusted voice in the media. We will align with the Integrated Care Board communications strategy and tell a clear and compelling story for our regulators.

Be innovative and learn from the best:
We will take opportunities to learn from others and continue to develop our communications approach to keep up with best practice.

Inclusive communication:
Ensuring different voices from a variety of backgrounds are heard, and that visual images are diverse and representative of all colleagues and the communities we serve. Communication methods including digital will take into consideration a variety of accessibility needs and formats so as not to exclude or isolate.

6. Communications and engagement objectives:

Internal communications, staff engagement and retention:

- Work with Workforce and Organisational Development team to establish Our Voice, Our Future as our staff engagement brand.
- Develop effective mechanisms to facilitate staff in having a voice in shaping the organisation and helping empower everyone to make change. Ensure staff know how to feed back, influence and engage, and how to raise issues or speak up when they need to, feeding back any actions that have been taken or changes made as a result of staff input.
- Support managers at all levels in delivering their responsibilities as communicators, and work with the organisational development team on contributing to the leadership and management development programmes.
- Create and promote opportunities to support leadership visibility.
- Refresh the 'Our staff matter' internal communications guide for induction/onboarding to introduce staff to how we communicate in the trust and how they can get involved.

External communications and partnership working:

- Continue to support an open and honest dialogue with patients and public, keeping them up to date with developments and working with the wider system to deliver this (for example, elective recovery, acute pressures, standards of care).
- Maintain a good relationship with the media and maximise opportunities for proactive, positive coverage.
- Support the patient experience team in developing the trust's approach to Patient and Public Involvement and encouraging increased engagement with our patients and wider communities.

Celebrating success:

- Continue to deliver the trust's reward and recognition programme and grow the ways we can celebrate success both internally (broadening participation in the monthly star award, supporting initiatives to increase peer-to-peer thanks and appreciation) and externally (for example, increasing entries for external awards).

Supporting recruitment:

- Support the organisation in further developing and strengthening its recruitment brand (identity, marketing collateral, USP/key messages etc) and support the active marketing and promotion of the trust as a current and future employer.

Developing the communications function and its processes:

- Provide a high standard of professional communications advice and support to the organisation, and ensure the team keeps up to date with professional development and best practice.
- Evaluate our internal communications channels to identify gaps and work with staff to create practical and effective ways of addressing these, to ensure that business-critical information is reaching the right audiences, for example the CQC action plan, workforce information, and progress against the trust's priorities. This will need to include the offline workforce, non-desk-based staff, community-based staff, and those who are not always well connected into the corporate communications channels (for example, medical staff).
- Clarify the process for commissioning communications support for projects to help with communications activity planning and to enable objectives to be identified from

the outset so that the best advice and support can be offered and resources can be prioritised and allocated appropriately.

- Introduce more creative/engaging ways of presenting content (infographics, animations, less reliance on narrative) to catch people's attention and simplify our content to increase impact.

7. Communications channels:

The table below outline the trust's current communications channels and how they will be developed.

Current channels	How we will improve
1. **Staff brief** Monthly briefing to senior leadership team delivered by the chief executive and wider executive team. Face to face at York, Scarborough and Bridlington, with onward cascade process. Reintroduced in July 2022 after being stood down through covid.	- Gather feedback on current approach and content - Revised guidelines issued outlining purpose of the briefing and expectations regarding onward cascade - Feedback form developed – helps understand attendance levels, who's being onward briefed, and also to receive feedback and questions for future brief/other communications - Work with DIS to explore options for virtual brief to supplement or replace current face-to-face model
2. **Staff Matters** Monthly magazine-style newsletter for the trust. Opportunity for staff to share good news and for feature-type updates on corporate projects. Published electronically and with a limited print run.	- Audit to assess engagement levels, what do people want to see, format, how might it be published etc. - Compile record of other newsletters produced outside of comms team, meet with owners to discuss purpose/audience/readership to identify what support may be given, and agree mechanism for sharing messages back to communications and vice versa for wider distribution
3. **Staffroom (Intranet)** Legacy system that is no longer fit for purpose. Houses key information on every aspect of employee life at the trust.	- A new platform has been procured and is in the process of being built. - Increased and improved functionality will facilitate improvements to internal communications and engagement - Will be accessible from mobile devices offering greater access for staff
4. **Staff bulletin** Weekly all-user e-bulletin that brings together a summary of all key operational news and updates. Provides click-throughs to more information. Works well in reducing requests for all user emails.	- Use analytics from intranet click-throughs to understand usage - Explore potential for other distribution tools to enable information to be gathered on open rates, deletion rates etc and work with DIS to understand potential for use of these tools within the trust. - Use analytics as a basis for identifying areas of improvement.
5. **Media relations** This has been challenging in covid (less time to be proactive, single issue of interest) but as	- Establish a mechanism/'battle rhythm' for gathering content, develop

we emerge from the pandemic we will redress the balance of proactive vs reactive media work.	relationships with key contacts who can connect the team with potential stories. - take advantage of the fact we are our own publishers now with our own channels. - Provide media handling training for key spokespeople
6. **Social media** Trust channels: All main platforms are used (Facebook, Instagram, Twitter, LinkedIn, YouTube) with a growing audience and strong engagement. Other trust-associated channels: significant growth in this area, continue to monitor and provide advice and guidance. Training and support is given to staff who want to run social media channels for their service.	- Ensure new accounts follow the guidelines and go through the application process - Encourage consistent use of hashtags (#ourvoiceourfuture, etc) and tagging in of the trust and vice versa to maximise reach - Monitor analytics to understand what works well in terms of generating engagement and use to inform future content - Continue to look at other trust's content to identify good practice and trends - Explore other platforms and assess risks and benefits of the trust adopting them for specific audiences or campaigns (e.g. TikTok) - Increased use of targeted/paid for content as a means of addressing specific campaign objectives (e.g. recruitment) - Explore introduction of a closed Facebook group or equivalent for staff.
7. **Visual/design-led content including screensavers, posters, materials for noticeboards, promotional materials** Currently an ad-hoc approach to the production of these, and no formalised method of distribution or management	- 'back to basics' survey of notice boards, agree simple process for updating these - Toilet door posters (currently used by staff benefits and the trust's charity) to be looked at as possible additional option for trust messages.
8. **Managers as a key communications channel** Other than as part of staff brief process, not formally articulated in terms of a formal channel for internal communications	- Develop the communications skills components of the leadership and management development programmes - Communications toolkit to support managers
9. **Trust websites** Well used and regularly reviewed	- Continue to provide support to teams in keeping the website up to date.
10. **Staff surgeries** 'Drop in' sessions where staff can share concerns or ask questions.	- Evaluate effectiveness of surgeries - Consider virtual sessions to supplement/support these (leadership forums, ask the director Q&A, topic-based staff briefings/Q&As – look at good practice in other trusts)
11. **reward and recognition** Monthly star award continued throughout the pandemic with good engagement. Other face to face activities reintroduced since June 2022 (long service, celebration of	- Continue with current reward and recognition programme (it is well evaluated) but review alongside wider reward and recognition/staff benefits offer to see where additional initiatives can be introduced or improvements can

achievement awards)	be made.
12. **video content** increasing usage and good traffic to the trust's YouTube channel	- Explore use of other methods, e.g. vlogs, blogs, podcasts and plan for building up as part of intranet functionality once required resource (capacity and capability) has been identified
13. **events** In addition to reward and recognition events, the team provides support to other corporate events including the AGM, open days, conferences, VIP visits, membership engagement events, official openings etc.	- Work with recruitment team to hold open days to support recruitment and careers promotion - Support the membership manager with member engagement events
14. **Corporate publications** Annual reports, strategy documents etc.	- Develop templates for people who want to design corporate documents such as strategies etc - Work with patient information team on developing how we share patient information, particularly the increasing transition to digital
15. CEO Week Ahead Weekly message from the chief executive.	- Consider ways to supplement this e.g. video, blog, podcast, and look to increase opportunities for this style of communication for the wider executive team

8. Stakeholder analysis:

Different stakeholders require different levels of communication and engagement depending on their level of interest and influence. Not all stakeholders require the same level and frequency of communication so efforts can be focused in particular priority areas.

Stakeholders can be grouped using an influencer matrix, measuring their communications requirements in terms of both their level of interest in the work and their influence on the successful outcomes of what we are trying to achieve. Using this approach stakeholders can be grouped into four potential categories:

- Key players (high influence/high interest)
- Active consultation (high influence/low interest)
- Keep informed (low influence/high interest)
- Monitor (low influence/low interest)

An analysis of the trust's stakeholders has been completed and will be used to prioritise activity and select the most appropriate channels.

9. Key messages:

A message grid will be developed. It will include messages on each of the priorities and how we are progressing with the actions under each of them. These are the high level, key messages that need to be frequently and consistently shared. They will be reviewed and

agreed monthly by the executive team and shared with the Board of Directors, executive committee members and care group leadership teams.

10. Resource:

The trust has invested in additional resource to support the delivery of major projects and trust priorities. Although the growth of such programmes has led to an increased demand for communications support, we are yet to make the corresponding investment in communications resource. The focus on the trust's priorities has also led to an increased demand for support, in particular for the workforce team, and there are a number of significant ongoing and future projects that require a considerable amount of input (capital programme, new EPR, outpatient transformation and quality improvement to name a few).

The communications team in its current configuration and establishment cannot meet this further increase in demand, which presents a risk to delivery of the trust's priorities. In a bid to mitigate this the team has refreshed roles and responsibilities, and rationalised how it can support current projects in a pragmatic way. In addition a clear process for commissioning project support from communications will be developed to help the team to plan and work more efficiently. However, a resource gap remains and will likely increase in the coming months, and with little resilience in the team there is a significant risk to delivery of current projects and core communications activity.

An options appraisal will be developed outlining a range of options for increasing capacity, including potential funding sources. It will also make recommendations for where time-limited external support could be considered to provide specific expertise currently outside of the core skillset of the communications team (for example, marketing/advertising).

11. Risks and mitigations:

Risk	**Mitigation**
Insufficient resource/capacity/resilience for delivery of trust priorities, both within the current team and within broader communications-related areas such as design, video production.	- Clearer process for commissioning of work to improve efficiency. - Bringing internal design resource into the team (medical illustration). - Addition of new role into the team (digital comms officer) - Options will be developed to support increased workload and skills gaps. Work with other teams to commission external support for key projects (e.g. DIS, recruitment).
Disengaged workforce, impact on reputation as an employer and impact on patient satisfaction/safety	- Ensure mechanisms for two-way communication are in place and are effectively promoted - Provide regular feedback to staff about actions that have been taken as a result of their input. - Use simple, clear key messages to describe what we are doing to resolve current issues and how we are progressing.

Offline workforce and people who can't/don't/won't access email or other e-comms channels (time poor as well as access related)	- Ensure we have a range of channels for different needs - Working group to identify best solutions for most impacted groups (to include YTHFM, medical staff, community services staff)
Ability of current digital infrastructure to support the needs of communications/future developments.	- Exploring options with DIS as part of the move to MS Teams.
Key operational and leadership messages not reaching staff in a timely way, unable to effectively carry out their role. Disengaged workforce, reports to the CQC that information is not being shared effectively.	- Ensure systems are in place across a range of channels, and check regularly that messages have reached people and are understood. - Develop training for managers in communicating with their teams. - Audit the briefing process to identify gaps. - Use analytics for digital channels to understand low engagement and where to target interventions
Lack of trust in corporate messages	- Be open in our communications: Do what we say we're going to do and then tell people about it, if we can't do it then be honest. - Increased visibility help build relationships and trust
Poor engagement with local communities, lack of trust resulting in reputational damage	- Ensure mechanisms are in place for this, working with trust's patient involvement lead and the wider system. Following good practice on meeting obligations around involvement.
Growth of trust-associated social media accounts, may lead to lack of coordination of messages, not delivered as part of coherent multi-channel campaign, carefully crafted messages lost. Risk of echo chamber effect where a limited number of people on social media are talking to each other and neglecting other methods which may be more appropriate for that particular messaging, and/or excluding other audiences.	- Account holders are asked to adhere to good practice principles and complete social media checklist before creating accounts. - Accounts are 'monitored' so that support can be given if needed. - Social media training available from the communications team for any staff. - Key announcements and developments managed within a wider project/communications plan, with key messages shared with people to inform their posts.

12. Success measures:

A number of measures will be tracked to assess the effectiveness of this strategy. Progress against the action plan will be reported to the People and Culture Committee.

1.Staff engagement:

- improvement in the overall staff engagement score in the annual staff survey
- reduction in whistleblowing due to concerns not being heard or perceived lack of information about actions being taken

2.Social media metrics:
- number of followers on trust accounts (Facebook, Twitter, LinkedIn, Instagram, plus Trust YouTube channel) increase by 10% on each platform.
- maintain engagement rates at current baselines
- number and sentiment of comments
- Social media engagement/analytics from paid-for campaigns

3.Staff bulletin/e-bulletins:
- Open/click through rates/hits on corresponding intranet pages (need to establish baseline once intranet in launched)

4.Reward and recognition:
- Number of nominations received for star awards
- evaluation questionnaires from long service events and celebration of achievement (key metric: feeling valued)

5.Media coverage:
- pick-up rate of proactive media releases
- sentiment of comments online
- sentiment of coverage (positive/negative/neutral)

6.Number of staff receiving a briefing and the quality of the briefing (measured through quarterly audits, completion of feedback forms, questions received).

7.Attendance levels at face-to-face and virtual events such as briefings, staff surgeries.

8.Website and intranet:
- analytics (most visited, click throughs, page shares). Need to establish baseline for intranet once launched.

9.Nature of engagement with the public/key stakeholders (e.g. Number and content of Questions to the CoG)
Attendance at key events (e.g. open days) and evaluation against event objectives.

10.Short spot-check surveys to check awareness and understanding of messages, and to gather people's views/feelings on specific issues.

11.Success of individual campaigns based on specific key measures (e.g. vaccination campaign) These measures are determined at the campaign planning stage and may include behaviour change measures/responses to a call to action.

13. Activity planner:

The activity plan to support delivery of this strategy is in appendix A.

Date: 2 November 2022

APPENDIX A
CORPORATE COMMUNICATIONS AND ENGAGEMENT STRATEGY: ACTIVITY PLAN

	ACTION	DETAILS	COMPLETION DATE
	Internal communications, staff engagement and retention:		
1	Learn from other sites who are regarded as exemplars in staff engagement and communication.	Arrange discussions with trusts in the top quartile for staff engagement to learn about approach. Continue to link with national NHS communications good practice networks.	March 2023
2	Establish joint communications and workforce team meetings to plan delivery of activity to support the workforce agenda and priorities.	Monthly meetings in place to support delivery of the communications work that comes out of the working groups for the People priority.	Complete
3	Calendar of awareness days to support workforce, health and wellbeing and ED&I priorities and to plan campaigns and comms activity/events.		2023 calendar to be published December 2022
4	Develop key message grid and supporting process for reviewing/updating it.		31 October 2022
5	Develop materials for new starters to explain different communications methods in the trust, for distribution at welcome events. Attend welcome events in person whenever possible.		Materials ready for welcome events form November 2022

			Attendance at events from January 2023
6	Spot-check short surveys to test whether messages have reached the right audience and are understood.	Email at first, move to intranet once launched.	From December 2022
7	Set up working group to look at how we can communicate with the offline workforce.	Group being set up jointly chaired by comms and staff engagement.	Feedback gathered by Jan 2023 Proposed solutions by March 2023
8	Develop and implement comms strategy for new intranet launch (how to guides, tour of new features etc).		From November 2022 onwards
9	Launch new intranet.		December 2022
10	Establish a working group to finalise the move of any remaining content from the old intranet sites to new platform, to enable the old sites to be switched off permanently.		By end of March 2023
11	Audit team brief to measure reach and identify gaps.	Guidelines issued October 2022. Audit in January 2023 (six months post relaunch).	Results and recommendations by end of February 2023.
12	Work with DIS on options appraisal for virtual briefings/Q&A sessions.	First options appraisal complete. Need to consider alongside audit data from above.	Proposal for discussion Q1 2023/24
13	Work with OD team to develop communications elements of leadership and management training. Toolkit for teams on how to support good comms and engagement, face to face as well as digital (e.g. get to know your staff, welcome the new starter, share success with the team).		March 2023 (TBC)
14	Work with the staff governors to raise their profile within the	Meet with the staff	March 2023

	organisation.	governors to agree methods and a timeline.	
15	Audit non-comms newsletters: how we can be more efficient, consistent messages etc.		March 2023
16	Staff Facebook group or equivalent: proposals for different approaches and how it can be administered.	Establish whether the new intranet and the introduction of MS Teams can deliver the same objective. Re-survey staff to assess if there is still a call for this.	June 2023
	External communications and partnership working:		
17	Continue to work with the wider health and social care sector to ensure consistent messages regarding future changes in local services. Participate in formal and information national and regional networks and maintain good working relationships with other communications teams in partner organisations.	ICB comms network established. NHSE/I network established.	Ongoing
18	Continue to work with wider system on broad issues to ensure one voice on issues/changes.	Align with ICB comms strategy. Continue to work in partnership on system-wide campaigns e.g. winter.	TBC Ongoing
19	Support PPI/patient experience team in developing and delivering plans for patient/public involvement and engagement, and how we keep key groups up to date.	Discussions ongoing with new trust leads.	TBC

20	Identify members of the senior team who require media training to ensure a broad range of credible and accountable spokespeople are trained across the Trust.	Key spokespeople identified. Quotes are being sourced from training companies.	March 2023
21	Continue to build a network of followers to our social media sites, increasing the number of followers to each site by 10% in 12 months.		November 2023
22	Continue to support staff within the Trust who wish to use social media in a work capacity. Meet with account owners to review good practice guidelines and offer support if required. Work with trust-associated social media accounts to increase reach and amplify trust content and key messages. Expand social media guidance to include style guide.	Contact owners of dormant accounts on a quarterly basis. Meet with all account holders.	Ongoing (quarterly) By June 2023 March 2023 March 2023
23	Increase media activity to a minimum of x2 proactive PR a month.		January 2023 onwards
24	Work with the governors and support them to engage with the membership in their constituencies. Support the membership manager to develop an annual programme of events for members.	Plans are being developed through the membership engagement group. Membership strategy to be developed.	June 2023
25	Website content review – all trust sites (particularly accessibility statements).		June 2023
	Celebrating success:		
26	Review the monthly star award to ensure it meets its objectives following the launch of the revised values and behaviours. Develop proposals for additional reward and recognition activities, and	Working group established to look at this against NHS Employers' best	March 2023

	assessment of current offer, particularly to strengthen peer-to-peer/in the moment thank you/appreciation.	practice guidance, in partnership with the other key corporate areas that deliver parts of the programme (staff benefits, HR).	
27	Produce calendar of external awards and develop a mechanism for identifying potential nominees (e.g. staff matters, celebration of achievement and star award nominees, QI projects) and support with writing nominations.		2023 calendar to be published December 2022.
	Supporting recruitment:		
28	Support the development and consistent application of our employer brand, including recruitment website, recruitment packs, and other materials.	May require external input, or additional resource into the team.	Ongoing, linked to capacity benchmarking
29	Support open days and other events as part of annual calendar.		Ongoing
30	Strengthen the link with staff benefits and support the team in aligning the brand to the trust's priorities.		March 2023
	Developing the communications function and its processes:		
31	Complete benchmarking of comms resource in other trusts and write options appraisal for growing capacity and capability in the team.		End of November 2022
32	Evaluation survey of current internal comms channels (online and paper survey).		Complete by end of January 2023
33	Introduce commissioning process for communications projects (e.g. documents, events, films, websites, and major projects) to support forward planning of communications capacity.	Briefing forms to be developed for completion by staff who want to commission a communications project to ensure objectives, timescales,	March 2023

		budget and activities etc are agreed from the outset.	
34	Options appraisal and costings for mailing and monitoring tools for e-bulletins to understand usage and effectiveness.		March 2023
35	‘Back to basics’ review of noticeboards, process for updating, distribution etc including toilet doors.		March 2023
36	Move in-house design team under the management of communications and work with the team to improve how we present information in a more engaging way (ie less narrative more infographics, video content etc).	Dependent on the team’s move to the community stadium.	January 2023
37	Carry out a review of graphic design requirements and associated resource and spend across the organisation. Make recommendations for meeting the organisation’s needs in this area.		March 2023
38	Ensure we maintain our current levels of responsiveness on social media.		Ongoing (monthly monitoring)
39	Explore growing our use of video content and other methods vlogs/blogs/podcasts and plan for how they can be resourced.		March 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Risk Management Update
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Mike Taylor, Associate Director of Corporate Governance

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 and Safety ☒ Elective Recovery ☒ Acute Flow	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System

Summary of Report and Key Points to highlight:

To approve the Q2 Board Assurance Framework, amends to the Risk Management Framework and to note the current Corporate Risk Register.

Specifically, to note and discuss:

- All BAF risks have been reviewed by the Risk Committee for Q2 2022/23.
- The CRR has been updated for October reporting.
- The Risk Management Framework has undergone minor changes to reflect the change in Committees of the Board of Directors.

Recommendation:

The Board of Directors are asked to approve the Q2 Board Assurance Framework, amends to the Risk Management Framework and to note the current Corporate Risk Register.

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

Meeting	Date	Outcome/Recommendation
Risk Committee	17/10/22	Approved

Risk Management Update

1. Introduction and Background

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

Risks have been identified for 2022/23 on the re-designed BAF, Executive leads assigned and controls and assurances defined. Monthly meetings have and continue to be held with the Executives in reporting the ongoing risk ratings with a gross (pre-controls and future mitigations) and net (post-controls) and target with completed mitigating actions. The Corporate Risk Register (CRR) has been updated for October as part of the review of the Care Group escalation process.

The Risk Management Framework has undergone amendments to reflect the change in the Committees of the Board.

2. 2022/23 Board Assurance Framework

The Trust's 2022/23 Board Assurance Framework will have its risks reviewed and challenged over the year both at the Risk Committee on a monthly basis, the Board of Directors on a quarterly basis and for assurance at the respective assurance Committees.

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

Each risk is broken down by its constituent parts; description, causes, consequences, controls (including gaps), actions and the applicable assurances; sources of assurance and positive assurance (including gaps). Then revised BAF with amends in red text is provided at appendix 1.

3. Corporate Risk Register (CRR)

The CRR is a high-level operational risk register which captures trust-wide risks and their controls. Used correctly, it demonstrates that an effective risk management approach is in operation within the trust. Risks on the CRR are owned by executive directors. The CRR will be reviewed and quality assured monthly by the executive directors and/or their delegates prior to presentation at the Risk Committee, which includes risks escalated from care groups and corporate service functions to be considered for inclusion onto the CRR.

Escalations to the Risk Committee will be considered by its members to determine whether a risk that is being proposed for escalation should feature on the CRR or should be de-escalated to its point of origin. For each risk that is escalated, rationale should be provided as to why the risk should be considered for inclusion on the CRR.

The CRR for October has been updated at appendix 2. The revised Care Group escalation process has supported this and the Interim Risk Manager is in post to support this further.

4. Risk Management Framework

The Risk Management Framework has undergone minor changes to reflect the changes in the Board Committees and is attached for Board of Directors approval.

Trust Priorities; Quality and Safety

Risk description	PR1 - Unable to deliver treatment and care to the required standard	**Causes** *What has to happen for the risk to occur?*	- Insufficient workforce resources - Professional competency of clinical staff - Lack of funding - Inadequate buildings and premises - Lack of space - Inadequate or aged medical equipment
		Consequences *If the risk occurs, what is its impact?*	- Potential patient harm - Increased financial costs - Reputational damage - Regulatory attention

Risk Rating	Gross	Net	Target	Risk Appetite Assessment	Committee Oversight: Quality & Safety Assurance Committee	
Likelihood	4	4	3	Risk Appetite: Exceeding		
Impact	5	4	2	Date to achieve target score: Year-End Review	Risk Owner:	Chief Nurse
Overall risk rating	20	16	6		Links to CRR:	CN1, COO1-2, WFOD1-3, DIS1-5, MD1

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Internal effectiveness reviews against national standards	None identified	-Clinical effectiveness team -Internal Audit	- Clinical Effectiveness reports - Internal Audit reports	None identified
Review of data from national surveys e.g. NICE, NSF	- Volume of data makes it difficult to focus on key issues - Data does not always flow through correct governance	-Healthcare Evaulation Data (HED) -Clinical Effectiveness Audits -NICE	- HED reports - National Survey results	None identified
Implementation of Clinical standards	None identified	-Board -Quality and Safety Assurance Committee	- TPR reported to April- June (IBR) and July, Sept, Oct Board and Quality & Safety Assurance Committee - Minutes and actions of papers April- June (IBR), July, Sept, Oct (Board, Executive, Quality & Safety Assurance Committee)	None identified
Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Annual Revalidation Report to Sept Board	- Revalidation requirements and links to appraisal

Oversight of performance	None identified	- Oversight & Assurance meetings and other governance forums	- TPR reported to April- June (IBR) and July, Sept, Oct Board and Quality & Safety Assurance Committee - Minutes and actions of papers April- June (IBR), July, Sept, Oct (Board, Executive, Quality & Safety Assurance Committee) - KPIs in Care Group dashboards - Q1 Minutes of Oversight & Assurance meetings	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Q1 Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings.	None identified
Implement Workforce & OD Strategy	Poor diversity in leadership positions (gender pay, race equality)	- Board, Executive and Digital, Performance and Finance Assurance Committee.	- Board/Committee papers - Oct Board Equality, diversity and inclusion data reporting	None identified
Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	-TPR reported to April- June (IBR) and July, Sept, Oct Board and Jul & Sept People & Culture Assurance Committee	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	-Limited visibility to investments required but not progressed.
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%)	-Training deferred/delayed due to operational pressures.
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- Risk stratified elective waiting lists.	- Diagnostic waiting lists to be risk stratified in July; outpatient list to follow.
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	- April & May Executive Committee and Board of Directors approved plan	None identified
Redeployment of speclialist nurses	None identified	Risk assessed each service; low, medium, high	- Quality Impact Assessments for each service	None identified

Routine monitoring and reporting against capital programme	None identified	-Financial Services	-Agenda, papers, minutes and action logs for internal governance meetings (CPEG), Digital, Performance and Finance Committee, Executive Committee, Board of Directors) -Reports to external bodies (the ICS and NHSE/I)	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Recruitment	Reintroduce open days (July); Launch recruitment website (Sept); International nurse recruitment (90 by Jan 23)	Polly McMeekin	**Mar-23**
Revalidation and appraisal to be discussed at a forthcoming meeting of the People & Culture Assurance Committee	Noted on work programme to be discussed with Committee Chair and Medical Director	Mike Taylor	**Nov-23**

Trust Priorities; Quality and Safety

Risk description	PR2 - Access to patient diagnostic and treatment is delayed	**Causes** *What has to happen for the risk to occur?*	- Increased waiting times - Insufficient bed capacity - Failure to transform patient pathways - Inefficiencies in buildings, premises and medical equipment - Insufficient and appropriately qualified staff - Failure of clinical staff to meet required professional standards - Lack of space for patient treatment and staff handovers
		Consequences *If the risk occurs, what is its impact?*	- Patients suffering avoidable harm - Damage to the trust reputation - Regulatory attention - Increased Financial costs

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Quality & Safety Assurance Committee**	
Likelihood	5	4	3	**Risk Appetite: Exceeding**		
Impact	5	5	4	**Date to achieve target score: To be reviewed end of Q3**	**Risk Owner:**	**Medical Director**
Overall risk rating	25	20	12		**Links to CRR:**	**COO1-2, WFOD1-3, DIS1-5, MD1**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Clinical standards	None identified	-Board of Directors -Quality & Safety Assurance Committee	- TPR Committee reporting of learning from Patient Safety Incidents - Minutes and actions of papers (Board, Executive, Quality Committee) - National Audit Clinical Standards	System pressures including ambulance and across local authorities with surges in activity leads to difficulties in applying consistent high clinical standards
Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Annual Organisational Audit Report to Sept Board	None identified

Conduct Incident Reporting and learning from Safety incidents	None identified	- Datix - Care Group Boards - Oversight & Assurance meetings - CPD	- Action plans following investigation of incidents - Datix incident reports - Monthly SI/Never Event reports presented to Quality & Safety Committee, QPaS, Care Group Boards and Oversight & Assurance meetings - Learning from deaths and 6 monthly Cancer Harm report to QPaS - Patient experience report reported to Oct Quality & Safety Committee - Medical Legal report - Escalations recorded on CPD	Overarching analysis and triangulation of all information

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Revalidation and appraisal to be discussed at a forthcoming meeting of the People & Culture Assurance Committee	Noted on work programme to be discussed with Committee Chair and Medical Director	Mike Taylor	**Nov-23**
Learnings from Serious Incidents (SIs) communicated to Care Groups	Reviewed SIs reported through Quality and Patient Safety Group, Quality and Safety Assurance Committee and Board of Directors. Learnings communicated to Care Groups.	Jim Taylor	**Dec-23**

Trust Priorities; Elective Recovery - Acute Care Flow

Risk description	PR 3 - Failure to deliver constitutional/regulatory performance and waiting time targets	**Causes** *What has to happen for the risk to occur?*	- Covid 19, increased waiting times - Insufficient bed capacity - Inefficient patient pathways - Nursing and speciality workforce recuitment challenges
		Consequences *If the risk occurs, what is its impact?*	- Patient harm - Reputational damage - Regulatory attention - Financial costs

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Finance and Performance Assurance Committee**	
Likelihood	4	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Dec 2022**	**Risk Owner:**	**Chief Operating Officer**
Overall risk rating	20	16	12		**Links to CRR:**	**CN1, COO1-2, WFOD1-3, DIS1-5, MD1**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Oversight of performance	None identified	- Oversight & Assurance meetings and other governance forums	- TPR reported to April- June (IBR) and July, Sept, Oct Board and Digital, Performance and Finance Assurance Committee - Minutes and actions of papers April- June (IBR), July, Sept, Oct (Board, Executive, Digital, Performance and Finance Assurance Committee) - KPIs in Care Group dashboards - Minutes of Q1 Oversight & Assurance meetings and Care Groups	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Minutes of Q1 Oversight & Assurance meetings - Minutes and actions of papers April- June (IBR) and TPR July, Sept, Oct (Board, Executive Committee , Digital, Performance and Finance Assurance Committee)	None identified

Implementation of surge plans	None identified	- Scenario testing of surge plans (Winter resilience) - Silver and Gold Command standard operating procedures	- Results of scenario testing - OPEL 4 daily calls assurance to YAS and NHSEI on Ambulance turnaround when required	None identified
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Implementation of winter plans and resilience plans	None identified	- Winter and resilience plans discussed at governance meetings (Executive, Board, Quality Committee)	- Minutes of Sept Board and Sept Executive Committee where winter and resilience plans were discussed.	None identified
Delivery of Building Better Care programme	Programme initiated but not fully embedded	- Programme structure established.	- April-Sept Transformation Committee reports and minutes inc KPIs	- None identified
Monitoring the effectiveness of waiting lists	None identified	- Elective recovery planning and monitoring of waiting lists	- Reporting on progress of meeting waiting lists	- None identified
Urgent Care working at place	None identified	- Collaboration of Acute Providers	- Engagement and participation at Collaboration of Acute Providers for elective recovery	- None identified
Deployment of health inequality assessment to inform waiting list management	None identified	- Board and Executive Committee	- Oct Executive Committee York City Council reporting of Health Inequalities across Trust area	- Specific system reporting against health inequalities

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Deliver the 2022/23 Plan on activity	Oversight provided through the Executive Committee as a Committee of Board. Assurance provided through the Digital, Performance and Finance Assurance Committee.	Melanie Liley	**Mar-23**
Rapid Quality Review Syetem action plan	Weekly place based monitoring meeting of actions and performance trajectories. Monthly ICB assurance meeting.	Melanie Liley	**Mar-23**
Deliver the Building Better Care Programme	Oversight provided through the Executive Committee as a Committee of Board. Assurance provided through the Digital, Performance and Finance Assurance Committee.	Melanie Liley	**Mar-23**

Trust Priorities; Our People

Risk description	PR4 - Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand	**Causes** *What has to happen for the risk to occur?*	- Insufficient supply of workforce - Lack of succession planning - Limited career opportunities - Operational pressures (inc Covid impact on staff absence/redeployment/release) - Inadequate buildings and premises
		Consequences *If the risk occurs, what is its impact?*	- Deterioration of staff wellbeing - High attrition rates - Increased financial costs from interim arrangements - Potential patient harm - Reputational damage - Regulatory attention

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: People and Culture Assurance Committee**	
Likelihood	5	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: March 2023**	**Risk Owner:**	**Director of Workforce and OD**
Overall risk rating	25	20	12		**Links to CRR:**	**WFOD1**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implement Workforce Strategy and People Recovery Plan	- Poor diversity in leadership positions (gender pay, race equality) - Lack of resources to fund intiatives	- Board, Executive and People and Culture Committee.	- Board/Committee papers June 2019 approval - Equality, diversity and inclusion data reporting of WRES/DRES Oct Board of Directors report	None identified
Deliver Board development sessions	None identified	-Board meetings	- Board development independent review	None identified
Conduct Talent Management Framework	None identified	-Trust intranet	- Learning Hub - PREP	None identified
Design and Deliver Internal Leadership Programmes	None identified	-Trust intranet	- List of programmes on Learning Hub	None identified
Leadership succession plans	None identified	- Board, REMCOM, Executive Committee	- Board papers (agenda, minutes, action log) ? - REMCOM papers (Oct agenda, minutes, action log)	None identified
Conduct NED development programme	None identified	- Gatenby Sanderson, external specialist recruiter	- Regular updates from Gatenby Sanderson	None identified

Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Board r(eporting on Equality, diversity and inclusion)	-Board papers (agenda, minutes, action log) -REMCOM papers (agenda, minutes, action log)	None identified
Implement Workforce models and planning on a case by case basis	National contract limitations National training programmes	-Director of Workforce & OD	-Board approved Workforce models and plans	None identified
Target overseas qualified staff	None identified	- Overseas nurse recruitment programme	- QIA for new nurse roles - CHPPD	None identified
Incentivise recruitment	None identified	-Reduced vacancy rates in IBR	- TPR and workforce reporting at July and September People and Culture Workforce Committee	None identified
Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	- Minutes and actions of papers April- June (IBR) and TPR July, Sept, Oct (Board, Executive Committee , People & Culture Assurance Committee) - Executive Committee Agency Usage Report	None identified
Oversight of rotas - e-Rostering (nursing)	None identified	- Internal Audit	- Internal Audit reports on E-Rostering - CHPPD	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	Limited visibility to investments required but not progressed.
Monitor performance against the People Plan	None identified	-Resource Committee updates against the People Plan	- Sept Minutes People and Culture Committee	None identified
Implement Workforce & OD Strategy	None identified	- Reporting on performance against the Workforce & OD Strategy to Board, Executive and Resources Committee.	- Board/Committee papers ? - Equality, diversity and inclusion data reports	None identified
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%) - Jul People and Culture Committee reporting, action plan and minutes	None identified
Thank You Campaign	None identified	Communications and hospitality provision in Spring/Summer 2021	- Well received by staff in feedback	None identified
Workforce resilience model	None identified	Executive Committee	Executive Committee approval October 2021	None identified
Communicate guidance for Managers for remote working	Space restrictions	- Trust intranet	- Agile Working Policy	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**

Culture change (Retention)	Values and Behaviours roll out continues; Behavioural framework launched; re-introduce face to face comms (staff brief to be re-launched (July); Relaunch reward and recognition awards (Sept); ceased command and control structure; Implement E,D & I gap analysis.	Simon Morritt	**Mar-23**
Working Life (fixing the basics)	Working group established. Rest areas identified – bid to be submitted to NHS Charities (Aug); transparent & equitable local pay (to be agreed);Medical rostering roll-out continues (remaining juniors in Aug); to be complete Mar 23); New intranet (Sept)	Polly McMeekin	**Mar-23**
Recruitment	Reintroduce open days (July); Launch recruitment website (Sept); International nurse recruitment (90 by Jan 23);	Polly McMeekin	**Mar-23**
Workforce Plan	Clinical Establishment review underway; Develop further alternative roles (Nov); CESR 'toolkit' (Dec); Transparent career pathway options (Mar 23); Increase Apprenticeship levy spend	Polly McMeekin	**Mar-23**

Trust Priorities; Our People - Quality & Safety - Elective Recovery - Acute Flow

Risk description	PR 5 - Financial risk associated with delivery of Trust and System strategies	**Causes** *What has to happen for the risk to occur?*	- Insufficient financial allocation distributed via the Humber and North Yorkshire Integrated Care Board - Failure of the Trust to manage its finances
		Consequences *If the risk occurs, what is its impact?*	- Inadequate revenue funding to meet the ongoing running costs of service strategies - Inadequate capital funding to meet infrastructure investment needs at the Trust - Inadequate cashflow to support operations - Net carbon zero objectives addressing environmental hazards not achieved - Imposition of financial special measures or licence conditions

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Finance and Performance Assurance Committee**	
Likelihood	5	4	2	**Risk Appetite: Inside Tolerance**		
Impact	5	4	3	**Date to achieve target score: Achieved**	**Risk Owner:**	**Director of Finance**
Overall risk rating	25	16	6		**Links to CRR:**	**FIN1**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Annual Business Planning process including Trust Strategy	Lack of clarity over funding from NHSE/I due to pandemic emergency financial regime.	-Business Planning process - Internal Audit	-Business planning schedules. - Internal audit reports on effectiveness of controls around the Business Planning process.	None identified
Preparation and sign off of annual Income and Expenditure plan, balance sheet and cash flow	None identified	-Executive Committee and Board of Directors.	-June Final Approved I&E plan (Board, Executive Committee, NHSE and ICS).	None identified
Routine monitoring and reporting against I&E plan	None identified	-Monthly updates to Care Group OAMs, Resources Committee, Financial Review Meetings, Executive Committee, Board of Directors, the ICS and NHSE/I.	- Minutes and actions of papers April- June (IBR) and TPR July, Sept, Oct (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) - Reports provided to external bodies (PFR monthly to NHSE)	None identified
Expenditure control; scheme of delegation and standing financial instructions.	None identified	-Board of Directors	-Approved scheme of delegation and SFIs. -System enforced delegation and approval management. - Written confirmation by prime budget holders or responsibilities	None identified
Expenditure control; business case approval process	Investments approved outside of the business case process. Unplanned and unforeseen expenditure commitments.	-Internal audit -Financial Management team	-Business Case Register -Internal audit reports on effectiveness of controls around the Business Planning process. -Reports produced by the Financial Management team on variance analysis.	None identified

Expenditure control; segregation of duties	None identified	-Finance systems	-System enforced approvals. -No Purchase Order No Payment policy.	None identified
Expenditure control; staff leaver process	Management failing to notify Payroll in a timely way of staff leavers	-Contract change notification process. -Routine reporting of staff in post (i.e. paid) to budget holders.	-Salary overpayment recovery policy. -Reports from Finance to budget holders on their staff in post	Limited visibility to issue
Income control; income contract variation process	Unforeseen and unplanned in-year reduction in income.	-Financial Management Team	Income Adjustment form register.	None identified
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-Executive Committee and Board of Directors approved plan	None identified
Routine monitoring and reporting against capital programme	None identified	-Financial Services	- Minutes and actions of papers April- June (IBR) and TPR July, Sept, Oct (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) and CPEG - Ad hoc reports to external bodies (the ICS and NHSE)	None identified
Overspend against approved scheme sums	None identified	-Financial Services	-Scheme sum variation process. -Scheme expenditure monitoring reports to CPEG.	None identified
Routine monitoring against cash flow	None identified	-Board of Directors - Finance team	- Minutes and actions of papers April- June (IBR) and TPR July, Sept, Oct (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) - PFR monthly to NHSE	None identified
Cash flow management through debtors and creditors	None identified	-Financial Management Team -Government	-Monthly debtor and creditor dashboard to Finance Managers and Care Groups. -Trend data reported to Executive Committee, Resources Committee and Board of Directors. -Better Payment Practice Code (BPPC) - monthly report	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Planning guidance and funding allocations expected shortly for 2023/24	Trusts to prepare 2023/24 I&E plan	A Bertram	**Mar-23**
Confirm efficiency requirement and match to identified plans with a view to identifying any residual requirement.	Ongoing	A Bertram	**Mar-23**
Model Elective Recovery Fund costs and income earning potential to maximise funded elective recovery activity.	Ongoing	A Bertram	**Mar-23**

Trust Priorities; Quality and Safety

Risk description	PR 6 - Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs.	**Causes** *What has to happen for the risk to occur?*	- Vulnerabilities in the trusts hardware and softwareInadequate policies and procedures - Lack of IT/IG training - Failure to report information incidents in a timely manner - Cyber attacks to Trust systems and data
		Consequences *If the risk occurs, what is its impact?*	- Potential patient harm - Regulatory attention (ICO) - Reputational damage - Financial costs

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Performance and Finance Assurance Committee**	
Likelihood	5	4	3	**Risk Appetite: Exceeding**		
Impact	4	4	3	**Date to achieve target score: April 2023**	**Risk Owner:**	**Chief Digital and Information Officer**
Overall risk rating	20	16	9		**Links to CRR:**	**DIS1, DIS3, DIS4**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Data Security and Protection Toolkit standards	Longstanding audit actions not implemented or partially implemented and not closed	Yearly internal audit report (audit committee) Bi-annual submission to DSPT improvement plan development and submission Quarterly report on updates to the Information Governance Exec Group - minutes provided to Digital, Performance & Finance Assurance Committee Monthly update on open actions from Audit Yorkshire	- Internal Audit report of IG compliance IGEG meeting minutes	Audit actions still active from 2020
IG and Security Governance arrangements in place e.g. IG Executive	No specific security group to feed into IGEG and committee	Quarterly report on updates to the Information Governance Exec Group - minutes provided to Digital, Performance & Finance Assurance Committee	Digital, Performance & Finance Assurance Committee minutes, papers, agenda, action log - IG Executive Group minutes, papers, agenda, action log Responsibilites identified within the Information Governance Strategy	Due to pressures and inability to get full attendance to the IGEG meetings

Trust Portable devices encrypted - mobiles and laptops	None identified	- IT Systems	- System enforced control e.g. bit locker encryption on Trust laptops	None Identified
Implementation of IG policies and procedures	No documented IG policy framework which identifies relevant IT protocols	Policies are available on the IG pages of Staffroom IGEG meeting minutes discuss new policies and processes	- Approved IG policies - Statutory/mandatory IG training for all staff - Regular Trust wide comms from the IG team regarding new policies and procedures	Resources and capacity to complete the necessary review and rewrite of these Old versions of process and protocols on staffroom pages
The identification, investigation, recording and reporting of IG incidents	Awareness of the breach management process is not tested	- Information Governance Team weekly review - Datix reports - Information Breach Management guidance	- IG breach reports - IGEG meeting minutes - breach information is reported monthly - TPR statistics monthly - Regular communications from the IG team regarding breach trends	Gap in terms of full awareness TRUST WIDE of the incident report process Access and understanding of datix in corporate areas
Review and sign-off of IG documentation	None identified	-Information Governance Team	- IG team sign-off	Resources and capacity to complete the necessary review and rewrite of these and engagement at IGEG
Delivery of Essential Services Programme/Delivery of IT Service	Funding to deliver the full commitments/ scope of the ESP Programme Capacity/ Capability to deliver the full commitments/ scope of the ESP Programme	- ESP Programme Board - Digital, Performance & Finance Assurance Committee minutes, papers, agenda, action log - Funding Forum - CPEG	- Multiple applications for external funding applied for including EPR - Holistic partner tender to ensure technical expertise - Reduction in open vacancies and increase in our retention rates	No successful funding bid that the trust is able to draw down capital funding.
Vulenerabilites across end user compute, platform and network	Linked to Delivery of ESP reducing risk	- DIS SLT - Technical Steering Group - Cyber Security Focus Group '- Digital, Performance & Finance Assurance Committee minutes, papers, agenda, action log	Production of Cyber Security Strategy	Comprehensive Pen Test across entire IT estate
IT Service management standards / processes	- Lack of modern Service Desk system with improved capabilities - High vacancies on Service Desk impacting serve - Low maturity due to lack of training	- DIS SMT - Technical Steering Group '- Digital, Performance & Finance Assurance Committee minutes, papers, agenda, action log	- Business Case in production for a number Service Desk Tool - Reduction in vacancies on Service Desk - Regular communications from IT Service Mgt team	Gaps in awareness of reporting using the correct mechanism for reporting incidents by end users No robust security and IG major incident management process

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*

Actions for further control	Progress to date / Status	Lead action owner	Due Date
Continue to review funding for ESP	COMPLETED - funding secured from Trust and UTF for 21/22. ONGOING - reviewing funding opportunities for 22/23 from Trust/external funding 11/10 multiple external funding opportunities applied for	J Hawkins	**Nov-22**
Implement the proposed DIS structure	ONGOING - Minimum funding secured and formal consultation process starting. Initial roles (i.e. CTO/Head of Delivery) in position. Further identified roles in recruitment process. 11/10 to support Trust Priority of Retention, career development paths created with runthrough opporunities over 10 people promoted with more responsibility	J Hawkins	**Ongoing**

Trust Priorities; Our People - Quality & Safety - Elective Recovery - Acute Flow

Risk description	PR 7 - Trust unable to meet ICS expectations as an acute collaborative partner	**Causes** *What has to happen for the risk to occur?*	- Ongoing Trust operational pressures; Urgent, Elective and Community Care
		Consequences *If the risk occurs, what is its impact?*	- Challenges in delivering overall quality of care provision to patients - Reputational harm in meeting system contribution targets required across the Humber and North Yorkshire region

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Executive Committee**	
Likelihood	3	3	3	**Risk Appetite: Inside Tolerance**		
Impact	3	2	2	**Date to achieve target score: Achieved**	**Risk Owner:**	**Chief Executive**
Overall risk rating	9	6	6		**Links to CRR:**	**N/A**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Integration with ICS on system wide planning	None identifed	- Attendance of members of Trust Executive Team across H&NY ICS governance structure	- Chief Executive update reports on Board of Directors Minutes and actions of papers April-Oct	None identified
Operational and Finance Plans 2022/23	None identified	- Board of Directors approval processes and sub-committee assurances of delivery	- Approval at Board of Directors and submission to NHSE&I for H1 and H2 plans	None identified
Trust involvement in the Collaborative of Acute Providers	None identified	Acute providers governance in decision making across 5 strategic themed transformation programmes; cancer, diagnostics, electives, maternity and paediatrics, urgent and emergency care	- Trust Building Better Care Transformational Programme - Engagement with H&NY ICS - Managing Director of Collaboration of Providers engagement with Executive Team - Workshop of the Humber and North Yorkshire Collaboration of Acute Providers (CAP) - OD Programme of Work	None identified
Trust CEO Provider representative on H&NY Interim Executive Group	None identified	H&NY Interim Executive Group meetings	Engagement with the H&NY Interim Executive Group	None identified
Trust CEO Provider representative on North East and Yorkshire ICS transition oversight group	None identified	North East and Yorkshire ICS transition oversight group	Engagement with the North East and Yorkshire ICS transition oversight group	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Attendance at Workshop of the Humber and North Yorkshire Collaboration of Acute Providers (CAP) - OD Programme of Work	Concluded	Board of Directors	**Oct-22**
Ongoing collaborative strategy development at neighbourhood, place and system level delivering for Trust patients and wider H&NY fo during 2022/23	Progress to be reviewed end of Q3 2022/23	Exec Team	**Dec-22**
Finance and activity planning for 2022/23 as part of H&NY system delivery	Progress to be reviewed Q3 2022/23	Exec Team	**Dec-22**

Trust Priorities; Our People - Quality & Safety - Elective Recovery - Acute Flow

Risk description	PR 8 - Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber & North Yorkshire ICS Green Plan	**Causes** *What has to happen for the risk to occur?*	- Failure to reduce greenhouse gas emissions from the Provider's Premises in line with targets in 'Delivering a 'Net Zero' National Health Service' (targets are 80% carbon reduction by 2032 and Net Zero by 2040) - Not achieving standard contract 18: Requirement to provide detailed plans as to how the Trust will contribute to a Net zero NHS in relation to a) reducing carbon emissions from Trust premises 80% by 2032; b)reducing air pollution through transitioning fleet to Zero and Ultra Low Emission Vehicles, installing EV charging for fleet and establishing policies which exclude high emission vehicle use and promote sustainable travel choices; and c)adapting premises to reduce risks associated with climate change and severe weather;
		Consequences *If the risk occurs, what is its impact?*	- Reputational risk in not achieving targets - Potential NHS England action

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Executive Committee**	
Likelihood	4	4	3	**Risk Appetite: Exceeding**		
Impact	5	4	2	**Date to achieve target score: 2040**	**Risk Owner:**	**Director of Finance**
Overall risk rating	20	16	6		**Links to CRR:**	**N/A**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Sustainable Design Guide	Internal Audit identified need to review the Sustainable Design Guide and its role to strengthen its contribution to the delivery of Net Zero	Design Guide being implemented for Scarborough new emergency department to reduce carbon emissions	UECC designed with reference to Sustainable Design Guide	None identified
York Hospital part of Carbon Reduction Pathway Modern Energy Partners Programme which estimated the cost to get York Hospital on track. Trust signed up to NHS Living Labs Innovation Programme to investigate new and developing technologies for achieving carbon reduction.	None identified	Modern Energy Partners (MEP) Concept design report received for York Hospital 18/01/21 NHSE Living Labs - MoU signed following Executive Committee approval 20/04/22	MEP Concept Design used as a basis for grant applications for PSDS projets NHSE Living Labs - first meeting held to discuss Innovation Projects	None identified
PSDS3 grant applications approved for £5million for Bridlington Hospital to achieve Net Zero and £5million scheme for York Hospital to start the decarbonisation prcess	None identified	Planning applications submitted and community renewal fund Business case objectives	PSDS Grant work commenced in March for delivery in 2022/23.	None identified
Feasibility funding awarded for reviewing carbon reduction potential at Scarborough and Selby Hospitals	None identified	Feasibility work to identify funding needs and practical implementation issues for Scarborough and Selby complete	Grant application submitted for Scarborough	None identified
Green Plan published setting out the overall Trust approach and latest carbon footprint	Internal Audit identified need to review the Trust Green Plan and its role to more closely align its plans , projects and business cases with contributions to the delivery of Net Zero	Trust travel plan Energy Saving Trust (EST) undertaken and a Fleet and Travel review and draft report realeased in April 2022 by EST.	Energy Saving Trust (EST) undertaken a Fleet and Travel reviewand draft report realeased in April 2022 by EST	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
New procurement exercise to commenced with CEF to take advantage of next round of grant funding and develop a plan for achieving reductions in line with Net Zero 2040 target	Procurement exercise completed and grant application now being progressed for Scarborough Hospital . Works on going at York and Bridlington will achieve a carbon reduction of approx 8% at York and 80-85% at Bridlington.	Head of Sustainability	**Reviewed Mar-23**
Contract negotiations on going for a contract which develops plans for York, Scarborough and Bridlington to 2040	York contract signing planned for November after gaining Board approval . Bridlington contract discussions on-going.	Head of Sustainability	**Reviewed Mar-23**
Trust Travel Plan to be updated to incorporate plans to achieve carbon emissions reductions in line with NHS requirements	Current focus of work is exploring support for staff commute options and facilities for York and Scarborough Hospital.	Head of Sustainability	**Reviewed Mar-23**
Improve internal temperature monitoring and control for vulnerable groups within the hospital estate to develop a plan in response to the changing climate	Funding agreed for a pilot ward project to improve monitoring, to start to develop a business case for hospital sites	Head of Sustainability	**Reviewed Mar-23**
Sustainable Design Guide to be reviewed when Net Zero Carbon Guide published	Awaiting Net Zero Carbon Guide from NHSE	Head of Capital Projects	**Reviewed Mar-23**
Green Plan to be reviewed	Delayed due to prioritisation of PSDS grant project and lack of progress to recruit/replace Environmental Awareness Officer	Head of Sustainability	**Reviewed Mar-23**

CRR 21 10 2022

BAF Ref	ID	Risk No.	Title	Opened	Description	Current Mitigation	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Actions (Risk)	Severity (Target)	Likelihood (Target)	Risk level (Target)
PR1 PR3	368	CN1	Failure to manage contagious infection outbreaks	20/08/2018	The risk of ineffective management systems caused by environmental issues, insufficient specialist and standard isolation capacity, reduction of bed base, a lack of adequate facilities at Scarborough Hospital and the recent spike of COVID and non-COVID patients in ICU which impact on separating separate COVID and non-COVID patients in ICU. The trust has no specialist isolation facilities for patients with airborne infection or potential high-consequence infectious diseases (HCID). This may result in serious harm or death to a patient, unsatisfactory patient experience, significant financial loss; loss stakeholder confidence; and/or a material breach of CQC conditions of registration	1.In response to the COVID-19 pandemic and post COVID -19 all IPC resource was re-directed to support the Trust response. 2.IPC precautions, measures and protective systems are in place including regular testing of patients and staff 3.Appropriate Patient isolation procedures 4.CDI Improvement Plan 5.Quality Improvement methodology adopted with a Trust wide HCAI collaborative 6.Personal Protective Equipment (PPE) 7.Cleaning process 8.Weekly monitoring of performance 9.Post Infection Reviews (PIR) 10.Monthly reporting to Board on infection rates. Further mitigation: The IPCT recovery plan which is essential to be able to monitor performance and reduce risk of Healthcare Associated Infection (HCAI)	Nurse, Chief	21/11/2022	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	1. The ICU POD in York has been completed and offers 6 extra side room capacity for the Critical Care footprint 2. Both Emergency Departments have developed plans for identifying and housing potential HCID cases within their existing footprint. 3. The actions are captured in the wider IPC improvement plan	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR6	409	D1S1	Cyber Security	01/11/2018	There is a risk of Cyber attacks due to a computer virus or malware, insufficient resources (financial and human), user behaviour, unauthorised access, phishing and unsecure data flows. This could result in patient harm, reputational impact, unavailability of systems, financial costs, inability to meet regulatory deadlines (NHSE/I, HMRC) and regulatory scrutiny/fines/censure (CQC/ICO).	1.Trust wide information and sharing of the risk of cyber -attacks occurring and preventative measures to reduce the risk. Compliance to standards i.e. DSP toolkit encompassing key aspects of Cyber Security (Patching, AV management, Education and Training) 2.Stakeholder steering group with Trust 3.IG and security measures and dashboard across operations (inclusive of toolkit) 4.Data Security and Protection Toolkit standards and principles (Joint Trust and NHS) 5.Joint DIS IG and Security Governance and Forums (Operational, Toolkit and ESP strategy) 6.Joint IG and Security strategy aligned to Essential Services programme informed by expert 3rd party (Co-Stratify) 7.Password protocols aligned to NCSC guidance.	Digital and Information Services, Director	21/11/2022	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	1.Refresh our suit of Information Security Management Policies. 2.Reduce insider threat by improving vetting processes 3.Improve our Vulnerability Management through improved patching response times 4.Introduce improved proactive monitoring of systems to identify potential attacks and responding to them prior to exploitation 5.Review approach to staff training and awareness 6.Review the cyber Target Operating Model 7.Identify and improve our approach to physical security	5 - Catastrophic Harm	2 - Unlikely	High

PR1 PR2 PR3 PR6	1696	CN2	Workstream Funding	17/10/2022	There is a risk that the Trust will be unable to deliver key work streams within the Maternity Transformation programme, due to a lack of available funding both Capital and Non-Capital. This could result in risk to patient safety, patient experience, regulatory non-compliance and reputational damage.	1.Review (discussion with Senior Leadership) current service and delivery processes which entail a risk assessment to determine the impact on patient experience, regulatory non-compliance and reputational damage. 2.Consultancy commissioned confirmed the outcome of the risk assessment, gaps in compliance and inform ongoing Transformation workstreams and inform the Senior responsible Officer. 3. The Maternity Transformation Group that reports to the Executive Committee was made aware of the Risk description and the impact on Maternity Department. 4. Frequent safety huddles 5. Schedule of audits to monitor compliance	Nurse, Chief	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Feasibility study plan is to be undertaken to identify the resourcing requirements.	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3 PR4 PR5 PR7	1699	C004	Failure to deliver the National Activity Plan	01/05/2022	There is a risk of the Trust not being able to deliver the National Activity Plan leading to the failure to deliver: 1. Zero RTT 104 week waits by June 2022 2. Delivery of zero RTT 78 week waits by end March 2023 3. Diagnostic 6-week performance recovery 4. Cancer 63 day waiters 5. Emergency Care Standards 6. Ambulance Handovers 7. Patients spending 12 hours in Department due to Workforce (sickness, vacancies & retention) Clinical capacity (Theatre, Outpatients Beds etc) and the number of patients without a right to reside impacting on the ability to carry out elective work. This could result in regulatory intervention, patient safety and quality of care.	1. Care Group Performance Meetings 2. Weekly Corporate led Elective Recovery meetings to review all potential RTT104 week breeches 3. Development of Care Group Dashboards 4. Build Better Care programme 5. TIF bids (Ramsey & Bridlington procedure space on Lloyd Ward 6. Care Group 12-month priorities for workforce 7. Work Force Planning & Development Lead appointed	Operating Officer, Chief	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Established Non-admitted pathway focused Corporate led meeting commencing in July 2. Executive escalation when not on plan	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR4	1698	WFOD3	Staff Shortages Trustwide	17/10/2022	There is a risk of not offering optimum care service and delivery due to National shortages of Clinicians (Nurses, Midwives and Medical Allied Professionals) this could result in a potential failure to protect staff and patients from associated risks, stakeholder confidence and breaches of CQC conditions of Registration.	1. Review of the working environment to make it more positive and safe working environment. 2. Retention initiatives including retention champions in various services. 3. Retention plan 4. Pastural work-life package in place 5. Recruitment drive with support from Health Education England 6. Ensuring eligible clinicians, nurses and midwives can join the temporary NMC and GMC 7. A drive to recruit NHS Professionals to support various Trust workstreams.	Workforce & Organisational Development, Director	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Safe Staffing guidance and the daily staffing sheets are reviewed every day by the ACN/Matron of the day. 2. Escalation pathway for Operational oversight	3 - Moderate Harm	3 - Possible	Medium

PR1 PR2 PR3 PR4	1695	MD2	Sustained significant pressure on ED workforce	17/10/2022	There is a risk of stress and burnout amongst staff due to sustained significant pressure on ED workforce. Factors contributing to this risk are: Reduced flow out of the hospital due to reduced capacity in social care Staff vacancies and illness in all of acute care This leads to the almost constant risk of; 1. Emergency Department crowding (excess number of patients managed in the space available) to include 2. Long ambulance queues 3. Concerns about resus capacity 4. Long waits in ED for admission to a hospital bed The above risk creates an environment that impacts on staff well-being and resilience causing additional risks to staff behaviours and performance and ultimately to patient safety	Interventions to reduce ED crowding include: 1. Diverting ambulances to other acute hospitals 2. Streaming more patients to alternative providers such as the Urgent Treatment Centre 3. Streaming more patients to other hospital delivered services e.g. Same Day Emergency Care/ Emergency Assessment Unit, Surgical Assessment Unit (requires expansion of SDEC services. 4. Consideration of lower threshold for discharging patients in the ED (however that may exacerbate stress in the staff if they feel that they are taking excess risks)	Medical Director	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. To reduce pressure on the ED Department Patients who do not fulfil criteria to reside if possible to be removed from the inpatient bed base	4 - Severe Harm	3 - Possible	High
PR5 PR7	1693	FIN2	Failure to deliver our Annual Financial Plan	11/05/2022	There is a risk to deliver our annual financial plan due to the failure to control expenditure within resource envelope, failure to manage inflationary pressures, failure to deliver the required level of elective recovery activity to secure ERF and/or failure to deliver the efficiency programme. This could result in reputational damage, our cashflow and our ability to deliver clinical services.	1. Trust Business Planning process 2. Agreed Annual Plan 3. Approval of operating budgets 4. Scheme of delegation and standing financial instructions Oversight of Trust. 5. Performance monitoring and performance management arrangements. 6. Executive Committee, Resources Committee and Board of Directors monitoring. 7. NHSE/I Reporting 8. ICB Reporting 9. Corporate Efficiency Team managing delivery of the efficiency programme. 10. Business case process to manage new investment requirements.	Finance, Director	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Develop enhanced reporting to Resources Committee 2. ICS collaborative working, risk share arrangements 3. Greater scrutiny of business case developments required to ensure a source of funds is sourced before investment is made	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3 PR4	978	WFOD2	Insufficient knowledge / skills	01/04/2018	There is a risk in maintaining adequate levels of professional accountability for all bank only workers due to inadequate training, SOPs and disparate skill sets. This could result in patient harm, non-compliance with training standards and regulatory scrutiny/censure.	1. Oversight of training needs 2. Senior Nursing Oversight 3. Bank Training Compliance	Workforce & Organisational Development, Director	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Statutory and mandatory training being addressed by managers Trust communications of training requirements needs to bank workers (blocking non-compliant workers after a period of notice)	3 - Moderate Harm	3 - Possible	Medium

PR1 PR2 PR3	377	MD1	Deteriorating Patients	20/08/2018	There is a risk in correctly identifying and managing deteriorating patients due to staff not escalating the risk, a key person dependency, inadequate treatment, discharge and admission plans and poor patient flows. This could result in serious patient harm/death, regulatory scrutiny/censure, financial costs and reputational damage.	1.Critical Care Outreach Team 2.Oversight of system entries and segregation of duties 3.Datix safety alerts 4.NEWS monitoring 5.Annual audit by Intensive Care Unit (ICU) on deteriorating patients. 6.Individual escalation protocols 7.National Early Warning Scores (and associated pathways NEWS, MEWS and PAWs) 8.Staff training 9.SOPs/pathways for managing deteriorating patients 10.Deterioration Policy 11.Ceiling of Care Policy within clinical pathways	Director, Medical	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	QI work on the deteriorating patient pathway to include consideration of human factors, psychological studies and patient feedback on safety incidents	4 - Severe Harm	2 - Unlikely	Medium
PR1 PR2 PR3 PR4	404	WFOD1	Insufficient staff	22/08/2018	There is a risk of delays in offering optimum diagnostics and treatment and potential reputational damage due to the failure to maintain adequate staffing levels arising from staff sickness, difficulties in recruiting, national staff shortages, finding of Nursing establishment reviews, vacancy rates and inability to provide seven-day service in non-emergency care. This may result in increased pressure in clinical services and delays in diagnostics treatments including poor experience for patients and staff.	1.Temporary staffing supports the Trust staff roster gaps. 2.Risk assessments of vulnerable staff Trustwide audits 3.Staffing reports are discussed at the following Committees QPaS, Executive Committee Quality & Safety Assurance Committee 4.Workforce Plan, staff wellbeing agenda and Retention and Recruitment Strategy 5.Review of staffing Bank rates 6.Ongoing campaign to recruit overseas qualified staff 7.Incentivised recruitment 8.Daily monitoring of staffing levels (temporary/permanent) managed by Associate Chief Nurse Matron of the day and escalated to Chief Nurse Team as appropriate, and this also includes oversight of rotas - e-Rostering	Workforce & Organisational Development, Director	21/11/2022	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Job Plan re-setting of expectations 2. Safer Care Investment Proposals to Board 3. Business case determining how to identify savings to fund further roll out	4 - Severe Harm	3 - Possible	High
PR1 PR2 PR3 PR6	1388	DIS2	Major IT Failure	18/12/2020	There is a risk of the failure of the core technology estate (e.g. CPD or network infrastructure) due to single points of weakness, loss of power/premises, insufficient funding in the infrastructure or poor data storage/sharing processes. This could result in patient harm, prolonged service disruption, poor quality of patient care, reputational damage, financial costs and regulatory scrutiny/censure.	1. Pro-active management and maintenance of systems and solutions i.e. upgrades, patching	Digital and Information Services, Director	21/11/2022	5 - Catastrophic Harm	3 - Possible	Significant	1.Make case to NHS England for further investment in infrastructure, storage, end user compute, networks and wifi 2.Improve our Vulnerability Management through improved patching response times 3.Review portfolio priorities to investigate prioritising non-functional upgrades	5 - Catastrophic Harm	2 - Unlikely	High

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Quality and Safety Assurance Committee
20 September 2022

Members in Attendance: Stephen Holmberg (SH) (Chair), James Taylor (JT), Jenny McAleese (JM), Lorraine Boyd (LB), Heather McNair (HM), Mike Taylor (MT), Caroline Johnson (CJ), Shaun McKenna (SM), Sue Glendenning (SG), Emma George (EG)

Attendees: Gary Hardcastle (GH – deputising for NS), Frances Healey (FH)

SH introduced GH and FH to the group and declared the meeting quorate.

GH gave an overview of the information to be used in the new Trust Priorities Report (TPR). He then left the meeting.

18-22/23 Apologies for Absence:

Apologies were received from Donald Richardson and Nik Coventry.

19-22/23 Declaration of Interests

There were no declarations of interest.

20-22/23 Minutes of the meeting held on 19 July 2022

The minutes of the last meeting held on 19 July 2022 were agreed as a true and accurate record.

21-22/23 Matters arising from the minutes and outstanding actions

Item 06-22/23 July – JM referred to the comment about the Matron role being focussed on mitigating the gap in nursing shifts rather than focusing on Quality and Safety agenda, and also the review of the Matron of the Day role, and asked HM for an update. HM informed that a paper would be going to the Executive Committee to secure funds for a Band 8a 24/7 Site Management Matron role who will have overall control of the site management structure. She will update at a future meeting.

Actions 11 & 12 – MT informed that a new Care Group Escalation Log will commence tomorrow with the Executive Committee. Once that is up and running, he will speak with SH on what deep dives could be brought to this Committee. CJ asked to see the Escalation Log template to determine how that would be used at QPaS and how to use the escalation framework on the clinical quality side as well.

SH commented that discussions have been ongoing for a number of years now around standardising and bespoking Care Group quality reporting for assurance purposes. CJ replied that a piece of work with the Care Groups has been undertaken. The problem was with data issues where some data was not available at Care Group level and she has escalated this issue to the Information Team. She has agreed a template for the Care Groups to use which hopefully should result in suitable escalation reports coming through.

SH asked CJ to share these once they start to determine which issues should come to the Committee. CJ agreed.

LB referred to the data currently available from Care Groups which CJ believed was not rich enough and was concerned that much of the NEDs assurance came from that data. She asked how this could be mitigated as an interim measure whilst the data issues were rectified. She was also concerned that issues on the 'shop floor' which had risks attached were not recorded anywhere in the system. MT replied that the quality and safety perspective linked to the Trust priorities will be discussed at the Executive Committee tomorrow. This will be the link between Ward to Board in that respect. He will pick up with CJ the issue around QPaS. SM added that he receives an Exception Report from each Care Group on a monthly basis noting escalations, assurance and information. That is going to Executive Committee this week and could come to this Committee for information.

SH said he was not comfortable with Executive Committee filtering this type of information in relation to assurance on matters of quality and patient safety. SM replied that in fairness this was the first time that the Exception Reports had gone to the Executive Committee. Historically, it used to be part of the QPaS report and listed in bullet points. CJ/MT added that they can tweak the process once it gets underway.

LB asked if the issue was with the process and not fundamentally around the make-up of the Care Groups. HM replied that there was a lack of consistency with Care Group reports dependent on who writes them, and this was the same with OAMS. She believed that representatives of each Care Group should attend a meeting of this Committee to get a articulate their concerns and give assurance MT agreed and advised that this was in hand.

JT advised that a lot of conversations were ongoing at the moment concerning the issues highlighted. He agreed that there needed to be a consistent process and channels for which issues were routed to where. There are plans to change how issues are managed. These will come to the Committee once agreed.

Action 13: On agenda
Action 14: On agenda
Action 15: Need to reschedule. SH/MT to discuss outside of meeting.
Action 16: MT advised that he will speak with JT outside of the meeting and bring back.
Action 17: On agenda
Actions 23, 32, 33, 34, 35: Closed

Action: CJ to send CG escalation reports to SH to determine which issues should come to the Committee.

22-22/23 Escalated Items

There were no escalations raised.

23-22/23 Ockenden Update

SG and Sarah Gallagher provided an overview of the report.

HM commented that reporting needed to change. There needed to be more detail attached to the reporting to reflect issues at ward level. SG and Sarah were working on this. LB added that there was a lot going on in maternity at the moment and a lot of concern that the Committee and the Board needed to be aware of. A lot of leadership churn has been ongoing for most of this year and the leadership currently in post was fairly new to the Trust and others are due to start soon. The feeling was that once the leadership has been

embedded then things should improve. The Committee should work out how to monitor this and have timescales because CQC will be visiting the Trust again in the near future. SG added that it was difficult to get into the metrics at the moment due to staffing issues because she is very much operational at the moment. Ensuring staffing is safe remains a daily challenge which currently is being managed and mitigated safely.

CJ referred to the unit closures and wanted to know the impact of that on patients and were there any mitigations going forward. An external advisor has been commissioned to work with the Trust on key issues. Work is ongoing around governance and the flow of information through the Care Groups ready for the CQC visit.

JM commented that there was a need to escalate this to the Board so it gets on the red risk register. LB commented that the idea of Clinical Directors coming to the meetings was good and Ben Adekanmi should be the first to attend. There were so many elements of it that the Committee needed to hear his thoughts. SH suggested that, from the report submitted, the Committee was not able to identify much assurance. JM agreed. HM suggested revising the report to identify what assurance can be given and where there were gaps and what is being done to mitigate those issues. These can then be escalated to Board.

SG commented that because of the staffing issues in the midwifery senior leadership team it was hard to understand what metrics were needed and finding the staff that could put it together. All the information that was needed to bring the assurance is not there at the moment. LB asked SG what the metrics would look like to ascertain whether the new leadership team was making an impact going forward.

Action: Invite Ben Adekanmi to the next Committee meeting.

Action: HM/JT to discuss which maternity issues to escalate to September Board.

24-22/23 Nurse Staffing Report

EG provided an overview of the report and suggested that this now went to the People & Culture Committee and she provide another report to this Committee showing assurance and escalation. LB advised that this was discussed at the recent People & Culture Committee and it was suggested that this Committee concentrated on risks around staffing and the People and Workforce Committee concentrate on the numbers. A discussion took place around feedback being given to other Committees to ensure alignment with each other. The Committee agreed there should be a distinction in information given to each Committee.

25-22/23 Infection, Prevention & Control Report

SH referred to page 8 of the Trust Priorities Report showing a couple of IPC markers and the Trust being in the 15th percentile for C.Diff infections. Was that 15th percentile for this month alone? EG replied that these figures come out quarterly and is an accumulation of the year.

SH asked about the spike in MSSAs. EG replied that a lot of these are related to line care and a task & finish group has been set up to deal with this. The improvement plan went to the Executive Committee last week for approval.

SH asked about the MRSA reported. EG replied that there was an ongoing investigation into this. The result should be reported this week and she will see if any learning was needed from that.

LB referred to the environment walk rounds not taking place due to lack of engagement and asked what was being done about this. EG replied that an SOP was in place and the walk rounds have been reinstated. Members of the LLP/IPC/Matrons need to be there, and recent ones have had to be cancelled due to lack of attendance.

JM asked if the Committee could see the NHSE/I reports for York and Scarborough when available. EG agreed she would send them.

SH said he still had a concern around IPC and staff not prioritising environment walk rounds and this comes out in the figures which continue to look poor. HM replied that the Trust was unable to recruit anybody to the full-time post. In the interim, she is in discussions with NHSE/I to support the Trust with this. MT added that this should come up through Care Group reporting if this was an issue. SH commented that it should be a Trust priority in order to give it traction. JT agreed and added that engagement had been patchy but was improving. It was regularly discussed at the Executive Committee meetings in order to improve engagement.

HM commented that one issue which should be escalated was around the environment. Tara Filby was producing a paper on the refurbishment of clinical environments and the lack of progress. She was waiting on some information from the YTHFM. JM added that the lack of a decant facility kept coming up and a discussion took place at Board a while back to use one of the mobile wards. She asked if that had progressed. HM replied that Andy Bertram had looked into it and the cost prohibited it moving forward. The lack of decant space at Scarborough is a recognised risk for the trust

JT advised that the PIR process had been simplified to make it easier for colleagues to attend. EG added that they know what the themes were and was a matter of working on them. It was a matter of going back to basics.

Action: EG to send NHSE/I reports for York and Scarborough to members of the Committee when available. (attached)

26-22/23 Serious Incidents Report (Including Never Events)

JT provided a summary of the report as follows: -

- 12 clinical SI investigations concluded in Quarter 1.
- 103 completed Clinical SI's analysed within the report
- No new themes emerged regarding Nutrition and Hydration
- Deteriorating Patient improvement work pace is slow without additional resource, which was not considered when escalated to July Executive Committee.
- Recent audits within Main Theatres highlight compliance with safety checks, these are reported to the LocSSIP Improvement Group.
- SIs by location - 64 York Hospital, 34 Scarborough Hospital, 5 Bridlington Hospital.
- SIs by Care Group – Wards 1,2 & 5 had the most, followed by the clinical departments, E&D and Obstetrics.

He then went on to explain the SI themes in more detail in the departments.

JM referred to the management of deteriorating patients and noted the options proposed to the Executive Committee in July but were not considered. JT replied that funding had already been allocated prior to the business case being submitted so there was no money for the project. Care Group 3 was revising the business case to secure funding for additional staff to progress the management of deteriorating patients' agenda. SH added that as well as additional staffing, the digitalisation of documentation and support with training will help.

LB referred to the theatre-based SIs and noticed there was a disproportionate number at Bridlington Hospital but no assurance on the Bridlington side. CJ replied that this has been investigated and no themes were highlighted. JT commented that he understood the figure included the Scarborough site as well.

27-22/23 CQC Compliance Update Report

SM gave an overview of the report and highlighted the following: -

- The Trust has two Section 31 conditions and four Section 29A warnings associated with registration for regulated activity.
- Appendix A provides a high-level summary of action plan performance utilising the InPhase Quality Oversight platform. This pertains to the most recent CQC inspection and is accurate as of 7th September.
- 13actions are overdue for delivery; each action has been assessed and determined to have minimal risk associated with the delayed delivery.
- Polly McMeekin is picking up the risks associated with whistleblowing.
- 2 whistleblowing concerns have been raised following the last report. Nothing has been reported for the past 4 to 5 weeks.

SM then gave an overview of assurance, metrics, good practice, and improvements highlighted in the report. He advised that the implementation of Nucleus was already having an impact. Risks were around the mental capacity assessments and they will be next on the list for digitalisation with a work timescale from mid-October. He referred to the Well Led recommendation and advised that a commissioning process was ongoing to secure an external organisation to carry out the review.

HM informed that Nucleus had been rolled out in 12 areas. It will be fully rolled out in York by the end of next week. It had started to be rolled out in Scarborough and will continue throughout October. They have already seen fantastic audit results and have shared this with the CQC. The repeated relatives/patients experience audit results were also positive. With regard to the System Support meeting, there were some actions coming out from that to look at ensuring some traction from the local authority with support for patients with no right to reside to move to their new place of residence

CJ commented that the CQC will be doing inspections in Maternity and they are prioritising organisations who have not had their Maternity services recently inspected. The Trust will be preparing for an inspection.

HM was confident that the Trust can show real improvement when the CQC return.

SH commented that when he read the CQC report there was more reassurance than assurance. We seemed to be missing quite a lot of targets. The audits were missing. SM agreed and replied that there were a lot of indicators that needed improving but the Trust can demonstrate to the CQC that it was improving from a safety perspective and will continue to improve.

SH asked what the top 3 improvements were that the Trust could evidence. SM replied that the top 3 improvements would be:

- The implementation of Nucleus on Ward 34 where many of their red indicators have now changed to green due to improvement in compliance.
- The audit tracking where now so much has been captured and the Trust can evidence that.

- Improvement plans and what has been achieved.

LB concerned about the story the staff will tell when the CQC return. SM replied that the CQC will still hear about the staffing challenges, but they can demonstrate some of those key improvements and staff actually feel the improvements from them. Staff morale and staff welfare needs a more focussed attention.

HM commented that 34 PSOs have been recruited which will support the medical wards with pastoral support, and an additional 70 HCAs. Not all will be in post if the CQC return imminently but hopefully all will be in post within a month. However, staff sickness and attrition would need to be managed. CJ added that the Improvement Academy was also supporting staff with training, support, etc.

28-22/23 Quality and Patient Safety Assurance Reports

All areas covered within the agenda discussions therefore nothing further to note.

29-22/23 Quality and Safety Assurance Metrics (TPR)

All areas covered within the agenda discussions therefore nothing further to note.

30-22/23 Clinical Policies Update

SM gave an overview of the report and highlighted the following: -

- 13 Clinical Policies overdue
- 335 Patient Information leaflets overdue

A large chunk of these can be fairly quickly resolved but cannot due to staff time constraints.

SH asked if this was because authors were giving themselves targets that were unnecessarily stringent. SM replied that the date was decided by the author and a 3-year review period was agreed instead of a 6-12-month period.

JM asked if information could be reviewed once an SI occurred or there was a change in legislation. SM agreed that this should happen but was not. The new intranet will be arriving soon in October and a piece of work was ongoing to research what needed to go on there. A system will also need to be put in place where each specialty will know what documents they have and which needed to be reviewed.

31-22/23 Clinical Effectiveness Report

SM gave an overview of the Q1 report. No further questions were asked.

32-22/23 Issues to escalate to the Board and/or other Committees

- Concerns remain regarding some aspects of maternity services and work to achieve Ockenden standards and metrics to provide safety assurance.

- C.diff infections continue to run at high levels. Recent spike in MSSA infections and an MRSA infection raise concerns about iv line management.

33-22/23 Issues to escalate for BAF and CRR

No issues for escalation were noted.

34-22/23 Any Other Business

No other business raised.

35-22/23 Date and time of next meeting

The next meeting will be held on 18 October 2022, 14.00 – 16.00

Minutes

Digital, Performance & Finance Assurance Committee
20 September 2022

19-22/23 / Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (AB), Melanie Liley (ML), Denise McConnell (DM), Mike Taylor (MT), Lynette Smith (LS), Jim Dillon (JD), James Hawkins (JH), Penny Gilyard (PG), Malcolm Veigas (MV), Gary Hardcastle (GH), Rhiannon Heraty (RH) (minute taker)

LM welcomed James Hawkins and Gary Hardcastle to the meeting.

20-22/23 / Apologies for Absence: N/A

21-22/23 / Minutes of the meeting held on 19 July

The minutes of the last meeting held on 19 July were agreed as a correct record.

22-22/23 / Matters arising from the minutes

Action 18 – DM said an agreement has not been reached yet, noting that that it is difficult to determine what is material given that the issue is more around staff morale, and that she would speak to Alan Downey (Chair) later today. It was agreed DM would provide Rhiannon with rephrasing of the action.

Action 19 – ML confirmed that YAS will now be providing the same service as CIPHER but across both sites. This is through funding as part of their workforce plan and is at no additional cost to the Trust. ML said this should help to improve ambulance handover times.

Action 20 – JH said he wanted to run further diligence checks to ensure everything is in place but assured the Committee that we have fully adhered to the national deadline and policy. Action extended to October.

Action 22 – the documented analysis is still being finalised by the Intelligence Team, but the action was closed.

Action 24 – LM requested more detail on social media strategy. JH said that Facebook is currently blocked on corporate devices whereas Twitter is not. Given that we may soon rely more on Facebook for communications strategy and staff engagement, we are looking at removing the block but not until risk is reduced elsewhere. Action agreed closed.

Action 28 – LM and JH to have discussion outside of meeting re LLP involvement in cyber desktop exercise. Action still outstanding and JH to provide new timescale for conducting the exercise.

Action 37 – AB and PG to agree new deadline to come back with lessons learned.

Action 40 – this was transferred from Quality Assurance Committee around de-prioritisation of schemes and any associated risk. JH agreed to pick this up and report back in October. AB added that it would be helpful as part of the review work to look at whether projects that are not on the list are scored on care group risk registers, and if triggered as a risk at corporate level whether it has been appropriately escalated. JH to look at this with Care Group Directors.

GH gave an overview of data insight and Statistical Process Control (SPC) originating from the NHSE 'Making Data Count' scheme, which encourages use at Board level. SPC can show whether a system can deliver a certain standard/target through variation and assurance and the Committee noted that it should only be used when there is a minimum of 17 data points. JH asked how targets are collectively set and LS confirmed that performance metrics are set through our operational plan. The benefits of SPC were discussed including how we are performing against national targets.

23-22/23 / Escalated Items

There were no escalated items to discuss.

24-22/23 / Operational Performance Update (to incl. performance indicators)

ML highlighted the following key points:

Gemma Ellison has returned from maternity leave into a secondment leading on the urgent and emergency care (UEC) programme. We are seeing focused leadership on key priorities, which will be monitored through the Building Better Care (BBC) programme. Jenny Hey is also doing work around productivity, which informs the elective recovery pathway.

Analysis on the combined SDEC and frailty unit in YH shows an average of 55 patients streamed through SDEC in September 2021 compared to 121 patients this year, due to the unit moving to a 24/7 provision. There has been a 50% increase from last year for patients screened directly from ED into the EAU (emergency assessment unit). There has been a corresponding decrease in the number of percentage of patients having 0 length of stay from acute assessment wards, meaning patients are streamed through the EAU appropriately rather than being admitted. There is a slight increase in patients transferred to wards from the EAU but nothing materially significant compared to previous years.

Our Covid position remains in the mid-80s (around half of which are symptomatic) and there have been some outbreaks on both sites. There will be discussion at Executive Committee whether we need to return to our surge plan and provide dedicated Covid wards instead of utilising side rooms or specialist wards with bays. This will be monitored through the Living with Covid Working Group.

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

We have commenced our Tier 2 regime and meet fortnightly with the regional team with a significant focus on our 78-week wait position. The primary focus is accessing mutual aid and we are still struggling with upper GI, urology and complex orthopaedic patients. The regional team is looking into a national digital platform to invite doctors that retired and returned during the pandemic to run digital triage or follow-up reviews to free up our clinicians. LS was supportive of this and said there were meetings scheduled to discuss further. We are off trajectory for cancer performance, which needs to be 121 patients or less waiting over 62 days on cancer pathway by the end of March. This is being reviewed.

In terms of key escalations, FIT testing should have been rolled out, but our primary care is not currently able to implement this on the necessary scale. We have asked the regional team for support on this. Another issue is our oncology provision, which is significantly limited. This has been flagged with the regional team but there is no solution to date. We are continuing to try and secure additional capacity through the independent sector, mobiles and sending patients to other sites.

DM asked if there would be any implications for elective recovery funding (ERF) and LS said these would be significant. Our main issue is bed capacity, particularly within anaesthetics and ODP departments. AB said the risk lies mainly in the second half of the year, noting the centre's concern that if ERF was withdrawn, it would cause Trust Boards to make decisions around correcting the financial position that may adversely impact elective recovery. The message for the second half of the year is not yet clear.

There was a discussion about the bank holiday and ML said the key issue reported to NHSE was that there were 0 planned discharges from the local authority. No patients were discharged on the YH site and only 4 were discharged from SGH. We have submitted a plan around how COY and NYCC can do more to get to the expected position. A recruitment event was held specifically around HCA and PSO roles and whilst there were three expressions of interest in local authority roles, these were later withdrawn in favour of ward-based roles. A second event is planned for 11 October that COY and NYCC are invited to and there are discussions about holding a specific targeted event for Selby (with NYCC attendance) and one for SGH, although our HCA position there is not a main concern. ML said there was a feeling that the NHS brand would be easier to recruit to than the local authority. The Committee noted that from the beginning of October, we will provide an additional 4 social care beds on the YH social care unit (Ward 29) with no additional workforce implications. We are working with Nimbuscare to provide GP cover. We have asked COY to run spot purchasing in the interim period re block booking of beds in 2-3 care homes. There is a keen focus on how we can increase our ability to deliver more domiciliary care. This has been discussed at Executive Committee and work is being done to allow the Trust to enter the market and become a provider of domiciliary social care.

There was a group discussion about Board support around 1) holding to account our external stakeholders/partners/system to help the Trust with its priorities and 2) providing programme resource to move forward the priorities. The Committee noted the importance of retention and said this should be included in the recruitment programme as part of the Workforce Committee. ML added that patient administration is a significant concern as we do not have the specific expertise or capacity to do this, but it needs to be done as an enabler to the new EPR. AB said that a debate may be useful to discuss how to appropriately apply pressure to the local authority and ICS. AB added that Board support is required to decide where funding comes from for investment decisions.

Ophthalmology remains one of the most high-risk specialties from a clinical perspective with the non-admitted position as our main focus. It had the highest proportion of patients with a follow-up more than a year overdue, many of which were glaucoma patients unable to identify deterioration. This is a known focus of the Quality Assurance Committee. To date there were 731 patients more than 2 years due a follow-up, c.300 of which were red patients (at risk of severe harm). We are now down to 8 high-risk patients overdue a follow-up.

LS said we are expecting 0 104-week waiters in September and there are no new BAF-related risks that the Committee is not already aware of.

Action: JH to review IT development linked to essential services assessment in light of Medinet software being stood down and update at next Committee

25-22/23 / Finance Update (to incl. performance indicators)

We are currently showing an actual I&E deficit of £3.2m against a planned £0.3m deficit, leaving us £2.9m over plan. This has doubled since last month. Our position is similar to other providers with the main overspend being on pay. Work is being done on recruitment and retention work by the Workforce Committee to tackle this. Whilst we are relatively consistent with our pay overspend and shortfall in proportionate delivery of our efficiency programme, our position is starting to attract attention. The expectation is that this improve as we move forward, which will be challenging. The current message is that staff should avoid making any staffing decisions that compromise safety but that non-pay decisions around expenditure can be made as long as elective recovery and/or safety of services is not compromised.

We are currently overspending against the Covid planned programme by £1.1m. This is a reasonably optimistic position, forecasting at £1m over in month 5. LM asked if the surge plan is factored into the forecast and AB said it was not. There is a clear expectation that the spend reduces and continues to do so throughout the year and the Committee noted that there is a 'break glass' clause in the national plan in the event of a national surge. If this were to increase it would be considered a risk. ML said that flu is also expected to be a significant pressure this year, and if we must surge back into both a Covid ward and a flu ward, the impact on elective recovery would be considerable.

GIRFT is being moved across into the BBC programme as it is a big part of the elective recovery programme.

There are no current concerns around cash or capital. AB said we know we do not have enough capital to deal with our estate issues, but we are progressing closely enough alongside the plan.

AB referred to the income and expenditure forecast on P22 and confirmed that the likely case scenario has formed the basis of our forecast submission to NHSE/ICB for month 5. AB said we should not take drastic action yet but must ensure we have a source of funding around investments. The two most significant points are 1) recruitment and retention work (the Committee noted an overspend on agency staff by c.£900k in August alone) and 2) delivery of our efficiency programme. Modelling assumptions have been made around the actual impact that CIP will have on the run rate spend and we are assuming only a c.36% impact based on past trends.

DM asked about the adverse variant on pay and whether this will be pulled back for the remainder of the financial year. AB said he still expected September to be a high-pressure month but that all predictions and trends suggest that we should start to see improvement from October onwards.

DM asked about our drugs position, noting a £7m increase between the original and final budget. AB noted that the narrative doesn't fully explain our position. We have two types of drugs – one type that we deal with in block allocations and more expensive ones that we have cost/volume contracts for. We are compensated in income for however much we spend on the latter and do not flex the budget. If this element is removed, our position is slightly under budget and reflects the lower levels of elective activity and recovery work.

JD noted the agency spends and asked for more detail. AB said a series of productivity panel discussions are scheduled with the care groups, to be chaired by Simon Morritt (Chief Executive). The care groups will share forecasts and plans and the corporate efficiency team will share a matrix of opportunities to potentially explore. JD said it would be helpful to identify alternatives that could potentially have the biggest impact. LM said it

might be beneficial to consider GIRFT in these alternatives too re how it can help with the acute backlog.

LM asked if there any changes to risks and AB confirmed there were not. The BAF has been significantly updated to reflect the risk programme and the Committee has been made aware of the ERF risk in the second half of the year. There was a discussion about the potential impact on Supply Chain as a result of the war in Ukraine. AB gave assurance that inflation is being managed through extra contingencies put aside and said this would continue to be monitored. It is a low risk at present but one to be sighted on.

Action: AB to bring update to November meeting around productivity panel discussions and outcomes

26-22/23 / Executive Performance Assurance Meeting (EPAM) minutes

DM asked about value engineering and whether it would affect long term sustainability. AB said there was no evidence to suggest that it would. The biggest concern was clinical team engagement, which is positive, and all changes have been signed off by the project team.

DM asked about the waste cost trainer as the minutes suggested that they could save money. AB said that as a general principle we would expect a business case to identify the benefits and we do select business cases for post-implementation review if there is a particular benefit component to be delivered. MV said that the post would have a focus on relationship management. He added that there are other posts in the works including a business improvement associate that should help with capacity issues around business process re-engineering.

27-22/23 / Digital and Information Report Update (to incl. performance indicators)

JH said we are progressing EPR, but access funding is not yet confirmed and the central business case hasn't yet been signed off by NHSE yet.

The roll out of 0365 continues: there was a specific CPD printing issue that interfaces to Microsoft 2010 that has been resolved but JH said he would check this. JH said he was concerned that we are relying on Office 2010, which goes out of support in October, so the focus is on implementing O365 with support from the Communications team.

Nucleus roll-out has gone well with positive feedback. Business information and intelligence is in a good position.

LM asked if the priority programmes (outlined on P37) are still correct and queried whether LIMS should be one. JH said LIMS is a regionally led programme that we hold a contract with and that we may need a formal review of progress as we are not currently receiving assurance. JH agreed to look at these priorities. LM asked what was being done to mitigate risks and re-assess progress. AB said that Jane Clayson's analysis work was the first step, which has ensured that the right people are in the room to be discussing risk mitigation.

The Committee noted the risks flagged on clinical coding including the high turnover of staff. The Committee also noted the linkage with the previously reported UX findings e.g. lack/lag of coding in ED due to limited staff time or process compliance. LM suggested this be flagged as part of this committee's Board report including to Quality & Safety Assurance Committee given the risk to patients if data is not recorded in a timely fashion.

Action: JH to review the DIS priorities including the LIMS progress to date and consider whether a formal review is required for assurance

Action: JH to update on potential impact of the risk around EPR programme funding

Action: JH to review risks around clinical coding and update at the next meeting. Agreed this would be raised by LM as a Committee to the Board, including Q&S and Workforce

28-22/23 / Digital, Finance and Performance indicators (IBR) – where not reported above

JH said he needed time to agree a set of KPIs which are meaningful for DIS.

29-22/23 / YTHFM Update Report

PG said agreement with the management group is needed for the name change from LLP to YTHFM, which is being linked to the strategy review and aligned to the BBC action plan.

As a result of the desktop cyber exercise, training is being done around team backfill roles as well as work on switchboard resilience. Switchboard modernisation is a key risk that is being reviewed. ML asked that the business continuity plan be updated if needed.

There is £926,545.00 forecast as recurrent savings and work is ongoing to fill the gap estimated between £150-200k. Inflationary pressures are being monitored and the Committee noted the decision to delay staff parking charges. There has been a slight deterioration in KPIs, but PG gave assurance that high risk cleaning scores have improved, including those in the York theatres.

Sickness absence remains a key risk but has gone down to 9.18% compared to an average of 7.5% in 2021. This continues to be managed and monitored against national trends and through the Sickness Absence Working Group, which MV described as a welfare interaction for staff.

Key challenges are retention, recruitment and hourly rates, which are recognised as a national issue. There is cultural work ongoing including embedding of values and behaviours, and these challenges are to be aligned to the BBC programme.

Key pieces of work include involvement in ‘fix the basics’ and national cleaning standards. There is also a governance review taking place with Internal Audit, and recruitment is pending for a new YTHFM chair.

There was a discussion about culture and behaviours. LM asked for assurance on whether all the culture areas highlighted by ACAS had been addressed, and the right outcomes achieved. MV said there are coaching exercises being held with a focus on empathetic management and what that looks like. It was agreed an initial linkage with the Trust’s culture workstream would be beneficial and an action for the Board to review in more detail the progress on culture overall including linkage with YTHFM.

ML noted the downward trend of performance against overdue maintenance and said that the lack of communication is becoming a source of frustration within the care groups. AB said that there are capacity issues within the team and staff are being assigned to the larger projects, leaving the smaller ones unallocated. AB added that there have been discussions around environmental improvement and cover arrangements for minor works

with Mark Steed (MS). MV confirmed that a senior representative from MS' team now routinely attends Care Group Boards as part of an engagement piece of work around reviewing services delivered in the Master Services Agreement (MSA).

MV said that YTHFM are looking at the 'Slack' messaging system supported by O365 and LM asked MV to link in with JH to ensure both are in line around opening platforms and applications.

Action: PG/YTHFM to review and prioritise all existing minor works requests to determine what can and cannot be delivered and communicate this to the care groups. YTHFM to lead with care group representatives to prioritise all current schemes and determine what can be delivered and set a process for all future requests.

Action: LM to raise from the Committee an ask for the Board to hold a review of the Culture workstream, and include YTHFM.

30-22/23 / YTHFM Sustainable Development Quarterly Assurance Report

JM highlighted the limited resources and challenges around meeting net zero targets. YTHFM are focusing resources on areas that can get funding, such as the public sector decarbonisation scheme.

This item was deferred to October to allow a more comprehensive discussion.

Action: JM to provide a Salix grant update at the October meeting

31-22/23 / Information Governance Executive Group (IGEG) minutes

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

32-22/23 / Consideration of items to be escalated to the Board and/or other Committees

LM confirmed that these would be included within the Chair's brief for Board of Directors.

33-22/23 / Any other business

PG said a meeting with JH would be helpful to discuss the YTHFM IT strategy and direction of travel.

There was no further business to discuss.

34-22/23 / Time and Date of next meeting

The next meeting will be held on 18 October from 9am-11am.

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	Quality Assurance Committee and Resources Assurance Committee Annual Report 2021/22
Director Sponsor:	Alan Downey, Trust Chair
Author:	Mike Taylor, Associate Director of Corporate Governance

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 and Safety ☒ Elective Recovery ☒ Acute Flow	☒ Quality Standards ☒ Workforce ☒ Safety Standards ☒ Financial ☒ Performance Targets ☒ DIS Service Standards ☒ Integrated Care System

Summary of Report and Key Points to highlight:
To receive the Quality Assurance Committee and Resources Assurance Committee annual reports for 2021/22.

Specifically, to note and discuss:
In line with best practice it is recommended that the Board Sub-Committees prepare annual reports to the Board of Directors and Council of Governors that sets out how the Committee has discharged its responsibilities and met its Terms of Reference. The attached report summarises the Quality and Resources Assurance Committee's work during the year 2021/22.

Recommendation:

The Board of Directors are asked to note as approval of the Committee's annual reports.

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

Meeting	Date	Outcome/Recommendation

Quality Assurance Committee Annual Report 2021/22

Introduction

This report has been prepared to provide the Council of Governors and the Board of Directors with a summary of the work of the Quality Assurance Committee during the period April 2021 – June 2022, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

This period has been reviewed beyond the regular 12 month process due to the Committee being amended in its terms of reference commencing July 2022.

Overview of the April 2021 – June 2022 period

Non-executive Directors make up the membership of the Quality Assurance Committee as follows:

- Mr Steven Holmberg (SH) Chair
- Dr Lorraine Boyd (LB) Chair
- Mrs Jenny McAleese (JMc)

The Quality Committee met on 14 occasions over the reporting period and all meetings were quorate.

Key officers attended the meeting to provide assurance to the Committee, including: -

- Chief Nurse
- Medical Director
- Chief Operating Officer (including Interim)
- Deputy Director of Planning and Performance
- Deputy Director for Patient Safety
- Foundation Trust Secretary/Associate Director of Corporate Governance

The Committee received secretarial and administrative support from the Chair and Chief Executive's office administration team. There was a documented work programme which scheduled the key tasks to be undertaken by the Committee over the period. Detailed minutes were taken of all Quality Committee meetings and were reported to the Board of Directors. The Chair also provided an escalated items log of those matters that the Quality Committee considered should be drawn to the attention of the Board.

2021/22 continued with the Covid-19 pandemic which saw the board and assurance Committee governance arrangements change following guidance from NHSE/I in March 2020 to support Trusts to free up management capacity and resources. In response the Quality Committee continued to meet monthly on a virtual basis.

The Chair of the Quality Committee also attended the Group Audit Committee over the reporting period.

Duties of the Committee

Following a review of the Committee's Terms of Reference, the key duties of the Quality Committee were as follows:

- To gain assurance and provide challenge about the actions being taken to ensure the Trust has appropriate systems in place to maintain compliance with achievement of the required quality and safety standards, performance improvement and transformational quality improvement.

- To work in conjunction with the other Board Committees sharing information and agreeing the location for the discussion of certain topics.

- To regularly review the Corporate Risk Register and the Board Assurance Framework to gain assurance about the risks and mitigations around quality and safety, performance improvement and transformational quality improvement.

- To escalate any areas of concern identified to the Board of Directors for further discussion and resolution. Issues will on occasions be discussed in private by the Board of Directors on the advice of the Committee.

- The Committee will escalate items to the Board of Directors following each meeting and will submit minutes from its meetings to the Board of Directors for information.

- To agree the Trust's quality priorities and receive the draft Quality Report and provide comment on the draft report.

Work of the Committee

1. Routine Reports

The Committee received and reviewed a number of annual, bi-annual and quarterly reports including:

Annual:

- National In-patient Survey
- National ED Patient Survey – every other year
- Annual Report of DIPC
- Annual End of Life Care Report
- Annual Report on Safeguarding (Child and Adult)
- Annual Report in Information Governance
- Mental Health Activity Report

Bi-Annual:

- Maternity Report
- Serious Incident Themes Review

Quarterly:

- Falls Report
- Pressure Ulcers Report
- Mortality Report
- Patient Experience Report
- IPC Report

- Out of Hospital Care Report
- Minutes of Patient Safety Group
- Minutes of Clinical Effectiveness Group
- Perinatal Mortality Review Tool Report

Monthly:

- Performance Report
- Medical Director Report
- Corporate Risk Register and BAF
- Nurse Staffing Report
- Information dashboard on Patient Safety and Quality
- Infection Prevention & Control Updates
- Ockenden Compliance
- CQC Action Plan and Monitoring

2. Themes and focus for the Committee over the reporting period

Over the reporting period a number of specific issues were identified within the scope of the Committee and some themes were identified. Lengthy discussions took place, encompassing key current risks around Infection Prevention and challenges of maintaining safe levels of nurse staffing.

The performance challenges were also discussed in this context and potential solutions and their wider impacts debated. In the face of these challenges maintaining Patient Safety remained paramount.

The Committee was assured by the contributions from all the Executive Directors and their teams to debate and evaluate the options. This enabled us to identify that, as these issues came together, our concerns were increasingly not just discussed in terms of quality and performance, but also the risk to safety. The need to more clearly capture and respond to potential harms was acknowledged along with the importance of linking, where appropriate, to the wider Trust challenges and the system financial challenges. This information would be invaluable as the Trust prioritises use of resources to ensure continued delivery of a safe service.

Key areas of discussion have included the following:-

Covid-19 Pandemic

It is clear that the past year has been a most extraordinary and difficult one for the NHS, its staff and its patients and has, of course, been impacted by the Covid-19 – a pandemic with consequences that will certainly have repercussions for many years in terms of direct illness and mortality but also mental health, missed diagnoses of early cancer and other important conditions and extended waits for investigation and treatment.

The Committee has subsequently overseen the return of demand to post pandemic levels during a time particularly on the York site of acute care capacity issues with the building of the new Emergency Care Department and Trust staffing issues.

CQC

The Trust began the year having several pieces of regulatory action in place from the CQC such as mental health care in the Trust Emergency Departments and the lack of a Paediatric Emergency Medicine (PEM) consultant at the Scarborough site. The Committee received assurance during the reporting period that the latter had been resolved. The Committee regularly received updates and assurance on the work to remedy the concerns underpinning the remaining regulatory action.

Over the year, the focus of the Committee moved more to considering wider improvement actions that would impact on the Trust's CQC ratings at a future inspection. A self-assessment against current CQC standards, suggested that the Trust would receive an overall rating of Requires Improvement and was very helpful in directing workstreams to remedying gaps in governance and other standards.

At the start of 2022/23 the Committee received reports on the unannounced CQC visit following staffing level whistleblowing concerns and sought assurance on the action plans put in place. CQC are expected to return to the Trust in the autumn of 2022.

Infection Prevention and Control

There has through the reporting period been a focus on IPC and the reducing of MRSA and C.Diff rates which has in part been due to the aging estate issues and the significant funding issues to maintain or replace this in the future. The lack of funding for infrastructure improvements with only some remedial work and ongoing operational capacity were areas of concern and the estate inability to isolate patients effectively. Significant mitigations have been reported to manage surgical site infections for example in the closing of a maternity theatre at York and the Committee has been assured of the mitigations put in place.

Separately there has been challenge to ensure that Care Group's clinicians have IPC as a significant priority and update from the Chief Nurse have provided some assurance. Compliance with mandatory training in this area has also been challenged alongside other staffing statutory and mandatory training requirements.

Staffing

The Committee has reviewed information from a number of sources including CQC inspections, Staff and Patient surveys and data from the IBR that has raised concerns about staffing levels in clinical areas.

The Committee received concerns over the levels of staffing exacerbated by the Covid-19 pandemic sickness levels and the subsequent redeployments of staff with knock-on effects on quality and safety of patient care. The Committee is aware from the Chief Nurse reports that staffing shortfalls exist, has been encouraged by a more detailed review to understand nursing staffing and subsequent plans to address across the whole Trust. Beyond nursing and medical staffing, the Committee has been advised that problems in relation to some diagnostic procedures, especially ultrasound, relate in part to staff shortages. The Committee, however, received assurance that there were plans both to clinically risk assess patients waiting and to develop innovative ways to mitigate staff shortages.

Ockenden Report

The Committee has received throughout the reporting period regular reports on the Trust's compliance with the Maternity Ockenden standards. Standards of care in maternity units have been of concern across the NHS arising from a number of highly critical reports from under-performing units.

Dr Lorraine Boyd as the Trust Board's Maternity Champion in working with the Trust's service on progress to the Ockenden report's compliance has provided assurance to the Committee on the Trust's progress to improving standards. Perinatal Clinical Quality Surveillance and Continuity of Carer reports have been received at each meeting, with the latter's required compliance towards the end of the year being eased nationally in acknowledging staffing levels.

Operations

With continued pressure on hospital services the Committee has continually received reports on the Trust's inability to meet performance targets. Concerns have been received on for example admissions with delays from ambulance handovers through to delayed transfers of care with the focus reported to the Committee on handover times and actions to minimise delays. Subsequent patient harms have been reported to the Committee on the evidence of patient harm such as falls. The large numbers of delayed discharges have put significant pressure on ward capacity with staffing levels having necessitated bed closures on some occasions.

It has been acknowledged that it is imperative for sufficient staffing levels to ensure timely triage at all times linked to the staffing levels reports. Access times for non-emergency care have been reported to the Committee causing concern as a result of staffing issues.

Other Issues

Beyond these areas of focus, the Committee has continued to monitor and receive assurance across a wide range of issues relating to safety, quality and performance.

Serious Incidents including maternity serious incidents have been reviewed at each meeting to facilitate Trust-wide learning from events in identifying themes and trends subsequently escalated to Board when required.

As a result of the Board of Directors focus on 4 priorities during 2022/23; Our People, Quality & Safety, Elective Recovery and Acute Flow and a subsequent aligned Board of Directors Committee structure, operational performance (Elective Recovery/Acute Flow) has been moved from the Quality Assurance Committee to the Digital, Performance and Finance Committee. The Quality & Safety priority is now assured through the Quality and Safety Assurance Committee as from July 2022 and has been revised in its terms of reference.

Conclusion

During the reporting period the Quality Assurance Committee has sought and gained assurance across the Board Assurance Framework, with a main focus on the following BAF risks:

- PR1 - Unable to deliver treatment and care to the required standard
- PR2 - Access to patient diagnostic and treatment is delayed
- PR 3 - Failure to deliver constitutional/regulatory performance and waiting time targets

Our work has encompassed patient safety, patient experience, clinical effectiveness and performance, seeking to understand how we are maximising the use of our available resources to minimise patient harms and maintain best possible patient experience.

Quality improvement is an important driver of the work of the Trust and key to this is the encouragement of learning and sharing when things have gone well and not so well and collaborating with and learning from partners and external sources.

There have been some significant performance challenges in this past year and, it has been important to recognise and follow the progress of the intensive and far reaching transformation work streams being undertaken to improve the situation.

The Coronavirus 19 pandemic has continued to influence the work of the Trust alongside the significant pressures on the emergency department and staffing levels through the Trust. In this context the newly named Quality & Safety Assurance Committee will continue to seek assurance that patient safety and experience remains a constant guiding principal as we deal with the challenges of delivering services fully to pre-pandemic levels.

I would like to thank the members of the Committee and their teams and the Board of Directors for their support during the reporting period.

I would also like to thank the Care Groups for their contributions and look forward to continuing to develop strong Ward to Board assurance in the coming year.

Stephen Holmberg, Chair of the Quality Committee
June 2022

Appendix 1 - Quality Committee Attendance

	Meeting Dates														
	Apr 2021	**May 2021**	**Jun 2021**	**July 2021**	**Aug 2021**	**Sept 2021**	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**	**Apr 2022**	**May 2022**	**June 2022**
Steve Holmberg	✓	✓	✓	✓	N/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lorraine Boyd	✓	✓	✓	✓	N/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny McAleese	✓	✓	✓	✓	N/a	✓	✓	✓	✓	✓	✓	✓	✓	Apol	✓

Resources Assurance Committee Annual Report 2021/22

Introduction

This report has been prepared to provide the Council of Governors and the Board of Directors with a summary of the work of the Resources Assurance Committee during the period April 2021 – June 2022, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

This period has been reviewed beyond the regular 12 month process due to the Committee responsibilities being reviewed as part of the corporate governance review of the Trust.

Overview of the April 2021 – June 2022 period

Non-executive Directors made up the membership of the Quality Assurance Committee as follows:

- David Watson (Chair April 2021-May 2021
- Lynne Mellor (Chair June 2021-June 2022)
- Jim Dillon
- Denise McConnell

The Resources Assurance Committee met on 14 occasions over the reporting period and all meetings were quorate.

Key officers attended the meeting to provide assurance to the Committee, including: -

- Finance Director
- Director of Workforce & Organisational Development
- Chief Digital Information Officer
- LLP Managing Director (LLP items only)
- Foundation Trust Secretary/Associate Director of Corporate Governance

The Committee received secretarial and administrative support from the Chair and Chief Executive's office administration team. There was a documented work programme which scheduled the key tasks to be undertaken by the Committee over the period. Detailed minutes were taken of all Resources Assurance Committee meetings and were reported to the Board of Directors. The Chair also provided an escalated items log of those matters that the Resources Assurance Committee considered should be drawn to the attention of the Board.

2021/22 continued with the Covid-19 pandemic which saw the Board and assurance Committee governance arrangements change following guidance from NHSE/I in March 2020 to support Trusts to free up management capacity and resources. In response the Resources Assurance Committee continued to meet monthly on a virtual basis where this was required over the reporting period.

Duties of the Committee

Following a review of the Committee's Terms of Reference, the key duties of the Quality Committee were as follows:

- On behalf of the Board of Directors, give detailed consideration to the Trust's workforce, finance, digital and LLP issues and, in turn, provide assurance that the Trust has in place the necessary controls to manage its risk exposure in these areas and, where this may not be the case, to make recommendations for action. In doing so, the Committee will review in detail and propose action on the Trust's strategic and operational plans for the following:

    - revenue, capital and working capital including the Trust's sustainability plan and associated governance processes
    - workforce and organisational development
    - digital strategy
    - the LLP
    - Research and Development
    - Transformation
    - Sustainability

- To review performance indicators relevant to the remit of the Committee
- Review the associated risks contained within the Board Assurance Framework and on the Corporate Risk Register
- Work in conjunction with the other Board Committees sharing information and agreeing the location for further discussion of certain topics.
- To examine any other matter referred to the Committee by the Board of Directors.

Work of the Committee

3. Routine Reports

The Committee received and reviewed a number of annual, bi-annual and quarterly reports including:

Workforce

- Integrated Business Report (Workforce and OD performance indicators)
- Staff Survey
- Occupational Health Annual Report
- Research and Development Strategy and Annual Report
- Library Annual Report
- Equality, Diversity and Inclusion Annual Report
- WRES and WDES standards Annual Report
- Gender Pay Gap
- People Strategy

Finance:

- Integrated Business Report (Finance performance Indicators)
- Internal Audit Progress report
- Efficiency Report
- GIRFT
- Capital Plan
- Operational Plan

Digital:

- Digital and Information Report Update
- SIRO Annual Report
- Information Governance Executive Group Minutes
- Digital Strategy

LLP:

- EPAM minutes
- LLP Quarterly Update Report
- Strategic Plan Update
- Sustainability Annual Report

4. Themes and focus for the Committee over the reporting period

The following provides a summary of the key committee activities during the past 12 months, seeking assurance where risks and issues were identified and providing support as required.

Workforce

The Gender Pay Gap report was reviewed by the Committee at its April meeting, the action plan being overseen by the Executive Committee with an update on this overseen by the Resources Committee in October to include the agile and flexible working policy as part of the People Plan. This was supported in helping the gender pay gap issue and the NHS People Plan alongside this was subsequently overseen by the Committee in May to deliver the action plan returned to progress at the September meeting to include the development of the values and behaviours implementation action plan.

The Workforce Race Equality Standard and (WRES) and Workforce Disability Equality Standard (WDES) report was overseen at the September meeting where discussions were held on the concerns around bullying, harassment and discriminatory issues from the report and the subsequent communications plan linked to the values and behaviours framework brought to the Board of Directors.

The Committee also oversaw the Equality, Diversity and Inclusion report noting the work in progress, the Annual Occupational Health report, the Research and Development Updates and scrutiny of the workforce aspects of the Integrated Board Report (IBR) through the year.

Finance

The Budget and Operational Plan at the outset of the year was reported to the Committee with the focus in compliance with the national guidance to return the Trist to pre-pandemic activity (2019/20) levels enabling the Elective Recovery Fund to be accessed. The Financial Plan for the year-ahead was reported including the Covid funding all provided by a fixed allocation. The plan was endorsed and recommended for approval to the Board. The previous year financial end position was overseen and accepted by the Committee including the lessons learned from the specific Covid funding allocation.

The Income and Expenditure of the Trust has been reported through the IBR and overseen by the Committee on a monthly basis. The capital programme was overseen by the Committee with scrutiny of the 2022/23 capital programme including the Committee receiving assurance on the reduction of the proposed overspend on the York ED scheme. The final capital programme was approved subsequently by the Board of Directors.

Finally the Committee had reported the 6 month Post Implementation Review (PIR) in the involvement and participation in York Community Stadium where the PIR process was discussed to gain assurance that the Trust was being successful in future investments.

Digital

The Digital Information Services (DIS) have provided updates including on funding to further the digital strategy in the context of the Trust's financial plan in also reviewed at the Committee, the links between DIS and the Trust's transformation programme and that of the wider Integrated Care System (ICS) digital strategy. Further updates focused on the committee gaining assurance of clearer DIS priorities, the road map of planned developments and the staffing issues concerning recurrent funding and the availability of specific CPD programing skillset.

The Committee requested further funding following a DIS benchmarking activity to be sought externally. The Committee welcomed the news that the Trust was successful in gaining extra funding, particularly for much needed network/infrastructure delivery as part of the Essential Services Programme. This was the highest amount of funding the Trust had received to date on Digital. The subsequent development of the Essential Services Programme was reported to the Committee throughout the year on current status, future plans, aspirations and the core programmes delivery for the year. The subsequent plan over the year mitigates the majority of risks challenged by the Committee with it overseeing key projects such as the CPD infrastructure, storage, cloud assessment and platform build and virtual desktop infrastructure.

As a significant risk to the organisation assurance over mitigations of cyber-attacks were reported to the Committee such as a Trust cyber incident desktop exercise including subsequent actions on education of staff and investigation of any near misses. The Committee subsequently challenged on delivery implementation plans with the Committee receiving monthly updates in the DIS update report.

The Information Governance Strategy for 2021-23 was presented with the Committee contributing for further assurance on the milestones of the strategy, how success will be measured, the sharing of data and its flow being monitored including its anonymisation and pseudonymisation. The SIRO Annual report was also presented where weaknesses were identified in subsequently assurance sought from the Committee.

Finally, demonstrations were provided of Core Patient Database (CPD) interoperability; GP Connect, Ambulance Transfer of Care, request for Expert Input and elective Palliative Care Coordination Services, and the electronic nursing documentation which was agreed as a great success in time saving, data security, staff and patient experience.

York Teaching Hospital Facilities Management (Local Liability Partnership - LLP)

The LLP manages the estates and facilities for the Trust including catering, domestic services, waste management, linen and laundry, car parking, grounds maintenance, security, medical device management, pest control, portering, energy and switchboard.

Throughout the year the Committee has received assurance of the Executive Performance Assurance Meeting (EPAM) minutes as the formal mechanism for the Trust managing the performance and delivery of partnering services of YTHFM LLP against the Business Plan and Estates Strategic Plan. These minutes have been received at every Committee meeting.

Quarterly reports of the LLP have been received by the Committee which have a series of Key Performance Indicators (KPI) for the 16 service specifications as part of the Master Services Agreement. The Committee challenged the performance and make-up of these indicators. This resulted in a more focused report, with a focused set of KPIs; enabling a more robust picture of performance assurance to the Committee, including the annual review of YTHFM's performance against the KPIs contained within the Service Level Agreements.

The Committee has also reviewed the New Start Programme (NSP), as the LLP's new 'People' dedicated plan that will support the establishment of a renewed employee focused culture within YTHFM with challenge on what barriers prevent progress of the work streams and the impact overall on KPIs. The Committee subsequently requested an interim report on progress at a later meeting where the cost/benefit analysis was described further. Updates were subsequently provided in the LLP quarterly update report.

Further challenge has been provided from the quarterly reports on prioritised backlog maintenance and the significant risks that this created with the overall plan commented that it could have benefitted from being risk rated. The Committee gained assurance that the estate-related backlog maintenance review process had been thorough, comprehensive and in accordance with NHS Guidance.

The Committee have also championed the work of the sustainability development group and reviewed the Annual Report of the Sustainable Development Group - Green Plan 2021-2026. The Committee provided comment for improvement including highlighting that patients and visitor travel accounted for the largest portion of the Carbon Footprint and on this basis the committee recommended that patients as well as visitors, partners and key stakeholders be considered as an inclusion into the revised plan's statement.

Specifically on staff of YTHFM the Committee received Covid Vaccination updates for assurance on the staff take up and plans or engagement to encourage the facilities workforce to be vaccinated. The Committee also received reports of the YTHFM sickness task and finish group to assure on the work undertaken to reduce sickness levels through for example focussing on the targeted interventions, revised approaches to recruitment and active links with the Occupational Health services in returning staff to work.

Conclusion

During the reporting period the Resources Assurance Committee has sought and gained assurance across the Board Assurance Framework, with a main focus on the following BAF risks:

- PR4 - Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand
- PR 5 - Financial risk associated with delivery of Trust and System strategies
- PR 6 - Failure to deliver the minimum service standard for IT and keep data safe

Our work has encompassed workforce delivery both from the Trust and LLP perspective, delivery of the Trust's financial plans, delivery of a robust and forward-looking Digital Information Service and the estates and delivery support of the LLP. Assurance has been sought in seeking to understand how we are maximising the use of our available resources to support patient care.

There have been some significant performance challenges over the reporting period and the Resources Committee has been focused on supporting the Trust by challenging for assurance in key areas.

The Coronavirus 19 pandemic has continued to influence the work of the Trust alongside the significant pressures on the emergency department and staffing levels through the Trust. In this context the newly named Digital, Performance and Finance Assurance Committee will continue to seek assurance that its duties of these areas are continued alongside now operational performance as we deal with the challenges of delivering services fully to pre-pandemic levels.

I would like to thank the members of the Committee and their teams and the Board of Directors for their support during the reporting period.

I would also like to thank the Trust and YTHFM staff for their contributions and look forward to continuing to develop strong Committee assurance in the coming year.

Lynne Mellor, Chair of the Resources Committee
June 2022

Appendix 1 - Resources Committee Attendance

Meeting Dates															
	Apr 2021	**May 2021**	**Jun 2021**	**July 2021**	**Aug 2021**	**Sept 2021**	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**	**Apr 2022**	**May 2022**	**June 2022**
David Watson	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lynne Mellor	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jim Dillon	✓	✓	✓	✓	n/a	✓	✓	✓	✓	✓	Apol	✓	✓	Apol	✓
Matt Morgan	n/a	n/a	n/a	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Denise McConnell	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓
Ashley Clay	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	n/a	n/a	n/a	n/a

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	2 November 2022
Subject:	HEE Self Assessment Return 2022
Director Sponsor:	James Taylor
Author:	Medical Education

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

Approve ☐ Discuss ☐ Assurance ☒ Information ☐ 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 is the HEE Self-Assessment (SA) annual report 2022 for training and education encompassing all clinical training programmes (excl Medical undergraduates)

The report identifies areas of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

We as a providers are asked to submit this report indicating our assessment to whether the standards have been met or not against the three main sections:

- Section 1: Organisation details
- Section 2: Education Contract KPIs
- Section 3: HEE Quality Framework Standards

The paper highlights the three main challenges and successes of training and education throughout the past year.

Recommendation:
We are seeking assurance from Board before submission back to HEE.

Report Exempt from Public Disclosure (remove this box entirely if not for the Board meeting) 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**

HEE Provider Self-Assessment - 2022 (North East and Yorkshire)

North East and Yorkshire

Please select your provider from the list below:
York and Scarborough Teaching Hospitals NHS Foundation Trust

Section 1 - Provider

Q1. Please provide details of 3 challenges within education and training that you would like to share with HEE. (100 word limit on each response)	
Example 1	A Medical Education identifiable space in York remains a challenge. Training rooms are not large enough to train full cohorts of trainees (GP training scheme and Doctors induction) and we have to often use off-site training venues. There is also a lack of access confidential space to address pastoral issues. Teaching space in the organisation remains a challenge due to expansion in the Medical School, alternative workforce groups such as ACPs and PAs and the increase in training schemes.
Example 2	Supervision is a challenge due and no educational role being identified when individuals retire and return. Medical Education teams are actively targeting new Consultants who join the Trust to be supervisor trained and further work is being undertaken to train our senior SAS doctors to be named supervisor - there is an increase required in supervisors due to the increase in employees.in
Example 3	Wider trust understanding of the remit of education and training function.

Q2. Please provide details of up to 3 key achievements within education and training that you would like to share with HEE. (100 word limit on each response)	
Example 1	Delivering of teaching using diverse methods ie advancement in technologies, sim and lifecasting.
Example 2	Organisational support to deliver/ keep face to face education and back to face to face inductions
Example 3	Having a visible and accessible practice education team

Q3. Please tick the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

Q4. Please confirm the date that board level sign off was received:

Section 2 - Contracting

Q5. Do you have board level engagement for education and training?

Yes

If yes, please provide their name and job title; if no, please provide further detail.

James Taylor - Medical Director
Heather McNair - Chief Nurse
Andy Bertram - Finance Director

Q6. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

Yes

Q7. Is an activity in the Education Contract being delivered through a third party provider?

No

Q8. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

N/A

Q9. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

Yes

Q10. Have there been any health and safety breaches that involve a trainee or learner?

No

Q11. Does the provider engage with the ICS for system learning?

No

Section 3a - Quality

Q12. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

Yes

Q13. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC		X	
GMC		X	
GPhC			X
HCPC		X	
NMC		X	
GOsC			X
Any other learner groups (please define in notes)			X

Q14. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

Yes

Q15. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Shared with College Tutors and departments
No - Please provide further detail	-

Q16. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

Yes

Q17. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Dedicated slot on corporate in duction and also attends FY1 teachings
No - Please provide further detail	-

Q18. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	new role to trust in recent months, in addition to this role the trust has Fairness Champions.
No - Please provide further detail	-

Q19. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	X	
Implement reasonable adjustments for disabled learners?	X	
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	X	
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?		X
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	X	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	X	

Q20. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	X	
A named Patient Safety Specialist/s	X	
A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	X	

Q21. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Submitted to the HEE KLS team
No - Please provide further detail	-

Q22. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

Yes

If 'yes' please add comments to support your answer; if 'no' please provide further detail:	
Yes – Optional comments to support your answer	BMJ Best Practice is promoted to all staff at inductions and included in the library marketing
No - Please provide further detail	-

Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

Q23. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:	
Yes – Optional comments to support your answer	Each learning environment in nursing has a learning environment manager who is the main connection between learners and faculty.Supporting students is an expectation of every nursing member and the focus is on valuing learning at all leavels.
No - Please provide further detail	-

Q24. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q25. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners			X
GMC Learners			
GPhC Learners			X
HCPC Learners			
NMC Learners			
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	As a Trust our culture is one that promotes inclusivity for all service users, staff and learners and the trust has policies in place.
No - Please provide further detail	-

Q26. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Feedback encouraged after all learning events
No - Please provide further detail	-

Q27. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners			
NMC Learners			
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Although we recognise the challenging environment in terms of service provision on the back of covid and the increase in acute presentations and lack of community bed places. That this environment can be challenging at times.
No - Please provide further detail	-

Q28. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q29. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Freedom to speak guardian, guardian safer working, exit questionnaires, staff survey, and the EDI lead
No - Please provide further detail	-

Q30. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	We recognise across sites in the trust that there is differentiating population demographics and take this into consideration, through different recruitment methods and training programmes.
No - Please provide further detail	-

Q31. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Associate Medical Director for QI has recently been appropriated and an active Research team. Clinical governance is promoted throughout trust and disseminated through all levels
No - Please provide further detail	-

Q32. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	GOvernance Teams for all care to consolidate the learnings and disseminate as required often via clinical governance. The use of Patient Experience feedback is valued within the trust as giving opportunities to learn from.
No - Please provide further detail	-

Q33. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners		X	
NMC Learners			X
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail for each facility:

Yes – Optional comments to support your answer	-
No - Please provide further detail	This is predominantly answered in this manner due to the lack of actual physical space and IT facilities on the York site to be able to facilitate all that is required.

Q34. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Trust Wide Grand Rounds, Clinical Governance and teaching opportunities that give multi disciplinary approaches
No - Please provide further detail	-

Q35. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

Q36. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Yes There is clear, visible and inclusive senior educational leadership. However, there is work to be done with promoting joined up working with other professionals
No - Please provide further detail	-

Q37. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q38. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q39. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q40. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	This can be accountable through room bookings, attendance lists, feedback received, courses booked, ES and CS lists are allocated using numbers and requirement of trainees
No - Please provide further detail	-

Q41. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q42. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GoC Learners			X
Any other learner groups (please define in notes)			X

Q43. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	This does happen but more can be achieved by working collaboratively when standalone clinical changes / policies are brought in to enable provision of training form Med Ed teams
No - Please provide further detail	-

Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

Q44. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Adjustments are made in teaching provisions and making adjustments for any impairments/ disabilities
No - Please provide further detail	-

Q45. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners			X
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q46. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing teams have the clinical educators and mentorship groups which provide a forum where such difficulties are discovered. Medical staff are given supervisors who meet with them on a regular basis.
No - Please provide further detail	-

Q47. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	However, improvements can be made in supporting in clinical environments in out of hour situations. Med Ed team need to ensure more regular supervisory courses are available to give assurance that all supervisors are trained.
No - Please provide further detail	-

Q48. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q49. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q50. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	There is more work to do to ensure this is fully embedded with all members of the organisation so ensure that everyone's position in the wider system is fully understood..
No - Please provide further detail	-

Q51. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners			X
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	All nursing members undertake a timely induction to the placement area. This is also part of the HEI documentation requirements.
No - Please provide further detail	There are instances when medics joint the organisation out of sync with any national changeovers that occur which can mean multidisciplinary inductions may not happen.

Q52. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners			
NMC Learners	X		
GOsC Learners	X		
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing are fully embedded with this.
No - Please provide further detail	Medics can be left without enough system knowledge if local induction is not robust enough.

Q53. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Yes learners are supported via methods such as teach the teacher, train the trainers, coaching and mentor methods. Different grades of all medical and nursing staff help induct and educate learners into the working environment.
No - Please provide further detail	-

Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

Q54. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners			X
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing provides mentors and educators time out of clinical to support and train and are supported / encouraged to undertake more junior colleagues. Care Groups are allocated funding to provide this into a supervisor job plans, although we are aware that more and more supervision is being squeezed out of these individuals that may not have been anticipately planned for.
No - Please provide further detail	-

Q55. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners			X
GMC Learners			
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing this is evidence via PARE. There are some training needs identified for medical supervisors to enable the ability to keep up with increase of training posts, - this has been identified and increase in course provision to become supervisors has been actioned.
No - Please provide further detail	-

Q56. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners	X		
Any other learner groups (please define in notes)			X

Q57. Educational Supervisors are familiar with, understand and are up-to-date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing - learning progression is supported through the completion of practice assessment documents and HEI staff visit placement areas regularly to maintain strong links between supervisors and academic assessors/tutors.
No - Please provide further detail	-

Q58. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners		X	
GMC Learners		X	
GPhC Learners			X
HCPC Learners			X
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	-
No - Please provide further detail	We know that improvements are needed to triangulate any support required especially in terms of new CS's or when updates in curriculum occur.

Q59. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners			X
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	ARCP's has identified that there are weaker supervisors that need some guidance that have not been picked up through appraisal, from these ARCPS we provided feedback to all supervisors who contributed.

Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

Q60. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	The gap is in educating senior within the organisation whether this be trainers or trainees.

Q61. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	-
No - Please provide further detail	We have active college tutors in all specialties, although there is varying in input/output from these. This has been identified an area from improvement.

Q62. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	-
No - Please provide further detail	Limited knowledge of trust change in clinical policy and procedures that may affect all learners.

Q63. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q64. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q65. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners			X
GMC Learners		X	
GPhC Learners		X	
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	
No - Please provide further detail	This is challenging due to service provision, and vacancy.

Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

Q66. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q67. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners		X	
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q68. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

Q69. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners			X
GMC Learners	X		
GPhC Learners			X
HCPC Learners	X		
NMC Learners	X		
GOsC Learners			X
Any other learner groups (please define in notes)			X

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

Yes – Optional comments to support your answer	Nursing - Students who have undertaken placements within the Trust are actively encouraged and supported to apply for vacancies within the final year. Then work in that area in final placement in to nursing preceptorship programme.
No - Please provide further detail	-

Final Submission

Q70. Confirm Final Submission to HEE

Complete Submission