Board of Directors – Public

Wednesday 25th January 2023
Time: 9:45am – 12.45pm

BOARD OF DIRECTORS MEETING

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

On: Wednesday 25th January 2023

TIME	MEETING	ATTENDEES
8.30 – 9.30	York and Scarborough Hospitals Charity – Corporate Trustee Year-End Meeting	Charity Trustees and External Audit
9:45 – 12:45	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
1:15 – 2:15	Board of Directors – Private	Board of Directors
2:30 – 3.30	Trust Priorities Report (TPR) development	Board of Directors

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	-	9.45
2.	**Apologies for Absence** To receive any apologies for absence.	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 30 November 2022** To be agreed as an accurate record.	Chair	Report	09	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	25	
6.	**Chief Executive's Report** To receive:	Chief Executive			10.00
6.1	• Chief Executive's Update		Report	(to follow)	
6.2	• The January 2022-23 Trust Priorities Report		Report	27	

Item	Subject	Lead	Report/ Verbal	Page No	Time
Trust Priority: Our People					
7.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 6.2).	Director of Workforce & OD	Item 6.2	-	10.20
8.	**Nurse Staffing Report** To receive the report.	Chief Nurse	Report	63	10.30
9. 9.1 9.2	**Public Sector Equality Duty Report** To receive the Public Sector Equality Duty annual review report. To include: • Workforce Report • Patient Report	Director of Workforce & OD	 Report Report	 71 111	10.40
10. 10.1 10.2	**People and Culture Assurance Committee** To receive: • November Committee minutes • January Committee exception report	Committee Chair	 Report Report	 131 (to follow)	10.50
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 6.2).	Medical Director/ Chief Nurse	Report	141	10.55
12.	**CQC Update** To receive an update on the CQC actions.	Chief Nurse	Report	151	11.05

Item	Subject	Lead	Report/ Verbal	Page No	Time
13.	**Ockenden Report Update** To receive the report to include the Perinatal Clinical Quality Surveillance Report including: • Apprendix D - Maternity Incentive Scheme Update (for information)	Care Group Director of Midwifery	Report	169	11.15
14.	**Q3 Guardian of Safe Working Hours Report** To receive the report.	Medical Director	Report	193	11.25
15.	**Quality & Safety Assurance Committee** To receive:	Chair of Committee			11.30
15.1	• November and December Committee minutes		Report	205	
15.2	• January Committee exception report		Report	(to follow)	
Trust Priority: Elective Recovery & Acute Flow					
16.	**Trust Acute Flow Current Pressures** To discuss the current pressures of acute flow in the Trust.	Medical Director/ Chief Nurse/ Chief Operating Officer	Report	225	11.35
17.	**Trust Priorities Report: Elective Recovery and Acute Flow** To receive an update on the Elective Recovery and Acute Flow priorities of the Trust Priorities Report (TPR) (Item 6.2).	Interim Chief Operating Officer	Report	231	12.05

Item	Subject	Lead	Report/ Verbal	Page No	Time
18.	**Digital, Performance and Finance Assurance Committee** To receive:	Chair of Committee			12.10
18.1	• November and December Committee minutes		Report	255	
18.2	• January Committee exception report		Report	269	
Governance					
19.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 6.2).	Finance Director	Item 6.2	-	12.15
20.	**Risk Management Update - Board Assurance Framework and Corporate Risk Register** To receive the Q3 Board Assurance Framework and latest Corporate Risk Register.	Associate Director of Corporate Governance	Report	273	12.20
21.	**Corporate Governance Framework Review** • Scheme of Reservation and Delegation • Standard Financial Instructions To approve amendments to the corporate governance framework.	Associate Director of Corporate Governance	Report	299	12.30
22.	**Group Audit Committee** To receive the September Group Audit Committee minutes and the December exception report.	Chair of Committee	Report	307	12.35

Item	Subject	Lead	Report/ Verbal	Page No	Time
23. 23.1 23.2 23.3 23.4 23.5	**Items for Information** • Executive Committee Minutes • Star Award nominations • York Health and Care Prospectus • Business Case: 2022/23-100 Endoscopy Equipment Replacement • TPR Mandatory Reporting	All		-	-
24.	**Any other business including questions from the public**	Chair	Verbal	-	12.40
25.	**Time and Date of next meeting** The next meeting held in public will be on 22 February 2023.				
26.	**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.				
27.	**Close**				12.45

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 04

Minutes
Board of Directors Meeting (Public)
30 November 2022

Minutes of the Public Board of Directors meeting held on Wednesday 30 November 2022 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:00am and concluded at 11:47am.

Members present:

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

Stakeholder Non-Executive Director
- Matt Morgan

Associate Non-executive Directors
- Ashley Clay

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
- Karen Stone, Medical Director

Corporate Directors
- Lucy Brown, Director of Communications

In Attendance:
- Mike Taylor, Associate Director of Corporate Governance
- Cheryl Gaynor, Corporate Governance Manager

Observers:
There were no observers at the meeting

The Chair welcomed everyone to the meeting.

95 22/23 Apologies for absence
There were no apologies for absence received.

96 22/23 Declaration of Interests
There were no declarations of interest to note.

97 22/23 Minutes of the meeting held on 2 November 2022
The Board approved the minutes of the meeting held on 2 November 2022 as an accurate record of the meeting.

The Board:
- **Approved the minutes of the meeting held on 2 November 2022.**

98 22/23 Matters arising from the minutes
The Board discussed the following actions:

Action 38 – It was confirmed that the Medical Director had since met with Jane Miller and had subsequently written a summary report following this which was agreed to be circulated to the Board following the meeting. Chair of the Quality & Safety Assurance Committee Steve Holmberg confirmed that the Committee had continued to discuss the case and confirmed that in receipt of the Medical Directors report, all were in agreement for the item to be closed.

Action 68 – Following recent discussions, it was agreed to amend the action of Community Services to become a regular update on the Board agenda as opposed to one session in January as initially planned. This would ensure that the Board would have clearer oversight of the community services that the Trust provides.

Action 73 – Amend the title to reflect 'Emergency Department'. On the back of the items initial title (Winter Plan) it was suggested that **the Board receive an update in January of progress against the previously approved Winter plan.**

Action 102 – this was included on the agenda as planned and consequently closed.

99 22/23 Staff Story
Staff Nurse Liz Alinaitwe attended the Board meeting, she described her experiences when being in an international nurse position at the Trust:

I graduated in 2016, my mum asked me my wish, as I had made her proud being named the 'Best performing student of the year in my university'. I had one wish, to work in Europe, in a world class hospital.

In 2018, the government wanted to sponsor brilliant nurses for a masters in critical care, I remember I was home and I got a phone call from one of the medical directors that my name had been put forward for a scholarship. My performance was excellent, but I still didn't like what I was doing as it was mainly theory, I thought I would thrive better in Europe. So, after my first year in June 2019, they gave us 2 months to work on our master's proposals. This was a great opportunity for me. I used 4 weeks to prepare for an EILTS exam (an English language test for study, migration, or work) and unfortunately the British council centre for EILTS in Uganda was full for that month. So, I had to go to another Country if I was to sit for the test. I checked in East Africa and the centre that had space at that time was in Tanzania. I had never been to Tanzania before,

but I wanted to follow my heart. I didn’t have money for a flight at that time. I travelled 38 hours by Bus to the exam centre, that’s a 76 hrs return journey. I was in love with what I was doing, and thankfully, I passed and the process of coming to the Trust began.

Before Arrival - When I was still praying for the big decision on which hospital to join, I received an email, and then a phone call from Emma Deans (International Nurse Project Manager), she spoke to me like someone she had known before, I told her my fears and she said she would help me. She had a lovely voice, and I somehow thought it was a scam. I told her I wanted to move as quick as possible. From that day, she kept in touch with me. Reality hit me a day before my flight that I was leaving my family. Emma picked me up from the airport and we chatted as though I had met a long-time friend. She kept messaging me to know how I was doing. She was so compassionate, and she emotionally supported me.

At the ward - When I arrived on the ward with another International Nurse, everyone looked the same. One of the ward sisters at that time, took us around the ward, but 5 minutes later, I didn’t even remember what I was shown. I just got anxiety of being in a new place, new ways of doing things, I had no idea what the Core Patient Database was all about, I even feared to touch the computers because I feared altering the information on it. I had lost my confidence.
Challenges - During my supernumerary period, a confused patient poured on me a jug of cold water as I was doing morning medication round, she called me an African monkey- I remember my ward manager acted swiftly and supported me. Another day, a Dr of Pakistani origin asked me to go in the room with him to examine a patient, and the patient rudely said, he didn’t want foreigners to work on him. When we told the ward manager, she told the patient that racism is not accepted in the Trust. I felt isolated at times in the beginning and was upset.

My turning point was during the covid period, my manager said to me that I had a choice to either go to another ward or stay on a covid ward and that the other International Nurses I had come with, had decided to move to another ward. I told her I had worked in many epidemics back home, so I was happy to stay on my ward. During that time, I worked with a diverse group, I loved the teamwork, we really had an excellent team that resurrected the dead skills in me, and I rediscovered myself. At the end of the first wave, all the staff were going back to their wards. I remember having a chat with the matron, and she told me that she was so amazed with how good I had become, and I also told her that I wanted to move to another ward. She asked me where I wanted to go, and I remember telling her and she said to me, just leave it with me.

July 2020 I joined Acute Medical Unit, the current day on Lilac Acute Medical Unit ward at the Scarborough site. Since it was a new team I had joined, the ward manager said she was going to do my appraisals so she would get to know me better, she did for every new member of staff. I still remember her words, she said she had heard how hard working I was and she was pleased to have me on her team. She added that if I needed anything, or if something wasn’t right, she would always be at the end of the phone, and her office will always be open. She made me feel welcomed, included, valued, and supported. Indeed, she has got the best out of me.

Emma Deans invited me to join the Stay and Thrive Working Group and she told me the objectives, she said we would have support from Associate Chief Nurse Emma George (she has been great!). I remember telling some of them that we had started a Stay and Thrive Working Group, and we would discuss issues International Nurses face and find solutions. I told them it would be done tactfully. I thought we could create a better working environment for others. I felt sad when some International Nurses told Emma that they were being discriminated at the wards. We started attending lectures online, and we felt we needed to do something to help the minority. We gathered information from other International Nurses, it wasn’t easy as most of them were afraid to speak out, but We promised to keep everything in confidence, and we planned on engaging as many people as possible so that we could create a better place for International Nurses.

I can’t fail to mention that Matron Sam Soulsby, who is my Matron. She did everything to help International Nurses. I trust her, and she gave me her word, she said I could get in touch with her anytime if any International Nurses had challenges. She helped greatly! She has also supported

me to the band 6 I am today, and I always have her support. If I do something wrong, she corrects me, just like what great leaders do.

It is undeniable that if these international nurses are given support, they work hard, and I can be honest and say that it's easier to practice here than back home. Secondly, when staff stay in any organisation for more than 2 years, the errors that they make are minimal, compared to when they have just arrived, so supporting them will help with staff retention and in return our dear patients will get high quality care, that we all strive for.

Achievements of Stay and Thrive Programme - There are many positives, to mention but a few; nowadays, when International Nurses join the Trust, they are given a buddy to help them at the ward, we have a matron – Matron Ginni and her amazing team that have developed a comprehensive ward induction and practical scenarios, so that International Nurses are well prepared before they go to the ward, as well as clinical educators helping out with clinical skills for all NQ and International Nurses, Matron Ginni is also organising a listening exercise across the Trust, that I will be discussing with her soon on how to go about it. We have anti-racism posters across sites, most International Nurses feel empowered to apply for posts when they come up-which is advancement in their career, we plan to have a career guidance workshop.

Cultural week - In lock down, I realised that many International Nurses were isolated, afraid to speak up, so I thought I would organise a party, and have some senior members attend and speak to them, so they can feel a sense of. and lots came, the recruitment team joined us in one of the restaurants. So, I planned to organise a bigger party. In one of our stay and thrive meetings, the Head of Nursing said the Trust was planning to have a similar party, but they didn't know how to go about it. I met Matron Ginni, we had several meetings with Emma Deans, and Matron Sam. We planned on how we could go about it. We wanted each culture to have a day where International Nurses shared their journey, International Nurses talked about their culture, discussed the cultural differences & challenges they faced when they moved to UK, International Nurses highlighted the difference in working practice between the countries where they trained versus the NHS. The reason behind this was while they were telling their stories, we could pick up the challenges so that we could be able to get solutions. It was an amazing week and we are now planning for the same in York and planning has started.

I had never nursed someone with COPD, I had studied dementia, but had never seen a dementia patient. We don't have many falls as relatives stay all the time with the patients. When it comes to oxygen, we don't use the same masks. Most, if not all International Nurses have heard the crash call bell for the first time on the wards. Nursing is so different in my country, when you arrive on the ward, you have like 28 patients to take care of , you interpret blood results and prescribe fluids, at degree level you do prescription for minor illnesses, we don't have clinical support so we do all cannulas, catheter, NG tubes and do all IV meds. When it comes to D/C, we don't have D/C plans. Family just pay the bill and take the patient home. The practice is very different.

Advantages of working for NHS - I had a dream come true, I see many opportunities, especially to advance in my career. I am currently a deputy sister on Lilac ward in Scarborough, and I have my eyes set to becoming ACP. It's something I really want to do, and I hope my dream will come true at one time. I love to progress.

I really don't blame anyone who thought we should know things from day one. They have never worked in Africa, Asia or Philippines before. Cultural awareness of each other is so important. I have made many friends here, I enjoy my work, and we need to come together and make our International Nurses feel valued and welcomed from the very first time they walk into our hospital.

Thank you.

The Board described their disappointment in hearing some of the negative experiences that Liz had encountered and were assured by some of the positive support received by staff which evidently was starting to make a difference.

Non-executive Director Matt Morgan discussed what the Board could do differently or add to support the International Nurses further when coming into the organisation, recognising that there were also other medical staffing groups that were recruiting Internationally to consider. The Medical Director highlighted that it would be imperative to work closely with Liz going forwards as the Trust expands on its international recruitment programmes of work. Liz gave positive feedback from a recent 'Festival of Culture Week' where team members from all different parts of the world came together at Scarborough Hospital and spent a week sharing, enjoying and learning about their colleagues' cultures. Liz explained that this event gave the opportunity to share the differences in cultures and for international nurses to feel a sense of belonging. The Board supported and encouraged further similar events in the future. The Board noted that the culture awareness week was based in Scarborough and in describing the support network based in Scarborough, Non-executive Director Ash Clay asked whether that was replicated or consistent on the York site. Emma George assured the Board that the learning from holding the culture awareness week was invaluable in evidencing the support and awareness it could provide and was consequently in the beginning steps of repeating the event in York and developing allies across site to support.

The Board went on to discuss further about Liz's experiences, in particular around the racism towards Liz. Non-executive Director Stephen Holmberg questioned whether this was from staff, patients or both. Liz explained that the main racist experiences stemmed from incidents with patients however there were also some occasions that included staff members. This was a concern for the Board and assurance was sought to ensure that the Trust was addressing incidents of racism from both staff and patients accordingly in particular encouraging staff to speak up about incidents and not continue to tolerate behaviours. The Board requested that the People and Culture Assurance Committee take this forward and consider this concern in all services across the Trust.

The Board:

- **Thanked Liz and Emma for their attendance at the meeting.**

Action:

- **People and Culture Assurance Committee to consider assurances in relation to the Trust policy and actions based on racism towards staff from both staff and patients.**

100 22/23 Chief Executive's Update

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

Industrial action - The RCN had now announced the first two dates for action, 15 and 20 December however, it was confirmed that the Trust was not selected as a site for the first strike but assuming this was to continue, potentially following the Christmas period there Industrial action – as read and closed 15th November. Not selected as a site for the first round of strike, maybe after Christmas assuming it continued.

Flu and Covid-19 vaccinations – Uptake had been lower than in previous years' campaigns, however the Trust was in line with the uptake in the rest of region for flu vaccination, and were above the regional uptake levels for the Covid-19 vaccine. 55% for covid and just under 50% for flu – the concern raised was the provision it had on sickness rates.

Celebration of Research - first Celebration of Research event, to mark the achievement of two significant milestones of over 1,000 studies hosted and delivered, and more than 50,000 people taking part in our research trials. The Board thanked Head of Research Lydia Harris and the wider team for hosting this successful event.

Humber and North Yorkshire Integrated Care Board update –

- York Place Director appointed - Sarah Coltman-Lovell will take up the post of Place Director for York from 19 December 2022.
- Cancer Alliance Chair appointed - Humber and North Yorkshire Cancer Alliance had announced that Stephen Eames CBE had been appointed as its new Chair. Stephen will officially take up the role from 1 January 2023 and he will combine the role while serving as Chief Executive of the Humber and North Yorkshire Integrated Care Board.

Board recruitment - The Board welcomed Dr Karen Stone to her first Board meeting as the Trust's new Medical Director. Shaun Stacey had also formally joined the Trust as Improvement Director on an interim basis, predominantly to focus on the Trust elective recovery plan and delivery of actions under the Trust's priorities.

Care Quality Commission (CQC) update – the Board noted that the Trust continued to be under inspection, as the CQC is yet to carry out a number of interviews, and they have requested further information and evidence, however we have received a letter from the CQC summarising their feedback from this latest part of their inspection. The Board acknowledged and discussed the CQC had flagged serious and significant concerns in the maternity department at York, specifically in relation to governance processes, and assessing and responding to risks for patients. The Board further discussed some broader observations from the well-led visit (22 – 24 November) outlined in a letter from the CQC which related to the assessment of and response to risk, with staff working in a reactive rather than proactive way, and concerns around the Trust's correlation of risks, incidents and complaints and the learning from these.

It had been recognised that the Trust had addressed a number of flags through the October CQC visit however there remained concerns in particular around the York Maternity unit. The Board noted the Trust's deadline of 23rd December to propose an action plan on this. The level of scrutiny from the CQC was seen to be helpful and welcomed to support embedding systems and processes in the department. The National Maternity Support Team will be with the Trust in early December and the Board acknowledged that they had been asked to focus their three days on the York site in light of the recent CQC inspection feedback.

Improvement Journey – continued challenge in relation to operational performance with continued experience of issues with flow and consequently leading to delays in emergency departments and the ambulance queue, in addition to the large cohort of patients who were waiting to be discharged. The Board acknowledged and discussed that the Trust had received formal confirmation of the move to Tier 1 due to the risk to delivery of the Trusts elective recovery programme. The first action under Tier 1 is a visit from the Elective Intensive Support Team for two days in early December to review processes and identify opportunities for improvement.

Further support in other areas was described and noted in the report.

The Board drew further focus on the CQC update and shared their disappointment around articulating things to action them and not acting on things that on occasions were known, or more effectively picking up on the signals. It was acknowledged that concerns were raised in relation to addressing concerns primarily through governance and a framework of accountability that clearly evidenced when action taken it has followed a formal line of responsibility/approval and applied at every level. The Board were assured that effort would continue to work towards demonstrating the right leadership and governance is in place, in particular in addressing those issues CQC had raised.

Trust Priorities Report
The main details of the report were described in each relevant section of the agenda. The Chair described that the report required further development and asked that consideration be given on including how the Trust was measuring its progress or lack of progress and how was this being recalibrated month on month to clearly understand positions on progress.

101 22/23 Trust Priorities Report: Our People

The Director of Workforce and Organisational Development presented the report and highlighted that the leadership framework had since been presented to the People and Culture Assurance Committee and discussed at length, in particular in regard to the infrastructure to support the 360 element that supports the framework. The framework was still being finalised and the implementation of it continued to be discussed with stakeholders and to be rolled out imminently. This remained positive as there had not been a leadership framework previously which articulated the offer at every level of the organisation.

22nd November marked the first new starters fair which went well and was well attended. Those who attended feedback that it was very informative. Currently finalising a welcome pack and digitising wherever possible.

The Board received an update on the workforce planning across the care groups and noted that every care group had made their submission. It was fair to say that there was huge diversity in workforce planning and thinking creatively about the different workforce profiles that the Trust can offer, some of which was interdependent on clinical establishment review etc. meetings were commencing with care groups to interrogate their submissions and try to refine them further.

The Board discussed the culture in relation to the priorities and non-executive Director Lynne Mellor asked whether the Board were doing enough to support culture, given the issues coming out of the CQC inspection systemically related to behavioural and cultural aspects. Lynne suggested that the Board may want to do some more in terms of external help and support on culture. Lynne also questioned if there was sufficient visibility of sub-priorities within the main priority actions and was the Board really clear from these reports what was making a difference so not just measurements but the focus areas of major change, this was not just in relation to the culture around HR/people but across all of the priorities. It could be seen in some of the performance but not in everything. The component around changing culture is multifaceted, the Trust had 304 values ambassadors across the organisation and leadership went to the heart of changing culture. Feeding back from the discussion from the People and Culture Assurance Committee, the external consultation around leadership generally focussed on key groups of individuals however, the Trust was aiming for a framework that works for all levels within the organisation. The Trust was developing an infrastructure that is sustainable and

where everyone gets the same level of input and opportunities to develop their leadership skillset and was why the internal learning hub platform/management was being explored.

The Chair confirmed that the Board had a scheduled deep dive session planned on culture in February 2023 where it was hoped to discuss this in more meaningful detail.

The Board briefly discussed sickness and Non-executive Director Jenny McAleese requested some assurance around whether the Trust's sickness policy and procedures were operating as they should. The Director of Workforce and Organisational Development advised of the mechanical maintenance of managing sickness absence proactively when it occurs and she was reporting on medical staff at the next Audit Committee in relation to the concerns raised in identifying individuals going off sick. It was a working progress but not yet fixed. In terms of non-medical staff it was felt that the Trust was proactively managing sickness and the area of focus was around preventing sickness initially through a range of health and wellbeing initiatives and mechanisms to support staff at work and many of which were around mental health at work, primarily impacted through various influencing factors such as cost of living, pressures at work etc. Other avenues of communicating support were shared such as staff brief to articulate all initiatives the Trust offers in retaining staff.

The Board focussed on the Working Life - (Fix the basics) and the status of the actions under the priority, Non-executive Ash Clay highlighted that this appeared as the only priority where there were no completed actions and questioned whether there was a danger of actioning too much complicated leadership work and not enough on fixing the basics which felt to be more pertinent to staff at the present time. It was explained that although on the face of it this would appear an accurate reflection and some actions appearing to be tangible, often there were financial implications attached to consider and work through.

102 22/23 Nurse Workforce Report

The Chief Nurse presented the report and provided the Board with information and assurance on how the Trust had responded to provide the safest and effective nurse staffing levels during September 2022.

The Board were informed that when the trajectory reported was established, it didn't consider a recent excursion to India which hadn't been anticipated. As part of a national international recruitment programme, Regional Integrated Care Boards had been allocated a targeted location in India (Kerala) to avoid any disproportion. The trip was notably successful and supported the realisation of embedding the groundwork into the organisation long before individuals arrive. During the trip a visit was made to the School of Nursing and also the Medical School, which forged some key links with a hope to bring newly qualified nurses over before they entered into the Indian healthcare system. What became apparent was the inability for the qualified nurses to be able to afford to complete the EILTS exam. The Chief Nurse explained that the Trust was looking to sponsor a number of nurses through the exam. The Board acknowledged that the trip would likely result in further nurses coming to the Trust and there was optimism for moving the trajectory forward however, it was recognised that it would be difficult to ascertain by how much at this early stage in the programme.

The Board discussed the programmes of work around staff retention, in particular in relation to the nursing workforce and it was acknowledged that this was key to success therefore it was important to continue to challenge initiatives to ensure that they remained to be effective enough to retain staff and improve the position. The Board were reminded

that the main finding of the establishment review was that there was a requirement for investment that was essential to be considered in 2023/24. The establishment review enabled a clear understanding of what was required to deliver the level of activity expected, against what was available and the identified gaps that would require consideration going into 2023/24.

The Board discussed the nurse vacancy figures and acknowledged that the figures now included actuals as well as trajectories to ensure that the Board were sighted on whether the Trust was delivering in relation to expectations. Non-executive Director Denise McConnell highlighted that the actual figures were lower than were projected and questioned whether there was any implications of that for future recruitment. The Chief Nurse assured the Board that there were no concerns and looking back historically the picture showed that it would often balance out.

Non-executive Director Matt Morgan questioned the establishment review undertaken and the expected recruitment. Clarity was sought around whether this was an additional gap and the consequence with safe staffing. Although the fill rate (calculated by comparing planned staffing hours and actual staffing achieved) was satisfactory, this was dues to an excessive spend on bank and agency to fill any gaps. However, this was not closing the gap up to the new establishment level but working towards and closing gaps to baseline establishment in the meantime. The investment into the 134.43 WTE Registered Nurses, 204.26 WTE Health Care Assistants and 115 WTE Patient Services Operatives would enable delivery of better quality of care. Currently safe staffing was mitigated daily to ensure the lowest possible risk to consistently safe care, highlighting the care of the Elderly wards as the most concerning in relation to this. The Board were assured that discussions were progressing in relation to turning the bank and agency staff into substantive staff and drive care forward but recognising that there was a gap between where the Trust was currently and where it would like to be. Non-executive Director Steve Holmberg suggested that a benefits analysis of releasing time to care, deriving from the launch of Nucleus digital documentation be carried out and shared. Chief digital Information Officer James Hawkins confirmed that this benefits analysis had already been requested through the Digital Performance and Finance Assurance Committee and was being actioned. Initially results were suggesting that this would reduce admission paperwork by at least 30% and evidencing that benefit may support the nursing establishment further.

The Board:

- **received and noted the report.**

103 22/23 People & Culture Assurance Committee

The Board noted the minutes of the latest People and Culture Assurance Committee.

104 22/23 Trust Priorities Report: Quality & Safety

The Chief Nurse presented the quality and safety element of the Trust Priorities Report. She highlighted that there was no longer any maternity data presented in the report which was felt imperative to be included going forwards, this was agreed by the Board.

The Chief Nurse reported a general sense of not improving in relation to the numbers of Trust onset MSSA Bacteraemia and C. difficile infections and there was a push to drive up compliance with the support of communications and engagement with medical staff. The Board were to receive a presentation from the Consultant in Microbiology & HIV Medicine

Infection Control Doctor, despite what is being done, the Trust remained a concerning outlier for hospital acquired infections

In terms of harmful incidents and patient safety incidents with moderate or above harm, the Board noted that these were ongoing pressures and that there was a clear association between pressure on services, staffing issues and patient harms/quality of care. Key risks highlighted to the Board were around pressures on services and capacity and national issues with staff shortages, recruitment and retention however, there had been an improvement in the availability of nursing staff in the last three months on Datix. Despite this, the Trust harms continued to rise indicating there was no correlation there to see but there was hope that the impact would begin to show some marked improvement.

Deputy Director of Patient Safety & Governance, Caroline Johnson attended the meeting for the item. Caroline sighted the Board on violence and aggression around staff and highlighted that there had been some incidents that were concerning. There had been a correlation picked up within the Falls Group around some of the impact on staffing having to report patients that require one to one supervision and taking staff away from patients with risks of falls. As an outcome of this the quality improvement team were working through to really understand what this means and why it was influencing. Running along side this piece of work was another in relation to staff training and keeping themselves safe, focussing on ow to prevent violence and aggression in the first instance.

The Medical Director raised the community services and questioned how this was being reported in and to also understand whether the data collated around violence and aggression was describing what was actually happening or if it was only what was being reported. Caroline described that there was indeed a sense of underreporting, in particular in areas such as older peoples wards and where patients are living with dementia. There was a sense of normalisation of incidents in these areas. Non-executive Directors Lynne Mellor and Matt Morgan shared their feedback from previous Patient Safety Walkabouts in the Trust where staff were describing to them their challenges around finding the time to report incidents, confidence in incidents being dealt with and also the support at the time of incidents such as security on hand or available in sufficient time. Often incidents could be predicted as being aggressive (because of the nature of the patient being dealt with), but it was understood at the time to be difficult to get plans in place to manage those incidents.

The Board noted the flagged issues around violence and aggression towards staff and were assured that it was being addressed through the Quality Improvement Team and that it was sighted on the Quality Patient and Safety Committee agenda where reports were frequently presented and discussed. There are also discussions and links through the Mental Health Steering Group. The Board recognised that is was equally difficult for staff to work in such environments and there was a known need to ensure staff were supported and had the right skills to manage the situation.

105 22/23 CQC Update

The Board noted that this was discussed earlier in the meeting and would also be further discussed at the Private Board Meeting.

106 22/23 Ockenden Report Update

Care Group Director of Maternity, Sue Glendenning attended the meeting to present the report. The Board were highlighted to the significant safety concerns raised by the CQC around maternity services and were assured that the Care Group had commenced an

improvement plan which identified immediate actions following the visit. It was noted that the CQC continued to request monthly assurance in relation to Tenable (a quality improvement and assurance tool) and MEWS (Maternity Early Warning Score) compliance on Ward G2. With regard to MEWS the Board noted the plans for G2 to mirror the approach on Hawthorn at Scarborough and this work would begin in November.

Progress against compliance with all 10 safety actions for Maternity Incentive Scheme (MIS) (formally CNST) was currently challenged due to compliance with the mandatory training compliance and the supernumerary status of the labour ward coordinator. It was noted that this may mean that the Trust would not meet the MIS requirements for 2022-23 and therefore would not be eligible to recover the contribution to the incentive scheme. A position paper on the progress towards achieving the safety actions was due to be presented to the Board in December 2022.

The Board noted that work continued towards the 7 immediate and essential actions from the Ockenden report published in December 2020 and to be fully compliance, the Trust was reliant on the formation of working relationships with the Integrated Care System (ICS) and the implementation of Maternal Medicine Networks.

The Board discussed the impact on staff following the CQC findings and concerns in the department and acknowledged that this must have had a significant impact on the staff morale, Non-executive Director Steve Holmberg questioned whether there were any observations to share with the Board and what the Board may be able to do to support that. It was advised that there had been some staff briefing sessions planned in to go through the findings and subsequent improvement plan, and also brief staff on the Section 31 and what that means for them. Professional Midwifery Advocates were also planning to put some dedicated sessions on for staff. There was an awareness that staff on the ward were feeling upset and it was acknowledged that it was important to share about the extensive good work that is consistently carried out, this was primarily reflected in no concerns raised by the patients during the visit. It was requested that feedback from the Board was that the CQC work was about getting on top of the shortcoming that the CQC had identified and to offer assurance that the Board was supportive rather then negative and want to make things better for staff as well as patients. A key message was that the staff were to be empowered as they were not the problem but the solution. Non-executive Director Denise McConnell raised whether the Section 31 may result in the loss of some staff but it was hoped that the added support provided over the coming months and reiterating the Boards support, would provide assurances enough to address any concerns.

The Care Group Midwifery Director shared her concern around the role of the Digital Midwife and that the expectations of this role was not sustainable. The Chief Digital Information Officer acknowledged that this was not of a surprise with added pressure of going live in the next 4-6 months with a new system with a heavy onus on staff to train, adopt and learn new systems and was acutely aware that there will be a lot of pressure on a lot of individuals as well as operational pressures. In terms of the signal compliance and meeting the signal data on the maternity dashboard, the Chief Digital Information Officer offered support for any more training or help around that to help improve compliance and further support the Digital Midwife pressures. This support was welcomed.

The Board:

- **received and noted the report**

107 22/23 Q2 Guardian of Safer Working Report

The Board received the report and noted the following points highlighted:

- Exception reporting rates have increased in Q2. This is an annual phenomenon related to junior doctor changeover in August
- 40% of reports were not addressed in the contractual time scale. Nearly 1/3rd of exception reports were managed by the Guardian due to delays and variable engagement from Educational and Clinical Supervisors
- A decision on how to spend the outstanding £15,000 national funding provided to "enhance junior doctor rest facilities" is yet to be made
- Recent Board Reports highlighted excessive working hours in surgery (York) over weekends. Rostering alterations to address this went live in August with excellent effect based on the reduction in exception reports
- Medical and Dental rosters that are not managed by the Medical Deployment Team lack a structure of governance to ensure all contractual rules are adhered to.

Non-executive Directors Jenny McAleese and Matt Morgan raised concerns around some of the commended in the feedback and some of the perceptions by Junior Doctors being that senior clinicians were not supportive of the reporting process, the actions for following up which fed back to the cultural piece of work within the organisation. The Medical Director responded that there was something about supporting Junior Doctors and ensuring that they felt welcome and valued the training that they receive. The reporting for their breaches was important because that meant that they had a route to inform about them. The Guardian of Safe Working had been working through educating not just the juniors about what they needed to report and how but the Education Supervisors too about how they needed to respond or what their response rate was. The Board were informed that this was being included in supervision training currently, so all new supervisors were being picked up as a starting point and the existing, who are already trained, were picked up as part of their ongoing education. The Medical Director assured the Board that she would continue to work through with the Guardian of Safe Working to improve.

The Board:

- **received and noted the report**

108 22/23 HEE Provider Self-Assessment Report

Head of Medical Education, Racheal Snelgrove attended the meeting and presented the resubmitted report detailing the Health Education England Self-Assessment annual report for training and education, encompassing all clinical training programmes (excl. Medical undergraduates). Through triangulation of data, the report aimed to identify areas of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation. There were currently no quality interventions for the education and training in the Trust however, it was acknowledged that there were concerns that required addressing.

The report describes how the Trust had benchmarked itself and some of the challenges in the organisation. One area raised to the Board was bullying and harassment, through the triangulation of data there is nothing in writing that would describe this as a concern however it was recognised internally as a concern through 'intel on the ground' and consequent an area of target.

The Board noted that there were now clinical educators in all clinical areas who are responsible for a variety of training and development duties with much of their focus on ensuring that students have the skills and training to succeed in their areas.

The Board discussed the presenting of the report and Non-Executive Director Matt Morgan suggested that, note that there is an expectation from HEE to confirm that the Trust's Self-Assessment response has been signed off at Board level before submission back to HEE, that the People and Culture Assurance Committee receive and discuss the report and subsequently next year there will be more assurance to the Board that what is included in the assessment is a reflection of what is happening in the organisation.

The Board were advised that HEE annually request to complete a self-assessment and this year it had been asked to be presented and agreed for sign off from the Board to ensure its oversight. The Medical Director confirmed her recommendation for its submission.

The Board:

- **read, discussed and signed off the self-assessment response for submission.**

109 22/23 Trust Priorities Report: Elective Recovery and Acute Flow

The Interim Chief Operating Officer presented the report and highlighted the following key messages:

- Continued ongoing urgent care pressures
- Reduction in the number of covid cases
- Increase in flu case 16 patients with flu (not necessarily admitted with flu but the same principles
- Now have a flu dashboard (with the same principle as the covid dashboard and can consequently track in the same manner)
- Enacted the flu plan as part of the Trust Winter Plan 22/23 – Teams operationally were managing this
- Focus on 2 components around acute urgent emergency care and elective recovery with constituted as previously described, a lot of the governance around the elective recovery care which would now flow up into Executive Committee now. Interim Improvement Director has begun the process of reviewing the programmes
- Three key parts of urgent emergency care pathway (details on page 202). Both York PLACE local plan, and now developing East Coast focus of the North Yorkshire Plan, the shared performance trajectory set for the York PLACE of combined pathways of 1, 2 and 3 seen in the report. Still off that trajectory despite the ongoing work. Are expecting, as a North Yorkshire and York PLACE, to receive in the region of around £11.5m – 40% to go directly to local government colleagues and 60% administered through the NHS. Ongoing work to confirm and challenge the plans that were already in place. Seen impact from some plans but not all – questioned whether some needed to be stopped, persevere, or expand plans. Hoped to be further information to present at the next Board meeting.
- Continued focus on emergency same day care, pleased to report the Trust streamed 19% of ED attendances direct to Same Day Emergency Care (SDEC) services in October, against a Trust target of 20% by March 23 so on trajectory. Pushing with the teams to overachieve this expectation. Also exploring dates in December with the former Clinical Chair of the Royal College of Emergency Medicine to support a review of the operating model at York.

- Urgent Care Review – work around this had commenced and The Trust was engaged in the Task and Finish Group for the Urgent Care review for York and North Yorkshire, led by the Integrated Care System.
- Continue to work with the Interim Improvement director to give some scrutiny on the Elective Recovery Programme
- Focus work on priorities – back to basics such as patient administration services and processes to ensure that the Trust is on form with its Standard Operating Procedures etc.
- Elective Intensive support team – to complete a visit as part of their support which was to include a review of access policies, escalations processes and any governance arrangements. Also particularly looking into RTT recovery plans and reports, outpatients, theatres and diagnostics, waiting list management and how patients are booked. Some data quality and validation would be carried out as part of the visit and working with the Care Groups around their management systems of their long waiting patients. This is because the data illustrates that the Trust was off trajectory for its Long Waiters plans
- Ahead of revised trajectory for 78+ week however this was a revised trajectory and did not enable the Trust to achieve the national target to reduce the number of 78+ week waiters to zero by March 2023. Expected the Elective Intensive Support Team would be looking into this and will challenge and support taking this further and more in line with the expectations
- The Skin, Head and Neck and Colorectal pathways continued to be challenged areas in terms of an elective recovery perspective. It had been agreed through Executive Committee to support the use of FIT diagnostic tool alongside Colorectal Fast Track Referrals
- Care Groups d been requested to adjust their clinic capacity to delivery 1st Outpatient plan expectations through the Oversight and Assurance Meetings held in October. This was to be a focus of the Star Chamber meetings for the high-risk specialities.
- October activity information illustrated ahead of plan for follow-up for outpatients (also part of the Star Chamber meetings).

The Chief Nurse highlighted how it would be worth adding how the Trust was clinically risk assess the waiting lists because there was lack of assurance through the report that the Trust was risk assessing these RTT patients and the implications. This was agreed and would be included in future reports.

The Board raised the additional funding to support discharge pathways, continuing to work through the York Place local system plan with a view to reduce the number of patients in the general and acute bed base who do not have 'criteria to reside'. Although the system remained above trajectory Non-executive Matt Morgan questioned if the trajectory goes down, whether having the funding was going to support the position and whether the funding was across the system and including local authority. It was confirmed that there were plans being prioritised as part of the listing work so that it was known exactly the sort of elements that would need to be enacted if they could be funded. Potentially taking some of the existing services further faster. There was confidence that there were a number of schemes that could be included in any plans and consequently, funding then would be drawn down through the local authority and Building Better Care. Where there was less confidence was around the impact and the Board were advised that this would be monitored by the ICS through the ICB with a real interest around impact and improvement against trajectory.

Non-executive Director Steve Holmberg highlighted the elective recovery self certification and raised his concern regarding the degree of scrutiny of the Quality and Safety Assurance Committee described in the certificate. It was discussed and agreed that the

Quality and Safety Assurance Committee required key visibility of performance data in relation to patient safety and lack of harm resulting from performance. This data was to include a reflection of the position rather that solely the original target information.

110 22/23 Digital, Performance and Finance Assurance Committee

The Board noted the minutes of the latest digital, Performance and Finance Assurance Committee.

111 22/23 Finance Report

The Finance Director presented the report to the Board and described that the Trust's was £4.6m adversely adrift of plan reporting two important elements to that overspend that it was important for the Board to be sighted on were 2 issues where still awaiting funding solutions, one being the pay award at £1.2m (at month 7) and the other is the mobile CT scanner which account to £1.8m. Together this was £2m of the £4.6m adverse variance and consequently leaving £2.6m remained as a concern for the Board. The report describe a collection of contributors relating to the £2.6m such as pressure on pay related issues, shortfall and efficiency programme delivery and excess expenditure against the Trust's funding position on covid costs. This was not an untypical position, and the system was also adrift which contributes.

The Board also noted the forecast outturn position as a balanced position however there were a clear set of assumptions described in the report with particular interest in the following:

- Utilities expenditure does not exceed the £1.5m pressure currently forecast
- A financial recovery plan is developed and put in place to reduce predicted spending by £2.5m

The utility position and price cap were now fully understood and how that impacts on the Trust on adjusted the latest projections going forward into the winter months. It was expected, despite significant additional funding for utilities coming from the centre at the start of the year, to be in breach of that position by approximately £1.5m and consequently played into the forecast outturn position.

In terms of the internal financial recovery plan, further action was required here and the issue was now a source of discussion with Care Groups through the Executive Committee with a view to discuss sensible actions around expenditure that can be carried out to take them to the final months of the financial year 22-23. A clear key message relayed to the Board was that safety trumps finance and that decision were taken to support staff and their safety, any that did not fall into this category were being discussed with relevant Care Groups to ensure straight and appropriate management of their expenditure.

There were no further apprehensions raised in relation to the cash position, understandably if the position was to deteriorate then that would be a concern however at this stage the Finance Director assured the Board that there was no concern.

The Board:

- **noted the report and the Trust financial position.**

112 22/23 Risk Management Update

Associate Director of Corporate Governance presented the report which illustrated the latest iteration for November.

Work continued with the Interim Risk Manager reporting with Care Groups embedding further the risk management framework with a view to improve escalations up to risk Committee and Executive Committee.

The Board:

- **noted the updated Corporate Risk Register**

113 22/23 Any Other Business

York Teaching Hospital Facilities Management (YTHFM) Chair

The Chair, Alan Downey shared a formal thanks on behalf of the Board to Mike Keaney for his 3 years as Chair of the Management Board in YTHFM. A replacement would be required, and it had been agreed that Graham Lamb was to carry out the duties of the position on an interim basis until a formal appointment had been made. It was shared that this appointment was felt to be suited to a Trust Non-executive Director position to maintain a key link between the Trust and YTHFM and subsequent management teams.

114 22/23 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 25 January 2023.

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
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
73	28 September 2022	Public Board of Directors	70-22/23	Emergency Department	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 03.11.22 - Update following meeting with MT, AD and SM to move to January 2023	Jan-23	Green
99	02 November 2022	Public Board of Directors	80 - 22/23	Patient Story	Associate Director of Corporate Governance to arrange a lessons-learned session, based on recent patient stories.	Associate Director of Corporate Governance	Will link Board Public action 99 and 100 together	Feb-23	Green
101	02 November 2022	Public Board of Directors	84 - 22/23	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report and Action Plan	Head of Equality, Diversity and Inclusion invited to report on Progress in 6 months.	Associate Director of Corporate Governance		Apr-23	Green

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TRUST PRIORITIES REPORT

January 2023

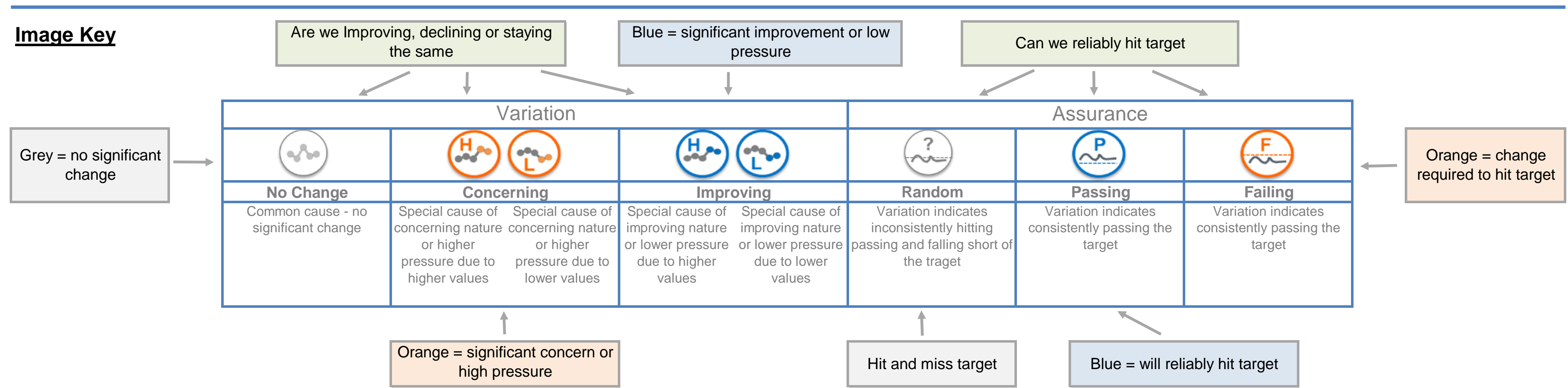
Board Assurance Framework supporting information for:

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

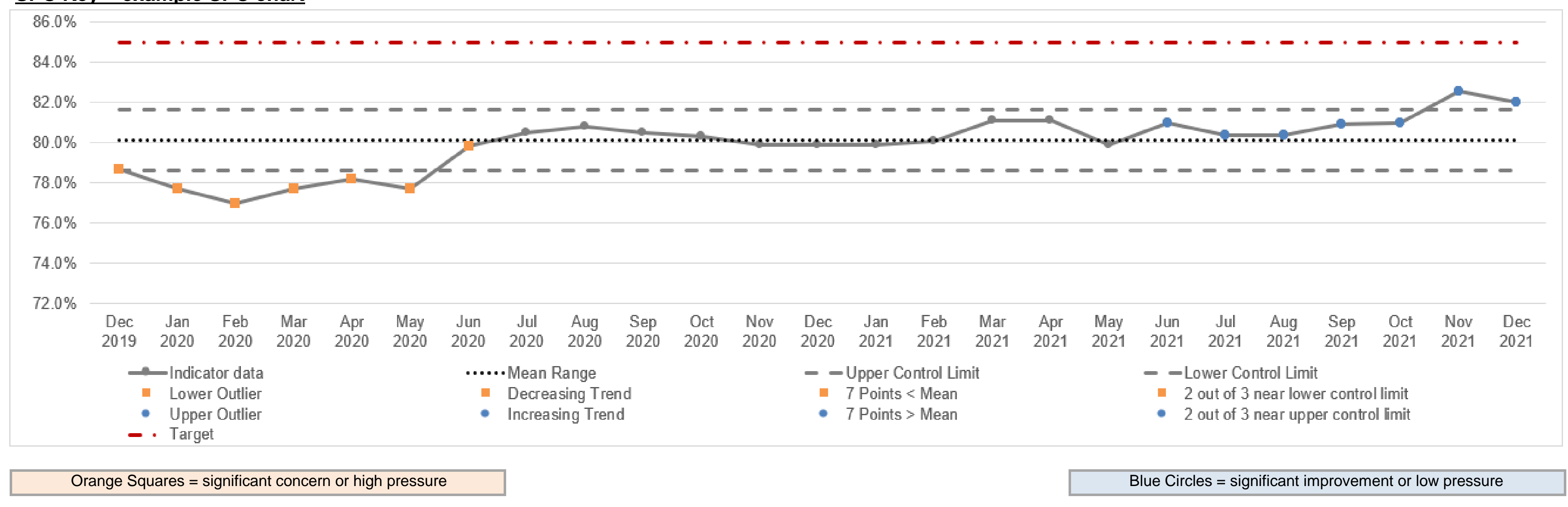
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

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



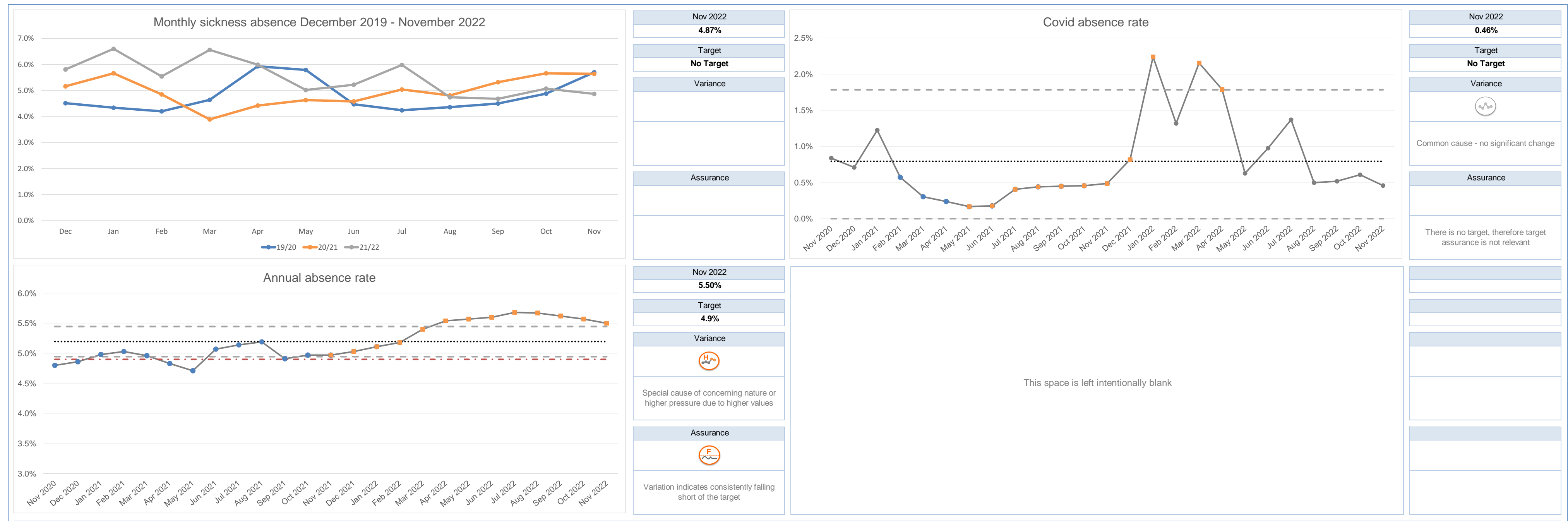
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

OUR PEOPLE - Sickness Absence

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Monthly sickness absence rate: This indicator is not presented as a statistical process control chart (SPC) so that the comparison of monthly sickness can be seen month on month for the past 3 years, and to allow for seasonal variation. The sickness rate for Nov 2022 (4.87%) is lower than that seen last year (5.64%).
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. April 2022 is slightly above the upper control limit.
Annual absence rate: The indicator is showing special cause concern since November 2021, with an increasing trend. The data points have been above the upper control limit since April 2022. The target is slightly below the lower control limit, so is showing as consistently failing target.

Operational Update

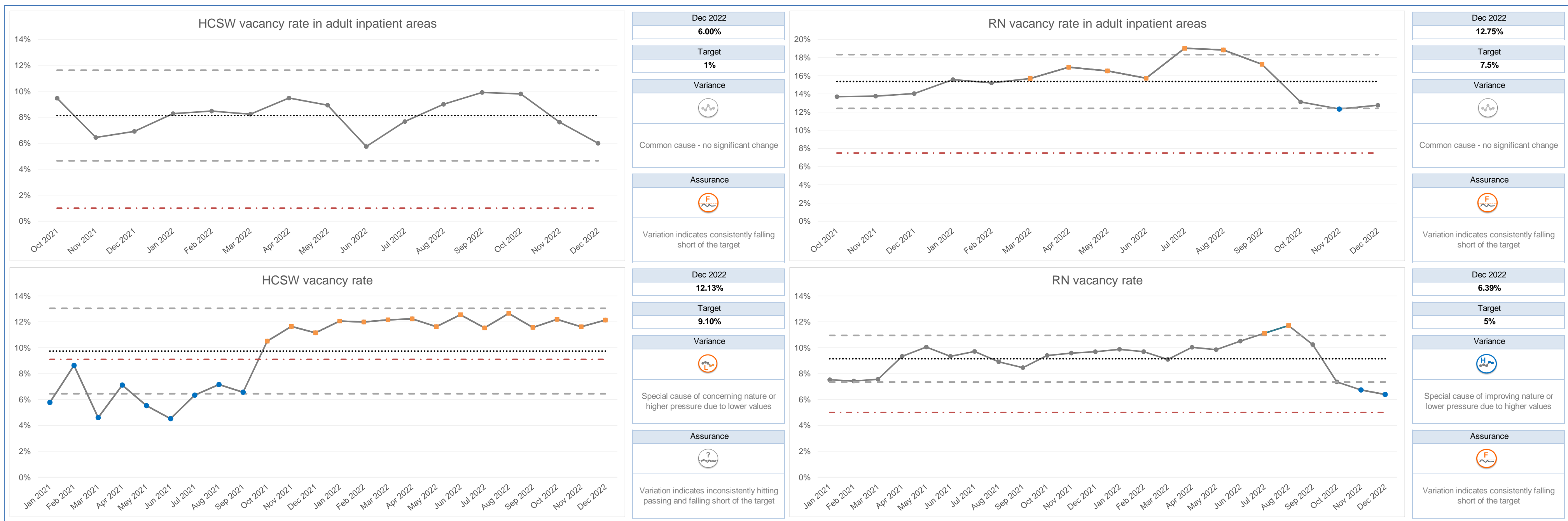
Staff survey results relating to staff engagement are only available once a year, via the national NHS staff survey. However, staff sickness absence is one of the more readily available indicators of engagement. As shown above, seasonal variations are expected in monthly sickness absence rates and annual absence rates have shown an increasing trend over the last year, with COVID absences also continuing to have an impact. Staff sickness rates impact the availability of sufficient workforce to safely staff all wards/departments at all times.

Initiatives to try and improve levels of engagement with the workforce continue, we have maintained free car parking over the winter months and continuing increased mileage rate payments until the end of the financial year, meal deals are available for staff members and whilst we were in enhanced OPEL 4 conditions free meals were provided to front line staff. The first chilled water dispenser is being installed on the Scarborough site with a view to these being rolled out across the Trust throughout the coming year following a successful trial.

OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

HCSW vacancy rate in adult inpatient areas: The indicator is showing common cause variation, however please note the vacancy rate is shown from Oct 2021 only. The target is consistently not being met.
RN vacancy rate in adult inpatient areas: The indicator is showing common cause variation with Nov 2022 being slightly below the lower control limit, however please note the vacancy rate is shown from Oct 2021 only. July and Aug 2022 were above the upper control limit. The target is consistently not being met.
HCSW vacancy rate: The indicator is showing special cause concern, above the mean but below the upper control limit, from Oct 2021. Please note the vacancy rate is shown from Jan 2021 only. The target is just below the mean and has not been met since Sep 2021.
RN vacancy rate: The indicator is showing special cause improvement, below the lower control limit in Nov and Dec 2022. Please note the vacancy rate is shown from Jan 2021 only. Jul and Aug 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

Following the recruitment trip to Kerala, India, the Trust has made offers to 96 RN's and 10 AHP's. Work is underway to process applications and support candidates with their English to enable cohorts to be drafted so we can plan commencement dates across 2023/24.

Events planned with NHS England to work through action plans relating to recruitment have been postponed due to operational pressures and industrial action, it is hoped these will be able to take place late January, early February.

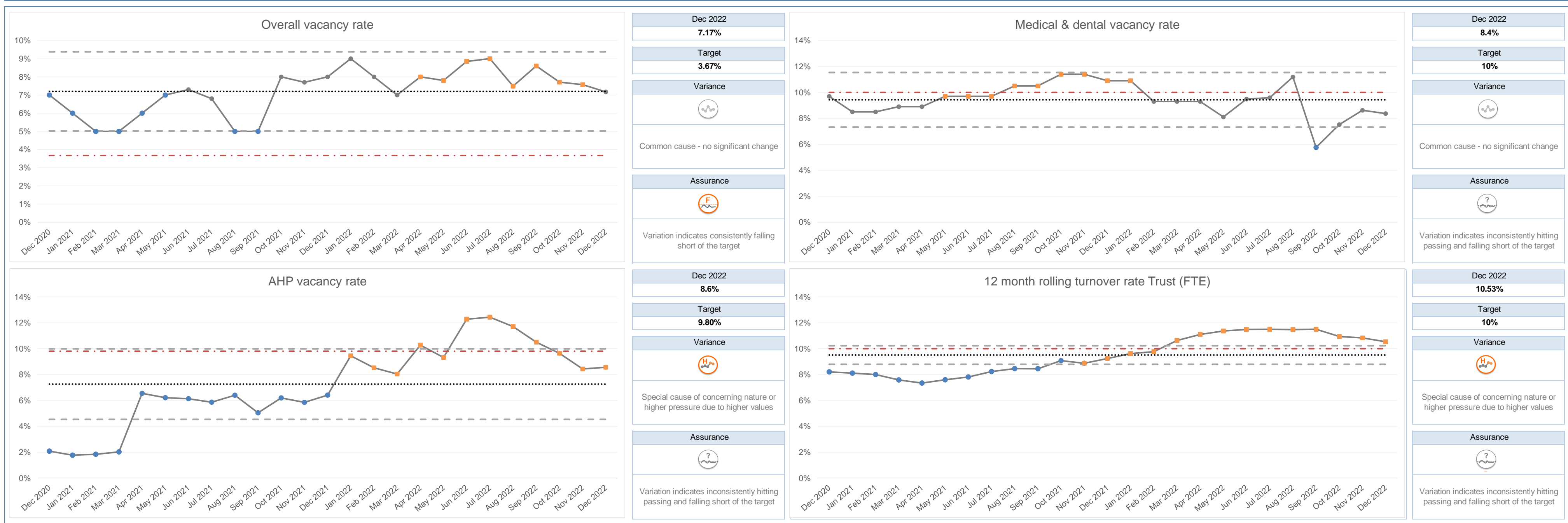
A HCSW recruitment event is planned for February.

The figures shown in the graph above for vacancy rates on adult inpatient wards does not account for those international nurses who have recently joined us but are still completing their OSCE training or awaiting their PIN. When these numbers are taken into the account the vacancy rate on adult inpatient wards across the Trust is reduced to 6.34%.

OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Overall vacancy rate: The indicator was showing special cause concern from April 2022 with a run of points above the mean, but is now showing common cause variation. The indicator is consistently failing target.
Medical & dental vacancy rate: The indicator is showing a period of nine points above the mean from May 2021 to Jan 2022, for Sep 2022 this was showing special cause improvement below the lower control limit, but has since returned nearer to the mean. The target is showing above the mean.
AHP vacancy rate: The indicator is showing special cause concern with a period of points above the mean since Jan 2022 and points above the upper control limit in Apr 2022 and Jun-Sep 2022. There are signs of a decreasing trend back towards the mean from Jul 2022. The target is showing as consistently passing.
12 month rolling turnover rate - Trust (FTE): The indicator is showing special cause concern since November 2021, with data points above the mean. The data points have been above the upper control limit from Mar 2022. The target is slightly below the upper control limit.

Operational Update

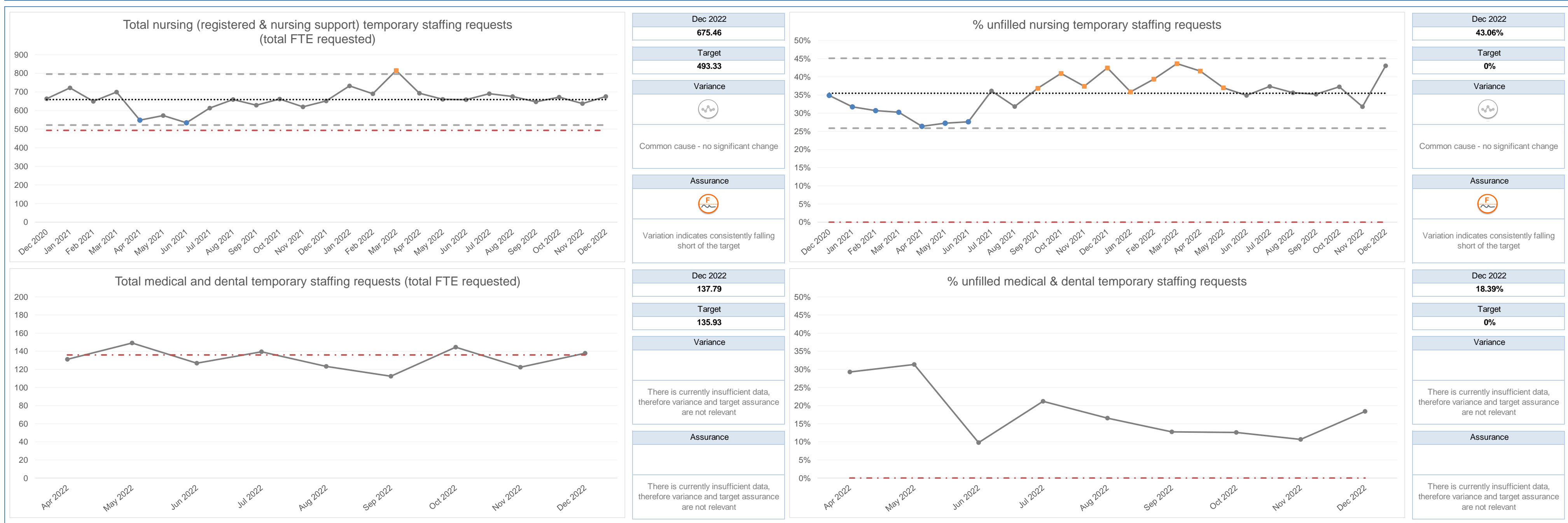
We are developing key actions to improve the retention of our staff, areas of focus include the on-boarding of staff as they join the organisation, career pathways, talent management and more opportunities for staff to share their views through fresh eyes (new starters) feedback, itchy feet (those who may be thinking about leaving) feedback and exit feedback - exploring if is there anything we could do differently.

One of the measures described in the Operational Plan linked to the Our People priority is to increase the % retention of non-medical students who train and qualify with us to achieve 80% retention. We have not previously had a baseline for this measure, but an exercise has been undertaken, using the information that is available to us to determine this. Of the third-year students who undertook a placement at the Trust during the academic year 21/22, around 30% are now substantively employed by the Trust. This includes registered nursing and midwifery and AHP roles.

OUR PEOPLE - Temporary Staffing

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Total nursing (registered & nursing support) temporary staffing requests (total FTE requested): The indicator is showing special cause concern above the upper control limit in March 2022. It is showing common cause variation for most recent month, and is consistently failing target with the target just below the lower control limit.
% unfilled nursing temporary staffing requests: The indicator is showing nine points above the mean from Sep 2021 to May 2022 but is currently showing common cause variation. It is consistently failing the target of 0%.
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, but the available data points are a combination of above and below target, with the latest month above target.
% unfilled medical & dental temporary staffing requests: This indicator is not currently shown as an SPC chart due to insufficient data points. For the available data points, it is consistently failing the target of 0%.

Operational Update

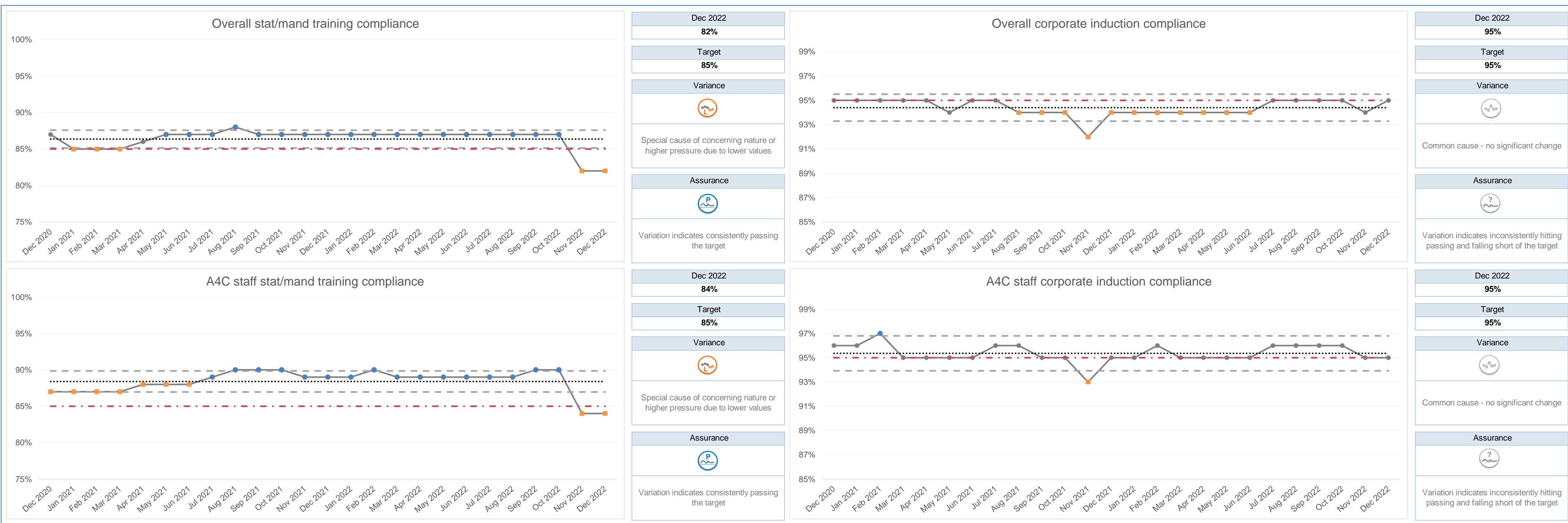
Feedback has been that the Winter incentives introduced in December have been working well to support operational pressures, of note is that more than 1,200 bank shifts which were either allocation on arrival or within maternity or paediatrics were worked in the five weeks from week commencing 28th November. These are shifts which are being offered at double time pay rate. From 1st November, a flexibility payment was available to substantive staff who moved specialty during their shift. As these payments are made in arrears they are reported retrospecitively, with reports showing that in November 2022, the flexibility payment was used 220 times. Despite this, staffing remains challenging.

Early figures show that the use of Thornbury reduced significantly in December as a result of our change in process and the introduction of winter incentives, dropping to an estimated £285k which is the lowest Thornbury spend since Feb 22. Operational pressures in January are expected to see this increase again.

OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Overall staff stat/mand training compliance: This indicator was showing special cause improvement since May 2021 with all data points above the mean and Aug 2021 being above the upper control limit. The target is consistently being met, however Nov and Dec 2022 are below the lower control limit and target.
Overall staff corporate induction compliance: The indicator was showing special cause concern with a run of data points below the mean from Aug 2021 to Jun 2022, with Nov 2021 being below the upper control limit. The indicator is currently showing common cause variation, however the target was not met in Nov 2022.
A4C staff stat/mand training compliance: This indicator was showing special cause improvement since Jul 2021 with all data points above the mean. The target is consistently being met, however Nov and Dec 2022 are below the lower control limit and target.
A4C staff corporate induction compliance: The indicator is currently showing common cause variation with special cause concern seen in Nov 2021 below the lower control limit. The target has been met since Dec 2021.

Operational Update

Statutory and Mandatory training compliance rates for all staff groups remain below target at 82%. Compliance increased steadily during the pandemic (85% in February 2020 compared with 87% in October 2022) due to increased provision through elearning and adoption of the Core Skills Training Framework (CSTF) standards which reduced requirements; however, the addition of Equality, Diversity and Human Rights (ED&HR) training to the programme in November has pushed compliance down.

ED&HR is part of the CSTF; however, it was only recently added into the Trust programme after being partly covered by induction previously. Between 15 November and the end of December, 980 staff completed this training. We aim to embed this programme and recover compliance by May 2023.

Outside of this addition, the Trust is continuing to track below the 85% target across a number of programmes, most significantly for Resus (compliance with specific programmes ranges from 53% for Paediatrics Advanced Life to 76% for Basic Life Support), Deprivation of Liberty Safeguards (DOLs L1 – compliance is 72%) and Safeguarding Children training (core training compliance for Level 3 at 77%). A new lead has been employed to support compliance with DOLS and Mental Capacity Act training, while plans are in place to increase capacity in the Resus team. The Safeguarding Children rates have been affected by staff turnover in the Emergency Department and Sexual Health service.

OUR PEOPLE - Training / Induction (cont.)

REPORTING MONTH : DECEMBER 2022

Medical & dental staff stat/mand training compliance

Dec 2022
68%
Target
85%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target

Medical & dental staff corporate induction compliance

Dec 2022
91%
Target
95%
Variance
Special cause of improving nature or lower pressure due to higher values
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 Aug to Dec 2022 was below the lower control limit and therefore is showing special cause concern.
Medical & dental staff corporate induction compliance: The indicator was showing special cause concern with a run of points below the mean from Aug 2021 to Aug 2022. The last time the target was met was July 2020. The indicator is currently showing special cause improvement with Nov and Dec 2022 close to the upper control limit.

Operational Update

At the end of December, Corporate Induction compliance returned to 95% in line with the Trust's target. Compliance rates in the medical and dental staff group, where there is greater movement of staff, is continuing to sit below target. There are plans for some bespoke induction sessions targeted in particular at doctors in Trust and Careers Grade roles to improve performance in this area. More generally, work continues to develop the content and delivery of induction with a focus on strengthening the quality of new staff members' early experiences. New Starters' Fairs were launched in November 2022 and a new Welcome Booklet launched in December. Further options to provide opportunities to increase people's understanding of and sense of belonging to the organisation on joining are being explored, including development of video content and options for virtual or face-to-face sessions.

OUR PEOPLE - Employee Relations Activity

REPORTING MONTH : DECEMBER 2022

No. open disciplinary cases

Dec 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

No. open disciplinary investigations exceeding policy timescales (6 weeks)

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

No. open bullying & harassment / grievance cases

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

No. open bullying & harassment / grievance cases exceeding policy timescales (1 month)

Dec 2022	1
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 over seven points above the mean from Mar 2022 and special cause concern above the upper control limit in Jun 2022.
No. open disciplinary investigations exceeding policy timescales (6 weeks): 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 with recent months being around the mean.
No. open bullying & harassment / grievance cases exceeding policy timescales (1 month): The indicator is currently showing common cause variation after a run above the mean from Jul 2021 to Jan 2022, although please note the figures are shown from May 2021 only.

Operational Update

We have seen a slight increase in the number of disciplinary cases this month, we have a number of cases that are awaiting appeal so the case remains open for this period.

OUR PEOPLE - Employee Relations Activity

REPORTING MONTH : DECEMBER 2022

No. open MHPS cases

Dec 2022
2
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

No. open MHPS cases exceeding policy timescales (4 weeks)

Dec 2022
2
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:

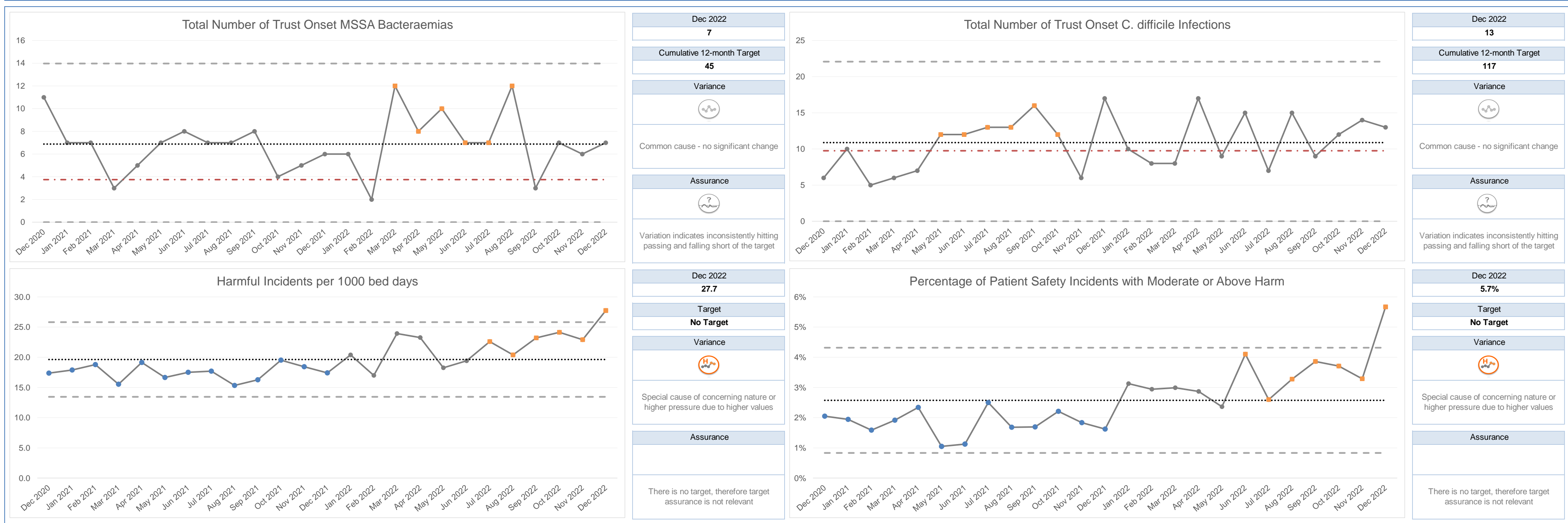
No. open MHPS cases: The indicator is showing special cause improvement with Aug and Sep 2022 below the lower control limit. A decreasing trend was seen since May 2022, prior to that the data points were all above the mean. Please note the figures are shown from May 2021 only.
No. open MHPS cases exceeding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

Operational Update

QUALITY AND SAFETY - Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA has shown a trend above the mean from Mar to Aug 2022, however is now showing common cause variation around the mean.
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 showing special cause concern due to the data points above the mean from Jul 2022, and Dec 2022 being above the upper control limit.
Percentage of Patient Safety Incidents with Moderate or Above Harm: The percentage of patient safety incidents with moderate or above harm is showing special cause concern due to a trend above the mean since Jul 2022, and Dec 2022 being above the upper control limit.

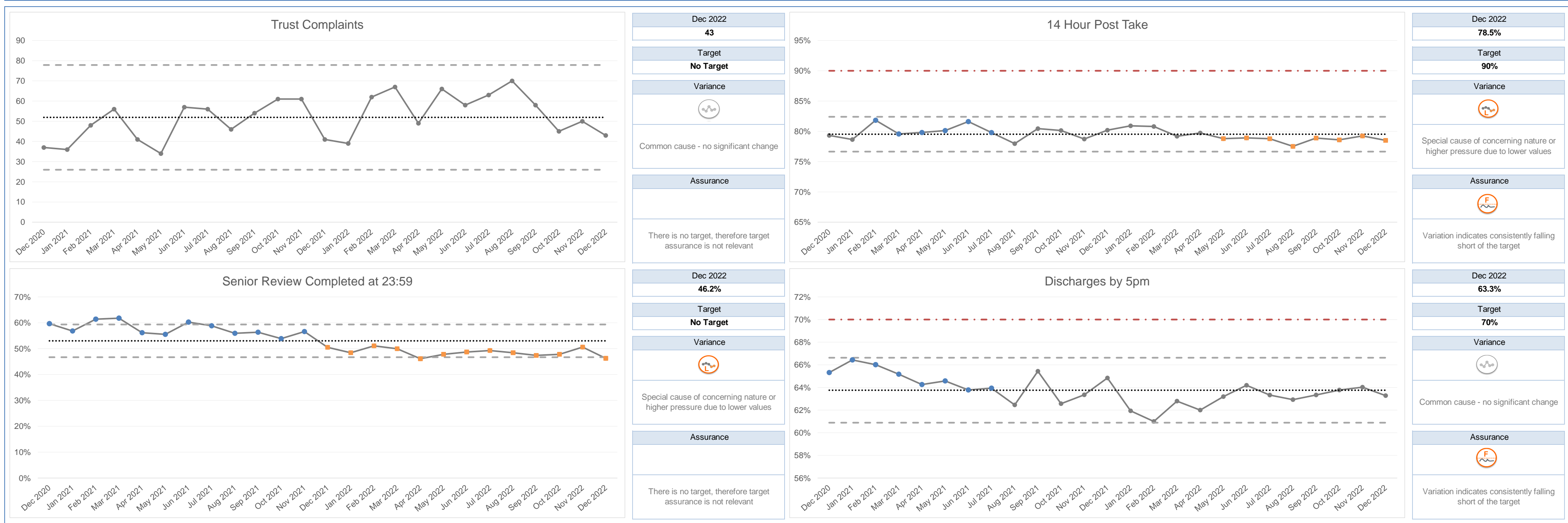
Operational Updates:

Total Number of Trust Onset MSSA Bacteraemias
Aseptic Non-Touch Technique (ANTT) practical training across the organisation remains low. Strategies to reduce Staphylococcus aureus bacteraemia are underway; with initiatives around improving ANTT training compliance, Visual Infusion Phlebitis (VIP) scoring and education around prompt removal of cannula. Support from an external company to audit practice with cannula inserting is being explored.
Staphylococcus aureus bacteraemia risk remains whilst this work is still developing. MSSA PIR process will be rolled out once the C.difficile PIR process is fully embedded within Care Groups

Total Number of Trust Onset C. difficile infections
Limited isolation capacity across the organisation and the lack of a decant space to facilitate deep cleaning (particularly in Scarborough, remains unresolved and a risk to the trust. A program of a ward bay by bay decant and HPV program continues at Scarborough as mitigation. A piecemeal HPV program is not as effective as decanting the whole ward. In York, a program to replace windows will involve full decant of the wards to carry out minor refurbishments and HPV. This program has been delayed due to unprecedented operational pressures seen from December 2022.
60% of C.difficile Post Infection Reviews (PIRs) have been completed. This is an improvement with Care Groups taking ownership of the PIR process.
Mattresses have become contaminated over time as they do not get checked regularly; possibly due to the quick turn-over of patients and staff not getting enough time to complete this task during bed making. This is a risk to transmission of infection. A budget to replace mattress covers and cells has been provided as mitigation whilst a contract for a full mattress replacement is awaited for May 2023.

Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
There are ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams. The pressure on services is especially severe at present with an enhanced level of OPEL 4 in place currently. There is a clear association between pressure on services / staffing issues and patient harms / quality of care. Improvement groups continue to progress initiatives in relation to falls and pressure ulcers. Key risks include pressures on services and capacity and national issues with staff shortages, recruitment and retention. Staffing challenges are recognised and various measure in place to mitigate risks as much as possible. Improvement in the availability of nursing staff has been seen in the last few months on Datix. A discrepancy with IPC new positive incidents at York means that over-reporting is likely to have caused skew in the data. This is currently being investigated to ensure consistency with reporting across sites.

REPORTING MONTH : DECEMBER 2022



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. A run below the mean has been seen since May 2022.
Senior Review Completed at 23:59: Special cause concern is showing with a run below the mean since Dec 2021. April and Dec 2022 were 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.

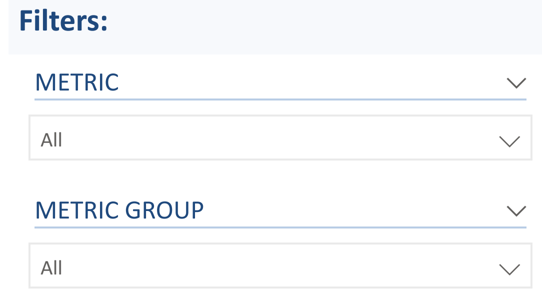
Operational Updates:

Trust Complaints
42% of all complaints related to care in Trust Emergency Departments, where challenges are well documented. The main issues were attitude of nurses and admin staff. The other main issue was communication with patients. Discharge arrangement issues are high this month and feedback will inform the work of the Trust discharge working group. Key Risks are that care groups still unable to address complaints in timely way, with the exception of CG2. Patient Experience Improvement Plan developed to address main themes - monitored by Patient Experience Steering Group

7 Day Standards
The challenges which are affecting performance against these measures:
•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

These factors present a risk of patient harm due to delays in appropriate treatment or diagnosis. The 7 Day standards group is 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. The effects are being mitigated through the wider Trust response to current and anticipated service pressures.

TPR: Icon Summary Matrix (Priority)



VariationIcon	P	?	F		Total
Improvement			**1**		**1**
H					
L			1		1
Common Cause			**1**		**1**
			1		1
Concern	**1**	**2**	**3**		**6**
H	1	2	3		6
L					
Neither					
Empty					
Total	**1**	**2**	**5**		**8**

MetricName	Date	Variation	Assurance	Target	Latest Value
Ambulance handovers waiting >60 minutes (%)	2022-12	H	F	10	38
ED - Total waiting 12+hours - % of all type 1 attendances	2022-12	H	F	8	23
ED: Median Time to Initial Assessment (Minutes)	2022-12	H	?	18	21
Number of patients waiting 63 or more days after referral from cancer PTL	2022-12	H	?	138	350
Proportion of patients discharged before 5pm (70%)	2022-12		F	70	63
RTT Total Waiting List	2022-12	H	P	44017	50379
RTT Waits over 104 weeks for incomplete pathways	2022-12	L	F	0	2
RTT Waits over 78 weeks for incomplete pathways	2022-12	H	F	97	623

TPR: Elective Recovery Priority Metrics

MetricName	Assurance	Variation
RTT Total Waiting List		

LATEST MONTH

50K

Target

44.0K

MetricName	Assurance	Variation
RTT Waits over 104 weeks for incomplete pathways		

LATEST MONTH

2

Target

0

MetricName	Assurance	Variation
RTT Waits over 78 weeks for incomplete pathways		

LATEST MONTH

623

Target

97

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

LATEST MONTH

350

Target

138

DATA ANALYSIS:

- **RTT Total Waiting List:** The indicator is showing deteriorating performance, with a series of points above the mean since Mar 2022. The target is consistently not being reached.
- **RTT Waits over 104 weeks for incomplete pathways:** The indicator has been improving since Nov 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 indicator was improving from Oct 2021, but the value is now back above the target and the upper control limit. The national target is to reduce the number of 78+ week waiters to zero by March 2023. Since Jul 2022, we have seen the trend deteriorating in performance.
- **Number of patients waiting 63 or more days after referral from cancer PTL:** The indicator has been showing variation within the upper and lower control limit since Sep 2020 to Aug 2022. The value is now above the upper control limit.

TPR: Narrative for Elective Recovery Priority Metrics

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Challenges: The Trust has moved into Tier 1 Elective Recovery support (national intervention). Delivery of 78 week trajectory is challenged. The Trust has resubmitted a trajectory to return to plan for patients waiting over 62 days on a cancer pathway. 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 December. 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 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.	Actions: 1. The Trust has received the final version of the Intensive Support Team report and support objectives agreed with the regional team. The report confirmed the areas the Trust had identified as concerns and notes the high risk to the delivery of the 78 week and cancer trajectories. Through the Tier 1 elective recovery regime, the Trust has been provided with management and analytical capacity through Ernst Young Consultancy funded by NHSE, with a dedicated member of staff to progress mutual aid and agreed support for analytics on diagnostic demand and capacity. This has commenced from 9th January. The Trust will also receive onsite support from the Intensive Support Team from the end of January, with a view to 6 months of support. 2. The 50 week SLA has been agreed, however is not yet mobilised due to job planning arrangements and the reduction in the Trust SLA 3. 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. 4. Waiting List Harms Task and Finish Group established. 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 launched in October. 9. The Executive approved additional capacity to support patient pathways, including use of Clinical Assessment Services, booking processes and improved PTL management. Work is ongoing to recruit to these positions. 10. Training Programme for operational managers to commence in February, with pre-requisite training on RTT, Cancer and Waiting List management.
Risks: Potential further COVID-19 variants and/or waves. Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work. Elective activity impacted in early January by Urgent and Emergency Care pressures. Growth in the non-admitted waiting list. Theatre staffing vacancy, retention, and high sickness rates. Industrial action on the 11th and 23rd of January (Ambulance Service - GMB and Unison) and 18th and 19th of January (Royal College of Nursing).	Mitigations: Tier 1 fortnightly meetings with National Team on elective recovery. 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. Plans in place to mitigate impact of industrial action. COVID surge plan in place and our RVI Flu plan has been published.

TPR: Acute Flow Priority Metrics

MetricName	Assurance	Variation	LATEST MONTH	Target
Ambulance handovers waiting >60 minutes (%)	F	H	38	10
ED - Total waiting 12+hours - % of all type 1 attendances	F	H	23	8
ED: Median Time to Initial Assessment (Minutes)	?	H	21	18
Proportion of patients discharged before 5pm (70%)	F		63	70

DATA ANALYSIS:

- **Ambulance handovers waiting >60 minutes (%):** The indicator is showing deteriorating performance over the last year with a series of points above the mean since Dec 2021. 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 a series of points above the mean since Jul 2022. The target has not been reached since Oct 2021.
- **ED - Median time to initial assessment (minutes):** The indicator is showing a trend above the mean in recent months, with Dec 2022 going above the upper control limit.
- **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).

TPR: Narrative for Acute Flow Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
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. The development has been delayed with a completion date of May 2023 rather than March 2023 anticipated. 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).	Actions: 1. Trust has participated in an ICB led Winter Pressures tabletop exercise entitled 'Arctic Willow'. Best practice and lessons learnt have been shared across the ICB. 2. 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. 3. Emergency Assessment Units now open 24/7, work ongoing to extend the clinical criteria and pathways. 4. Project on track to extend the range of specialities operating through a Surgical Assessment Unit E.g. Orthopaedics and Gynaecology. 5. 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. 6. The refreshed Urgent and Emergency Care Programme key aim is: To deliver high quality, safe, urgent and emergency care, for our communities, with our partners, delivered in the right place, at the right time, appropriate to our patient's needs. There are three primary drivers: • Develop pre-hospital attendance avoidance • Improve internal systems and processes • Increase post hospital access to required care These have informed the 7 key workstreams and an over-arching theme of health inequalities. The existing Care Group Transformation Programmes continue and also include relevant care group specific urgent and emergency care improvements. 6.1 Urgent Care: Review of the current service with the aim of co-producing a new integrated care model to be in place before October 2023, including single point of access for health care professionals and improved signposting to service users. Initial workshops have taken place and plans are being made for further discussion in January. 6.2 Children and Young people Integrated Care and Assessment: To work as a partnership to improve and integrate assessment and care for C &YP in York and North Yorkshire. The partnership group is now well established and four streams of work are being progressed: Understanding behaviors and population, workforce, models of care, access and delivery. The initial focus is on understanding children and their family's behaviour around accessing healthcare and progress is being made with the population health team as well as with detailed work by our analyst team. In addition, a social prescriber has been appointed who will specifically work with families where a child has attended on multiple occasions to understand this. Alongside this, models of care such as the CAT hub are being further developed and testing delivery options to inform the future model. 6.3 Virtual Ward: Strategic scoping to identify the infrastructure required and clinical priority for the expected 300 virtual beds to be in place by December 2023. An initial workshop is being scheduled for February to explore the opportunity available to this organisation and local clinical ambition. PTO for further actions

TPR: Narrative for Acute Flow Priority Metrics

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
	6.4 SDEC: Maximise use of all SDEC areas in line with four pillars: SDEC direct, protect estate, Rapid diagnostics, capacity &demand. The December UEC Programme Board focussed on the four pillars as well as digital requirements for SDEC, following a baseline assessment of all areas and agreed a number of actions to take forward in 2023 to ensure that SDEC units are maximised to their full potential. The Trust streamed 16.77 % of ED attendances direct to Same Day Emergency Care (SDEC) services in December, against a Trust target of 20% by March 23. As planned Dr Matthew Cooke visited the York ED in December and has provided a comprehensive report which is now being reviewed to ensure the key themes are integrated within the programme. To summarise he identified the following key actions: • Professional standards with other specialties and wards in terms of referrals and associated behaviours as well as improving communication with the site management office. • Clear plans for maintaining patient flow out of the front door services (UCC, ED, SDEC) – to be done by considering earlier transfers to the discharge lounge or reducing the number of ward moves for patients. • Capacity and demand analysis to ensure adequate and responsive staffing in all acute areas. As well as full hospital escalation to implemented when appropriate and boarding. • Agreed clinical pathways including externally to improve non conveyance and GP referrals to ED. • Clarity over the five-year vision for front door urgent and emergency care and the milestones on the way. 6.5 Discharge: Develop and implement a pan-trust discharge framework. This document is being drafted and developed with the medical director and will be the focus of the January Urgent Care Programme Board. The framework will set standards for consistency across the organisation and build upon existing work in this area. It will provide a refreshed focus especially for patients on Pathway 0 (no additional support required on discharge). Across the Trust, 57.62% of all patients were discharged before 5pm in December, however, this remains below the Trust target of 70%, the earlier the patients are discharged, the quicker the bed can be used for a patient awaiting admission. 6.6 7-day standards: Work is progressing to ensure that plans are in place to achieve the four priority standards in relation to post take, diagnostics and review of patients. At the January programme board these actions will be confirmed, following detailed discussion in December. 6.7 Access to post hospital care: To scope provision of a domiciliary care service and associated options to improve access to post hospital care for our patients. A discussion paper has been completed and debated with the Executive Committee and Corporate Directors. The preferred options are to expand capacity in our existing care units as well as increasing capacity of community response teams to allow prompt discharge of patients needing care after hospital. These options were put forward for the additional social care funding as the Trust's priority. Funding has been confirmed for Bridlington Care Unit and some funding towards York CRT, however the funding is still under review for the other areas. The Trust is continuing to work with partners in developing a wider system plan to include admission avoidance actions as well as supporting discharge actions, with a view to reduce the number of patients in the general and acute bed base who do not have a 'criteria to reside'. The system remains above trajectory, with a weekly meeting in place to review progress and expedite actions. 7. Continued focus on the 100-day Discharge Challenge to optimise discharge planning and flow. Ongoing engagement with system partners. A pan-Trust discharge framework will be developed as part of the wider system plan. 8. Exploration of the development of a domiciliary social care service to support the discharge of patients who do not have the right to reside. 9. NY and York place have agreed to fund CIPHER at Scarborough (ambulance clinical handover and PTS discharge) and York (ambulance clinical handover working with VCS-PTS) through to the end of March 2023. This has commenced in December 2022.

TPR: Narrative for Acute Flow Priority Metrics

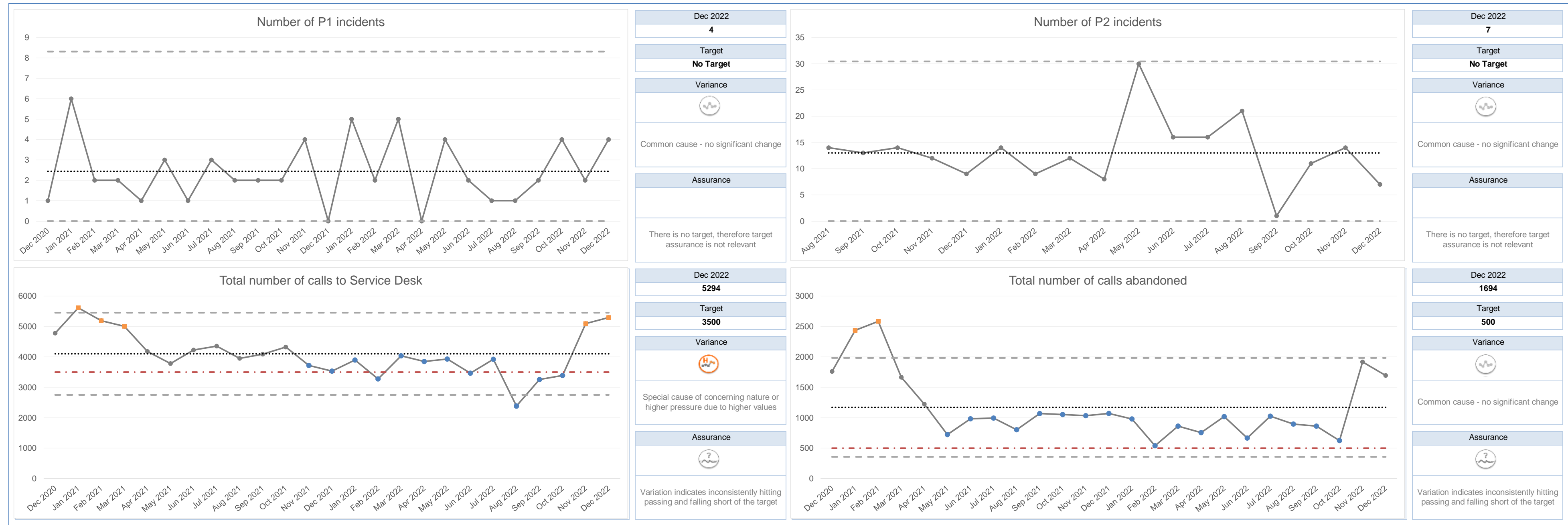
BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
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 Industrial action due to take place in January following the Royal College of Nursing ballot action.	Mitigations: Daily review of medical and nursing staffing to ensure appropriate skill mix – ongoing. 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 supporting 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. Plans in place to mitigate impact of industrial action. COVID surge plan in place and our RVI Flu plan has been published.

DIGITAL - Digital Indicators

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : DECEMBER 2022



Data Analysis:

Number of P1 incidents: The indicator is currently showing common cause variation, with a wider degree of variation around the mean seen in the last 12 months.
Number of P2 incidents: The indicator is currently showing common cause variation, with a sharp increase in P2 calls in May 2022, with only one P2 call showing in Sep 2022. A wider degree of variation around the mean has been seen in the last eight months.
Total number of calls to Service Desk: The indicator is showing a run of points below the mean from Nov 2021 to Oct 2022, with a sharp rise in Nov and Dec 2022 close to the upper control limit. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. Nov and Dec 2022 have not met the target, and the target is not being met consistently.
Total number of abandoned calls: The indicator is showing a run of points below the mean from May 2021 to Oct 2022, with a sharp rise in Nov 2022 close to the upper control limit. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. The target is not being met consistently, but the target line is above the lower control limit.

Operational Update:
P1 incidents:
- 07/12 CPD performance issues during a software go live, regressed and services restored
- 13/12 GP Connect & Yorkshire Ambulance interfaces affected by a network configuration problem
- 20/12 CPD performance issues
- 28/12 CPD performance issues

CPD performance problems are being investigated and tuning/optimisation actions taken where opportunities arise. Further incident in January and ongoing actions to monitor and review for root cause.

Total number of calls / number of abandoned calls
- Continued high demand arising from rollout of Office 365, resulting in high call traffic, positive that the expansion in the team has enbaled us to pick this number of calls and abandoned calls due to all operators being on a call.
- Vacancies within team further compounding this, but improving as new team members become more proficient and further recruitment is underway.
- P1 incidents produce spikes of calls and abandoned calls since they impact across lots of users.
- During a P1, a greeting message is played and Abandoned calls will have heard this and be aware of the ongoing incident. This one reason for high number of calls been abandoned.

DIGITAL - Digital Indicators (cont.)

REPORTING MONTH : DECEMBER 2022

Number of open calls (last day of month)

Dec 2022
2551
Target
1000
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target

Number of end user devices over 4 years

Dec 2022
3436
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 open calls (last day of month): The indicator was showing a run of points below the mean since April 2021, however Sep to Dec 2022 were all above the mean. Nov 2022 rose above the upper control limit. The indicator is consistently failing the target.
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 was 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 from Sep to Dec 2022, but increased in Dec 2022, with 3436 devices now over 4 years old.

Operational Update:

Number of open calls (last day of the month)
- Number of open calls remains high, although it should be noted that **824 / 2551 (32%)** are deferred and awaiting replies/action by users, or delivery of equipment. Actions for all teams to review and prioritise resolution of older tickets / closure of inactive tickets
- Increased support demand from Office 365 deployments, reactivating NHSmail accounts, setting passwords and applying licences.
- Staffing changes within the Service Desk team with 2 experienced staff leaving and 3 new team members who require support from colleagues to become established in the role.

Number of End User Devices over 4 years
This continues to fall however in January we will see a sharp increase of devices of approx falling into the over 4 years bracket. From November the number will start increasing as the refresh programme has ran out of devices. In addition at the last committee we have investigated on how we better control our laptop/desktop estate and have active plans in place to tackle following on from our digital amnesty.

DIGITAL - Information Governance Indicators

REPORTING MONTH : DECEMBER 2022

Number of incidents reported and investigated

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

Number of Patient SARs

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

Number of FOIs received (quarterly)

Dec 2022	Target	Variance	Assurance
137	No Target	Common cause - no significant change	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, however Oct 2022 saw a sharp increase closer to the upper control limit.
Number of Patient SARS: This indicator is currently showing common cause variation after a run of eight points above the mean from Jan to Aug 2022, and Nov 2022. A high number of Patient SARS were seen in Mar 2022 (405), which is above the upper control limit, and also in Nov 2022 (393).
Number of FOIs received (quarterly): This indicator is showing common cause variation, with the latest trend moving back towards the mean.

Operational Update:

FoIs:
Challenges faced are 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.

Actions are to 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.

Key Risks are not meeting statutory responsibilities and intervention from the regulator (ICO)

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 – December 2023 (Month 9)

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 £6.4m against a planned deficit of £0.4m for December. The Trust is £6.0m adversely adrift of plan. This represents a deterioration of the position reported in prior months.

The largest adverse variance relates to pay at £10.2m. Premium rate pressures linked to vacancies and high sickness levels are continuing to contribute to the adverse position. As reported last month, there is a £2.1m annual pressure (£1.6m year to date) linked to the 22/23 pay award to most staff groups other than junior doctors who have a separate three-year deal. Confirmation has only just been received that funding will be made available by the ICB to cover the pay award pressure and this is expected to be received in February. The report for January will reflect this.

The position also remains 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 remains unconfirmed. The scanner is a fully serviced scanner at a cost of £1.4m for the full financial year; at month 9 this is adversely impacting our position by £1.05m.

Of the £6.0m total reported adverse variance, the unfunded pay award and the additional CT scanner account for a pressure of £2.65m for which recompense has been confirmed for the pay award, and some is still expected for the CT scanner. This leaves a balance of £3.35m created through other pressure for which additional income is not expected.

Following the CQC visits the Trust has responded to identified improvement requirements to its maternity and emergency services at additional cost. To date this amount to £140k and is contributing to the overall adverse financial position.

On top of the locum and agency pay pressure noted above other notable variances include drugs overspend of £2.8m (£2.0m relating to out of tariff drugs with compensating additional income from NHSE), an overspend on other costs of £2.7m (including particularly a pressure on utilities of £1.8m due to the further price increases seen last autumn) and a CIP shortfall of £1.5m with some compensation from an underspend on clinical supplies and services of £4.7m.

Also of note is that we spent £7.2m for the year to date on covid costs compared to a plan of £5.6m; therefore we are £1.6m adversely adrift of our covid plan.

Income and Expenditure Account

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	FOT £000's
NHS England	75,296	56,471	60,318	3,847	79,378
Clinical commissioning groups	529,258	396,754	396,124	-630	520,604
Local authorities	4,793	3,588	3,612	24	4,740
Non-NHS: private patients	514	386	306	-80	324
Non-NHS: other	1,186	891	1,184	293	1,998
Operating Income from Patient Care Activities	**611,047**	**458,090**	**461,544**	**3,454**	**607,044**
Research and development	1,765	1,324	1,909	585	2,805
Education and training	24,231	18,084	18,754	670	23,046
Other income	49,084	36,841	37,393	552	45,102
Other Operating Income	**75,080**	**56,249**	**58,056**	**1,807**	**70,953**
Employee Expenses	-447,175	-334,226	-344,463	-10,237	-438,317
Drugs Costs	-61,987	-46,536	-49,343	-2,807	-64,927
Supplies and Services - Clinical	-74,971	-55,480	-50,744	4,736	-62,055
Depreciation	-18,291	-13,718	-12,440	1,278	-18,291
Amortisation	-1,521	-1,141	-1,141	0	-1,521
CIP	4,405	1,588	0	-1,588	4,405
Other Costs	-68,501	-51,683	-54,416	-2,733	-79,683
Total Operating Expenditure	**-668,041**	**-501,196**	**-512,547**	**-11,351**	**-660,389**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**13,143**	**7,053**	**-6,090**	**17,608**
Finance income	30	23	613	591	507
Finance expense	-975	-731	-731	0	-975
PDC dividends payable/refundable	-8,014	-6,010	-6,011	-1	-8,013
NET FINANCE COSTS	**9,127**	**6,425**	**924**	**-5,500**	**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**	**6,425**	**924**	**-5,500**	**9,127**
Remove Donated Asset Income	-9,607	-7,208	-7,659	-451	-9,607
Remove Donated Asset Depreciation	452	342	342	0	452
Remove Donated Asset Amortisation	28	18	18	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**	**-424**	**-6,375**	**-5951**	**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 - December

		December 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	£2,075	£1,022	£1,054	£1,507	£1,507	£1,375	£132	£0
2. Acute, Emergency and Elderly Medicine (Scarborough)	£1,404	£967	£967	£0	£1,300	£105	£1,300	£0	£0
3. Surgery	£3,008	£2,071	£1,266	£805	£2,279	£728	£2,070	£209	£0
4. Cancer and Support Services	£2,552	£1,757	£1,208	£549	£1,843	£709	£1,843	£0	£0
5. Family Health	£1,595	£1,098	£1,022	£75	£1,392	£202	£1,392	£0	£0
6. Specialised Medicine	£1,639	£1,128	£1,339	-£211	£1,958	-£320	£1,852	£106	£0
7. Corporate Functions									
Chief Exec	£65	£45	£76	-£31	£77	-£11	£77	£0	£0
Chief Nurse Team	£164	£113	£101	£12	£134	£30	£134	£0	£0
Finance	£184	£126	£631	-£504	£683	-£499	£683	£0	£0
Medical Governance	£15	£10	£125	-£115	£125	-£110	£125	£0	£0
Ops Management	£101	£70	£50	£20	£50	£51	£50	£0	£0
Corporate CIP	£16,890	£12,668	£12,744	-£76	£18,923	-£2,033	£17,968	£955	£0
DIS	£289	£199	£154	£45	£255	£34	£255	£0	£0
Workforce & OD	£314	£216	£577	-£361	£800	-£485	£800	£0	£0
				£0					
Sub total	**£31,234**	**£22,541**	**£21,280**	**£1,261**	**£31,326**	**-£92**	**£29,924**	**£1,403**	**£0**
YTHFM LLP	£1,123	£773	£446	£327	£1,030	£92	£821	£210	£0
Group Total	**£32,357**	**£23,314**	**£21,727**	**£1,588**	**£32,357**	**£0**	**£30,744**	**£1,612**	**£0**

Delivery in month 9 has improved but remains £1.5m behind plan in terms of the core programme delivery. Plans have been identified to deliver the total programme of £32.4m, and of this sum £30.7m (95%) is identified as low risk.

Recurrent delivery is 26.5% of the year-to-date target and remains a key risk to the programme.

Productivity and Efficiency Review Sessions

Review sessions are to be chaired by the Chief Executive with attendance from Care Groups and Finance colleagues.

The table below shows a revised schedule of dates for these sessions:

Care Group	Date
CG1	25.11.2022
CG2	29.11.2022
CG3	04.01.2023
CG5	12.01.2023
CG4	20.01.2023
CG6	20.01.2023

Format of sessions

The sessions will form 2 parts:

- Part 1 will be a summary of the planning and delivery position for 2022/23 and plans for 2023/24. A review of the **Matrix of Opportunity**, potential opportunities, and results of deep dives relevant to the individual Care Group.
- Part 2 will be an opportunity for the Care Group to discuss current and future challenges in terms of meeting the efficiency ask.

Ongoing Developments

- ### Robotic Process Automation

Work is under-way with Robotic Process Automation (RPA) with a 'proof of concept' project in Accounts payable. This has the potential to be rolled out into other areas within Finance and across the Trust where appropriate and was approved at the Finance and Procurement Transformation Board. This is also being looked at across the ICS. Currently awaiting a DPIA (Data Protection Impact Assessment) to be complete.

- ### Collaborative Programme of Work

We are working with the North Yorkshire and York Place Finance Director Forum (NY&YPFDF) to pull together a programme of work that will support delivery of System savings. The table below identifies some of the schemes that have been discussed and will be worked up and prioritised.

Scheme no	Care Group/Trustwide/System	Benefits	Next Steps
1	Inventory Management within Community – CG1	Improved stock control Improved pricing through purchasing of products via Supply Chain Gain/Share savings circa £40k recurrent FY22/23. Further opportunity to make savings through roll-out to other community sites – circa £80k recurrent.	Direction of travel: scanning of 'product to patient' ; all about patient safety, better governance and compliance Part 2: Trial at Tang Hall HC (BC attached) eventually roll out to other Health Centres in York area. Review formulary with TVN's once switch to Supply Chain Possibility of rolling out across ICS. NHS Supply Chain Key Stakeholder in process.
2	Pharmacy - Excluded Drugs : Set Target for Pharmacy	Regional Collaboration. Improved pricing.	MH System Top Ten Drugs/Biosimilars. Drugs Spend Provider/Community/Place Agree appropriate Task and Finish group. DoF Place Group to agree & Assign Target
3	Pharmacy: Prescribing	Improved prescribing Reduction in Waste Reduce number of products prescribed Cash reduction £TBA	Review current practice, delivery, spend & volume. Review across ICS and Health sectors. Identify opportunity and timescale. Agree appropriate Task and Finish Group DoF Place Group to agree and priortise.
4	Pharmacy & CG1 - Nebulised Drugs	CF Drugs, High Cost Nebulised Medications	Share CG1's paper identify saving and evidence from other Trusts. Savings opportunity reflects Hull and York activity (York are commisioned to provide both). CG1 are leading on this. Is there opportunity for Harrogate.
5	Pharmacy - Formulary Review	Rationalisation of products. Improve patient outcomes. Reduction in Cost.	Formulary review and rationalization of products across ICS and health sectors Agree appropriate Task and Finish Group. DoF Place Group to agree and prioritise.

Getting It Right First Time (GIRFT) Update

We are awaiting feedback from the National Team on the following reviews:

Urology - 21 October 2022
Emergency Medicine and Acute and General Medicine - 16 November 2022.

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 £1.05m pressure on our plan. ICS CDH team are submitting national case for support, working with the Trust. No timeline information available, expect January 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 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 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 more than £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. 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. This assumption is fully reflected in the reported position for the period to date.

6. Current Cash Position

December cash balance showed a £2.8m adverse variance to plan; this is mainly due to the payment of outstanding capital invoices. 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	48,796	35,012	30,711			

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 9 Planned Spend £000s	Mth 9 Actual Spend £000s	Variance £000s
86,513	52,927	34,765	(18,162)

The capital programme at month 9 is £18.2m behind plan. This is partially 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 £10m (26%) behind plan. The 3 main schemes contributing to this adverse variance are Scarborough UEC scheme (£5.5m), Salix Scheme (£2.3m) and York Cardiology VIU (£2.2m). which are partially offset by other schemes running ahead of plan.

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 has recommenced. CIP panel meetings have been reconvened with the CEO.	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 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 £1.8m 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.	This review work has been completed and all the £4.3m reduction requirement has been identified.
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 has now been notified that it will receive up to £2.1m from this fund.
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 the financial year progresses, we continue to review and update 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	615,674
Non-Clinical Income	79,352
Expenditure	-685,899
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 three months of the year.
- The remaining CIP left to achieve will have a 36% impact on run rate.
- Additional income is received to cover the full pay award.
- Utilities expenditure does not exceed the £2.2m pressure currently forecast.
- The financial recovery plan discussed at the last Board is developed and is successful in reducing predicted spending by £2.9m.

This forecast has formed the basis of our forecast submission to NHSE/ICB for M9.

Within the overall Trust forecast are differing forecast variances across the Care Groups. Linked to the recovery plan agreed by the Board at its last meeting, the Care Groups have been asked to develop their own recovery plan using the initiatives identified in the Board paper, and to report on their assessed impact on the Care Groups forecast outturn position as at M7.

The table below illustrates the Care Groups respective forecast net expenditure positions at M7, and how their identified recovery actions improve on these positions. Overall the table shows that of the £2.9m target for the financial recovery plan £2.1m of low to medium risk initiatives have been identified to date. Work continues with the Care Groups to reach the target and on lowering the overall delivery risk.

Care Group etc.	Budget	Actual Forecast	Forecast Expenditure Variance	Offset by income	Underlying expenditure variance	Sum of Recovery Actions	Revised Forecast Outturn
Acute Elderly Emergency General Medicine and Community Services - York	105,243,917	109,324,147	-4,080,230	-992,417	-3,087,813	-236,000	-2,851,813
Acute Emergency and Elderly Medicine-Scarborough	53,495,453	58,470,342	-4,974,889	-811,472	-4,163,417	-97,000	-4,066,417
Surgery	100,407,767	104,350,540	-3,942,773	-1,359,741	-2,583,032	-236,113	-2,346,919
Cancer and Support Services	119,305,973	120,548,156	-1,242,183	-709,172	-533,011	-221,000	-312,011
Family Health & Sexual Health	49,970,411	50,668,590	-698,179	0	-698,179	-308,490	-389,689
Specialised Medicine & Outpatients Services	86,648,645	85,596,359	1,052,286	0	1,052,286	-165,000	1,217,286
Other	0	0	0	0	0	-874,000	874,000
TOTAL	515,072,166	528,958,134	-13,885,968	-3,872,802	-10,013,166	-2,137,603	-7,875,563

Using the deficit position with the Care Groups reported above, after recovery actions, and after taking into account the full corporate reported position and YTHFM position we remain targeting a balanced outturn position for the wider group.

Recommendation:

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

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Director Sponsor: Andrew Bertram, Finance Director

Date: Jan-2023

TRUST PRIORITIES REPORT : December-2022

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

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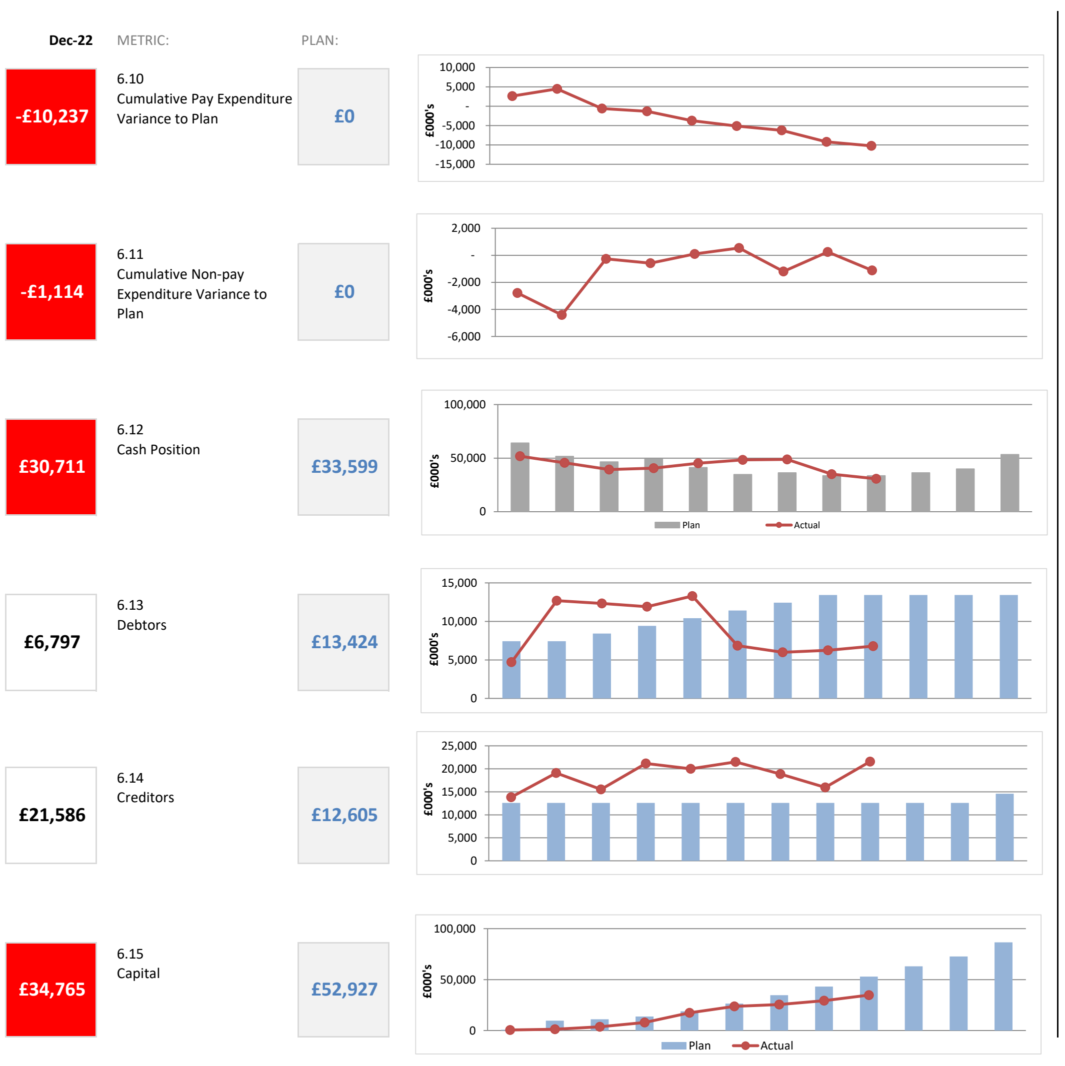
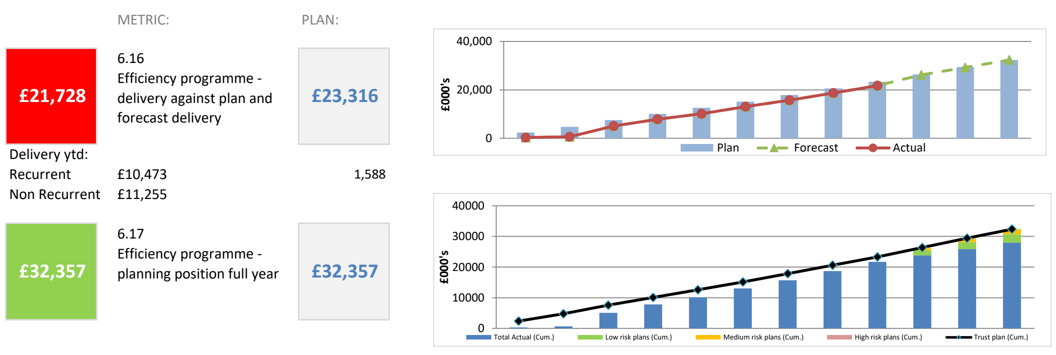
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY





Planning (Gap)/Surplus

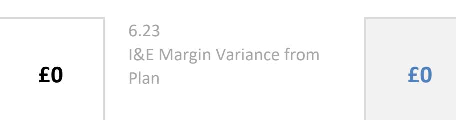
	December £'000	EOY £'000	Comments
Target	**23,314**	**32,357**	
PLANS			
Low Risk	22,916	30,744	
Medium Risk	269	1,612	Medium Risk Plans being reviewed re delivery in year.
High Risk		0	
Total Plans	23,185	32,357	
Planning (Gap)/Surplus	**-130**	**0**	
Actions			**New Plans** - continue to work with CG's to identify u/spends; opportunities presented in Model Health System (more likely medium/longer term)

TRUST PRIORITIES REPORT : December-2022

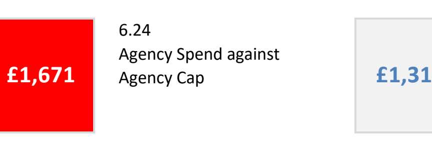
SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Dec-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

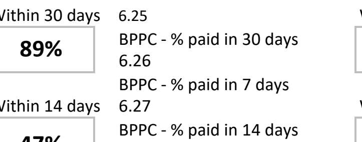


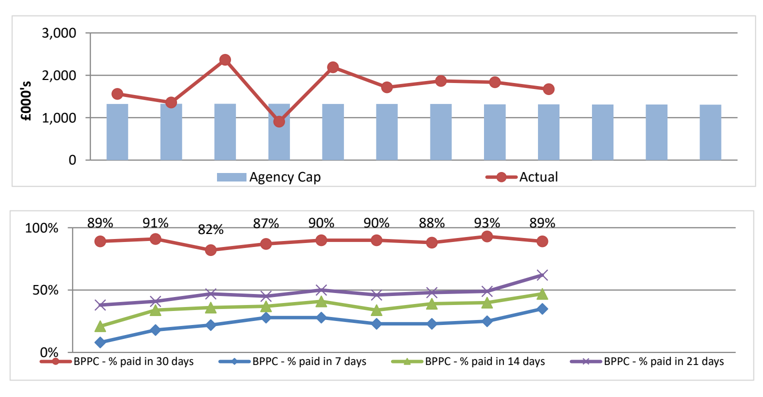
£1,671	6.24 Agency Spend against Agency Cap	£1,314



BPPC Performance

Within 30 days	6.25 BPPC - % paid in 30 days	Within 7 days
89%	6.26 BPPC - % paid in 7 days	35%
Within 14 days	6.27 BPPC - % paid in 14 days	Within 21 days
47%	6.28 BPPC - % paid in 21 days	62%





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 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 89% of suppliers being paid within 30 days.

Research & Development Performance Report : Dec-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 3250 patients into clinical trials so far this financial year, against a target of 3506, so we are almost there and will certainly reach our target this year
•We have been informed to expect a budget cut next year due to some changes to the local funding model proposed by the Clinical Research Network (that in part I do not agree with). The cut will be in the region of 4-6% and can be dealt with in the R&D department as staff retire and leave in the coming 12 months (and not replaced).
•We have received our report from the Critical Friend review held in Oct 2022, where a visiting review party came from another hospitals R&D Department (Calderdale and Huddersfield Hospital) to review our processes and practices. We will feedback their findings next month
•We are exploring the possibility of creating a Dermatology Clinical Lectureship post and we are aiming to have a meeting to discuss this in January
•We have submitted a bid to the Clinical Research Network to add some additional staff to the Scarborough MLTC Hub for the next 12 months. We have asked for support for a Specialist Diabetes Nurse and a Physiotherapist, that will allow us to extend the depth and breadth of the research we offer our patients at Scarborough. The decision on this bid will be known in January
•We have appointed another fee waivered PhD with York St John from one of our Specialist Occupational Therapist in the South Hambleton and Ryedale Primary Care Network (PCN). Ruth Kay aims to look at delaying and reversing frailty in rural communities
•The team supported the Trust Education Bursary call and attended the funding panel to make the sections

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: Jan-2023

TRUST PRIORITIES REPORT : December 2022

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022-23	494	570	225	239	217	361	764	214	166				3250
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 December 22

Care Groups	Accruals Running Total 22/23
CG1 Total	**376**
CG2 Total	**171**
CG3 Total	**360**
CG4 Total	**130**
CG5 Total	**51**
CG6 Total	**103**
RP's Total	**525**
Cross Trust Studies Total	**1534**
ACCRUAL TOTALS	**3250**

Accruals Still Required	**256**
Trials Open to Recruitment	**102**

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	**37%**	**15%**	*Weighted 11*
Observational	**50%**	**62%**	*Weighted 3.5*
Large Interventional	**4%**	**4%**	*Variable weighting by study*
Large Observational	**5%**	**16%**	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	**4%**
Non Commercial	**96%**

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

APPENDIX : National Benchmarked Centiles

REPORTING MONTH : DECEMBER 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 06/01/2023
* 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%)	Dec-22	63.0%	70%	83	21/121	*Nov 22
	UEC	ED: Median Time to Initial Assessment (Minutes)	Dec-22	21	18	19	96/119	*Oct 22
	RTT	RTT Total Waiting List	Dec-22	50379	44017	30	118/168	*Oct 22
	RTT	RTT Waits over 104 weeks for incomplete pathways	Dec-22	2	0	31	117/168	*Oct 22
	RTT	RTT Waits over 78 weeks for incomplete pathways	Dec-22	623	97	13	147/168	*Oct 22
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Dec-22	7	45 (12-month)	6	129/137	*Sep-22
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Dec-22	13	117 (12-month)	21	108/137	*Sep-22
	Patient Experience	Trust Complaints	Dec-22	43	No Target	23	162/210	*Q4 21/22

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 08

Report to:	Board of Directors
Date of Meeting:	25 January 2023
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 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 provide information and assurance to the board on how the Trust has responded to provide the safest and effective nurse staffing levels during October and November 2022 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
To decide whether further actions or additional information is required
To consider items for assurance
Acknowledgment of the retention plans

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.

2. Considerations

The Trust has complied with the submission of CHPPD data for October and November 2022 submission (tables 1 and 2).

Table 1 October 2022

Care Group	Day				Night			
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
CG1	69%	68%	18%	-	82%	91%	12%	-
CG2	82%	93%	8%	-	91%	97%	54%	-
CG3	73%	84%	-	-	80%	106%	-	-
CG4	69%	71%	-	-	97%	90%	-	-
CG5	67%	78%	-	-	74%	94%	-	-
CG6	-	-	-	-	-	-	-	-
Total	72%	78%	26%	-	83%	95%	38%	-

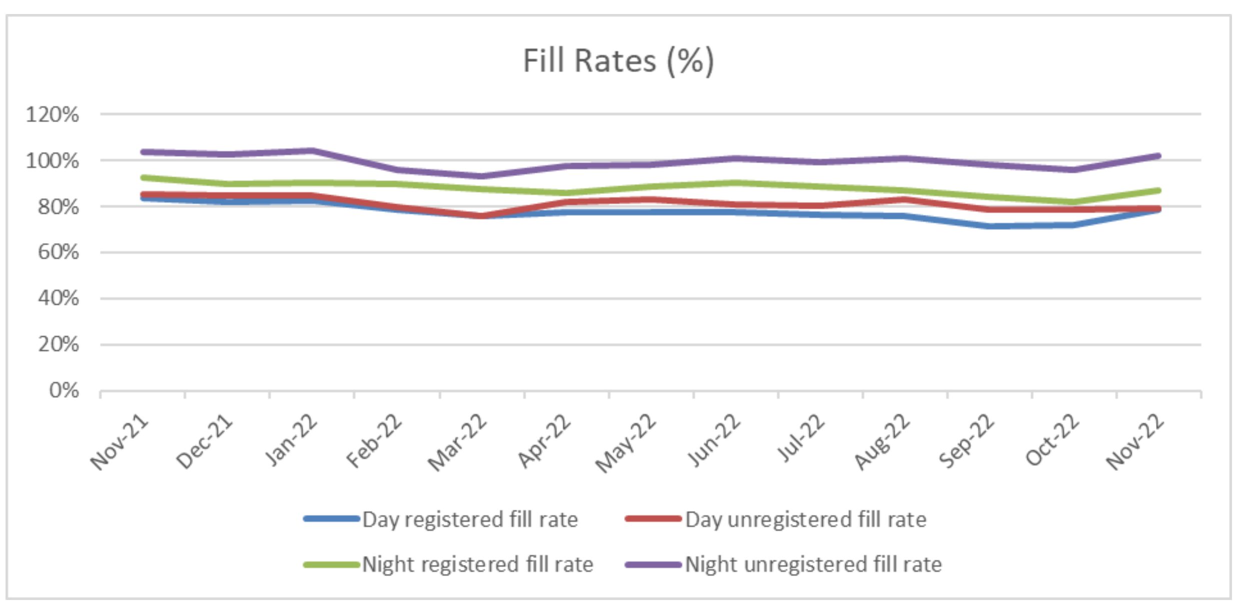
Table 2 November 2022

Care Group	Day				Night			
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
CG1	86%	77%	31%	-	96%	113%	10%	-
CG2	84%	92%	12%	-	92%	106%	39%	-
CG3	81%	89%	-	-	88%	109%	-	-
CG4	86%	84%	-	-	92%	89%	-	-
CG5	76%	81%	-	-	93%	100%	-	-
CG6	-	-	-	-	-	-	-	-
Total	82%	84%	35%	-	92%	109%	35%	-

The average day fill rate in October 2022 for Registered Nurses was 71% and November shows an improvement at 82%. The night fill rate has also improved from October to November and each component has increased above 80% for all domains in November.

Graph (3) below identifies the fill rates since Sept 2021, splitting day and night, registered and unregistered. It indicates that above 80% was achieved for the night shifts since June 2021 for both Registered and Non-Registered nurses and an improvement in day fill rates for November 2022. All above 80% for the organisation.

Graph 3



3. Current Position/Issues

Nurse Vacancies

Registered Nurse

Table 5 below shows the current RN projections for December 2022 and actual starters and leavers are available. The table indicates a positive position for adult inpatient wards by May 2023 on the current trajectory.

Table 5

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Establishment	937.5	937.5	937.5	937.5	937.5	937.5	937.5
Projected in post	*865.61*						
Actual in post (ESR as at 301122 + 1 NQs on band 4 av	873.99	892.45	916.91	914.37	911.83	909.29	939.75
Projected leavers	*5.88*	*5.72*	*5.72*	*5.72*	*5.72*	*5.72*	*5.72*
Actual leavers	2.64						
Projected International Recruits	*14.76*	*17*					*33*
Projected UK qualified starters	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*
Projected NQs/direct apprenticeships	*3*	*4*	*27*				
Total projected new starters	*20.94*						
Actual new starters	24.28						
Vacancies	-63.51	-45.05	-20.59	-23.13	-25.67	-28.21	2.25

There has been an improvement in RN leavers figures from October, where the average is 5.88 per month, November shows 2.64 WTE leavers. These figures will be presented every month to monitor the projected against the actual. The table indicates all the starters, including NA who are topping up to RN, international nurses, and PRNs (newly qualified). Projected starters were 20.94 and actual starters are 24.28 for November.

Health Care Assistant

Table 6 HCA Vacancy Levels Trust wide projected and actual 2022/23

Band 2/3	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Establishment	695.34	695.34	695.34	695.34	695.34
Projected in post	***630.2***				
Actual In post as at 3011	612.26	631.15	650.04	668.93	687.82
Projected leavers	***5.7***	***6.11***	***6.11***	***6.11***	***6.11***
Actual leavers	7.35				
Projected New Starters	***25***	***25***	***25***	***25***	***25***
Actual new starters	24.2				
Vacancies	-83.08	-64.19	-45.3	-26.41	-7.52

Table 6 above details the current HCA position for adult inpatient wards for the Trust. The leavers figures due indicate a higher number for November than the average. We continue to recruit HCAs at trajectory. There is an HCA recruitment event in York on 13 Feb 2023. Detailed work continues through the HCARRG, with an improvement plan, shared and supported by the NHSE Direct support team. Retention of the HCA role is paramount, an HCA appreciation day took place on 23 November supporting the HCA role and its value to the organisation. NHSE direct support is ongoing and there is a site visit planned for February 2023 to look at our current processes. Further development work continues with a timeout in January to look at the recruitment processes and a dedicated matron supporting the HCA process.

Temporary Staffing

The Trust is being supported by NHSE to reduce our high off framework agency spend in nursing. An improvement plan has been developed to focus on key areas that can help reduce our reliance on agency, these include our utilisation of eRostering, our processes for engaging temporary staffing and our recruitment processes. A workshop is planned for 8 March 2023 from NHSE to support this ongoing work

In preparation for winter pressures the Trust has already implemented several incentives from December 2022 including, flexibility payments for substantive staff moving wards, 10% bank incentive, double time overtime for substantive staff working in areas with exceptional workforce challenges and the utilisation of allocation on arrival bank shifts, paid at double time, to target priority shifts. The incentives are being offered in place of automatic off framework agency use, with the expectation they will reduce off framework spend.

The graph below 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, over 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 7) with an ongoing demand for temporary workforce. In October 2022, 40% of all shift requests were unfilled.

Table 7 Temporary staffing demand

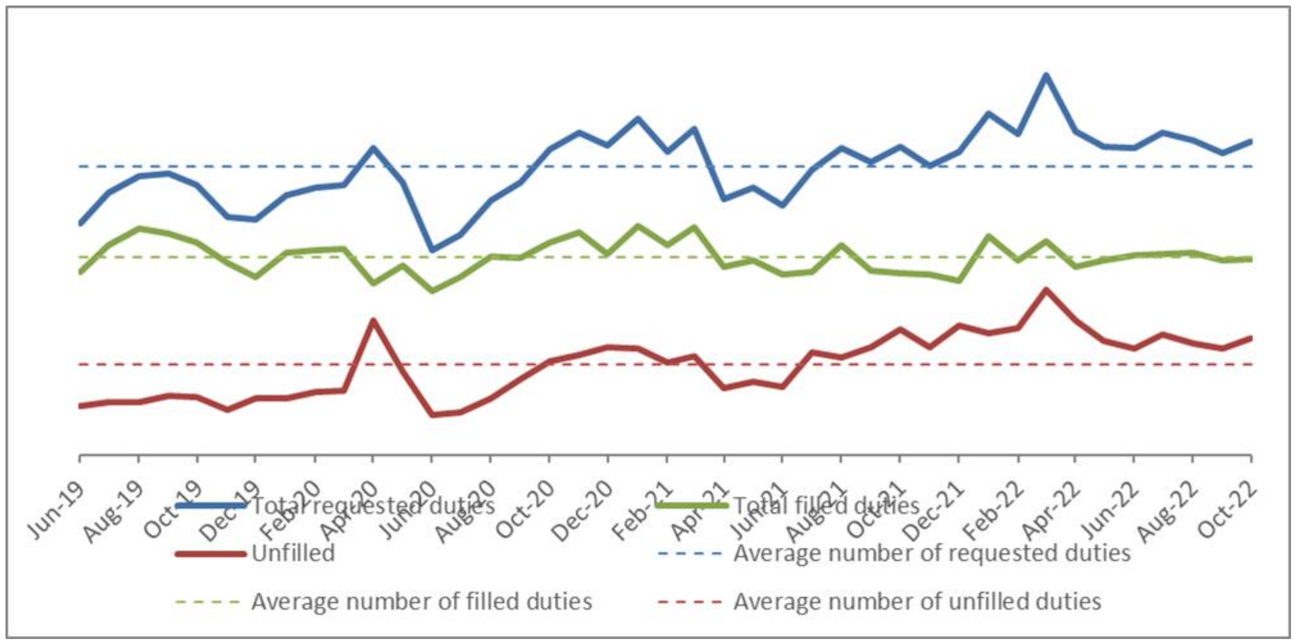


Table 8

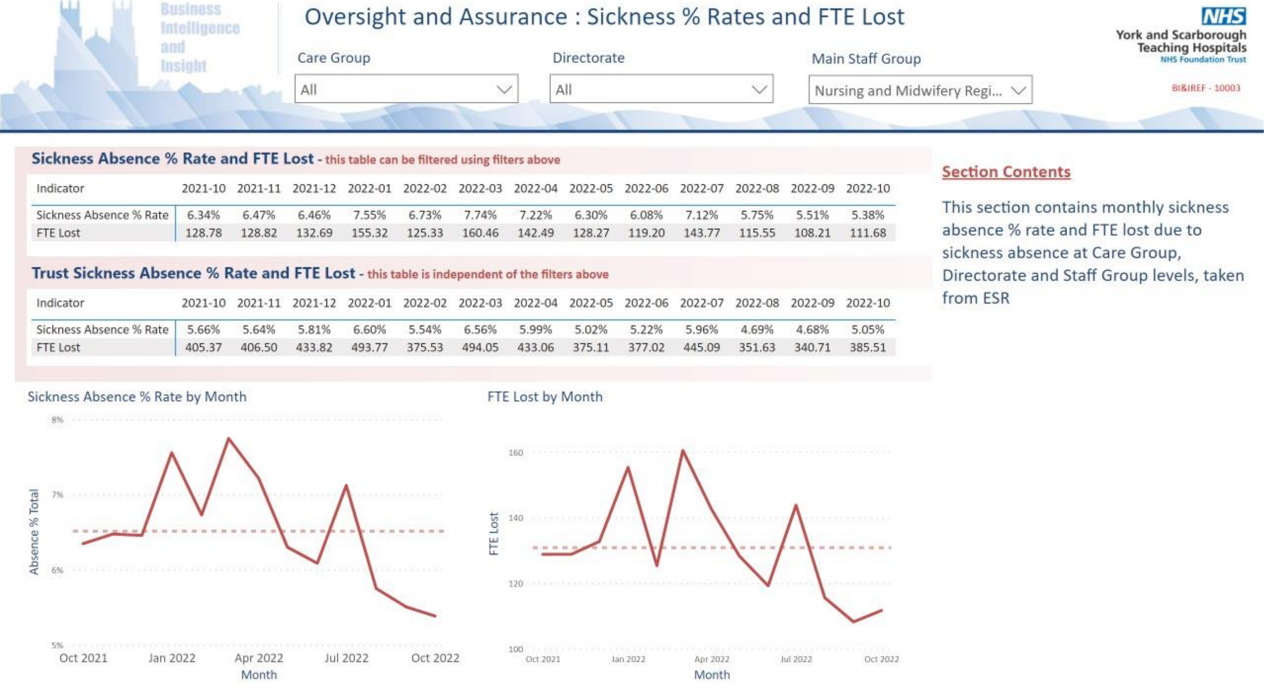
Month	01/10/2022

	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	5979	6478	12457	217	1505	1722	14%	3240	2533	5773	46%	60%	2522	2440	4962	40%
York	3677	4444	8121	216	1144	1360	17%	1870	1802	3672	45%	62%	1591	1498	3089	38%
Scarborough	2302	2034	4336	1	361	362	8%	1370	731	2101	48%	57%	931	942	1873	43%

Impact of sickness absence

The table below shows a steady decrease in Registered Nurse and Midwifery sickness absence over the months, with 5.38% for October 2022 from 5.51% in September 2022

Table 9 Sickness for Registered Nurses October 21 – October 2022



Oversight and Assurance : Sickness % Rates and FTE Lost

Care Group: All | Directorate: All | Main Staff Group: Nursing and Midwifery Regi...

Sickness Absence % Rate and FTE Lost - this table can be filtered using filters above

Indicator	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10
Sickness Absence % Rate	6.34%	6.47%	6.46%	7.55%	6.73%	7.74%	7.22%	6.30%	6.08%	7.12%	5.75%	5.51%	5.38%
FTE Lost	128.78	128.82	132.69	155.32	125.33	160.46	142.49	128.27	119.20	143.77	115.55	108.21	111.68

Trust Sickness Absence % Rate and FTE Lost - this table is independent of the filters above

Indicator	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10
Sickness Absence % Rate	5.66%	5.64%	5.81%	6.60%	5.54%	6.56%	5.99%	5.02%	5.22%	5.96%	4.69%	4.68%	5.05%
FTE Lost	405.37	406.50	433.82	493.77	375.53	494.05	433.06	375.11	377.02	445.09	351.63	340.71	385.51

4. Summary

This report highlights the current workforce analysis of CHPPD for October and November 2022, vacancies for Registered Nurses and Health Care Assistants (HCA), actual and projected figures and the amount of temporary workforce requested, filled and unfilled.

Date: 11 January 2023

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Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	Public Sector Equality Duty (PSED) Workforce Annual Review Report 2022
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion (EDI) 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 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:

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions, these are to:

1. Eliminate discrimination, harassment, and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and people who do not
3. Foster good relations between people who share a protected characteristic and those who do not

This Workforce Annual Review Report is a requirement of the Public Sector Equality Duty (PSED) which places additional specific duties on public authorities, including NHS Trusts, these are to:

- Publish sufficient information to demonstrate compliance with the general duty by 31 January 2012 and thereafter annually, and:
- Prepare and publish 1 or more equality objectives by 6 April 2012 and no more than four years thereafter.

The Trust's 2020-2024 Equality Objectives were approved by the Trust in 2020 and covers Patients, Buildings Environment and Workforce. It was previously decided upon that the Patient and Workforce agendas would be reported upon separately. Therefore, the PSED Patient Annual Review Report was presented by the Patient EDI Lead to the Quality & Safety Assurance Committee on 17 January 2023. The Head of Equality, Diversity and Inclusion (EDI) has made the decision to combine both reports in the future, this will provide a more holistic overview of progress against the objectives and is normal practice. This will coincide with the finalisation of the current Equality Objectives.

This report provides a thorough account of the work that has been carried out by the Trust to meet its Workforce Equality Objectives in 2022.

The objectives are:

Workforce:

To be regarded as a fully inclusive employer by:

- Continuously reviewing our recruitment processes to remove any unintended bias.
- Continuing to undertake activity which ensures we maintain our disability confident status.
- Engaging with members of our community, local charities and internal stakeholders to become a fully diverse employer that is reflective of society.

To contribute to the overall Trust's retention strategy by:

- Working to reduce inequalities experienced by staff from across the protected characteristics by engaging with key stakeholders to fully implement the Trust's EDI action plans, which include Gender Pay Gap, Disability Confident, WRES, WDES and also, the annual staff survey action plan.
- Providing a voice to our workforce through the development and implementation of Staff Networks.
- Fully equipping our workforce through training and development to proactively support staff to work in an equal, diverse and inclusive manner and environment.
- Ensuring that our HR policies and procedures support the needs of a diverse workforce.
- Supporting our staff to work flexibly wherever possible.

The areas covered that demonstrate our progress are:

- EDI Governance
- Communication and Engagement
- Recruitment and Selection
- Disability Confident and Mindful Employer
- Staff Survey
- Freedom to Speak Up and the Fairness Champions
- Employee Relations Practices
- Organisational Development and Improvement and Learning
- Training
- Chaplaincy
- Staff Networks
- Staff Benefits
- Celebration of Cultures
- Gender Pay Gap (GPG), Workforce Race and Disability Equality Standards (WRES) and (WDES)
- Workforce Equality Monitoring Information

Conclusion

This report shows the good progress the Trust is making with its Equality Objectives, this will be enhanced through the establishment of an EDI Workstream which will support our work further. Care Groups and Corporate Services will be able to develop their own local action plans which support the objectives.

The Head of EDI has created an EDI action plan to address the recommendations of the external review conducted in 2022. This action plan incorporates elements of the PSED Objectives as does the WRES, WDES and GPG action plans.

The Trust, communities, partners and stakeholders can be assured that the Trust continues to work towards meeting its Equality Objectives 2020-2024.

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

Meeting	Date	Outcome/Recommendation
N/A		

Equality Act 2010: Public Sector Equality Duty (PSED) Workforce Annual Review Report 2022

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   1.1. The Equality Act 2010 and the Public Sector Equality Duty (PSED)… Page 3

   1.2. Equality Delivery System (EDS) 2022… Page 5

2. Our Commitment… Page 6

3. Equality Objectives Progress – Equality, Diversity and Inclusion activity… Page 7

4. Gender Pay Gap Report... Page 19

5. Workforce Race Equality Standard (WRES)… Page 20

6. Workforce Disability Equality Standard (WDES)… Page 20

7. Workforce Equality Monitoring Information… Page 20

8. Conclusion and Next Steps… Page 36

1. Introduction.

York and Scarborough Teaching Hospitals NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles.

We manage 8 hospital sites and have a workforce of around 10,000 staff working across our hospitals and within the community.

We are an NHS Foundation Trust. Foundation Trusts operate independently of the Department of Health but remain part of the National Health Service (NHS). This gives us greater freedom and more formal links with patients and staff. We are accountable to them through an elected and appointed Council of Governors.

Our hospitals

- York Hospital
- Scarborough Hospital
- Bridlington Hospital
- Malton Hospital
- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- Nelsons Court Inpatients Unit

(Click location above to access link)

York and Scarborough Teaching Hospitals NHS Foundation Trust is a diverse employer and provider of care. Our aim is to create a culture of inclusion where everyone feels valued and respected for who they are and what they bring to our organisation.

Our Public Sector Equality Duty (PSED) Workforce Annual Review report highlights the progress we have made in 2022 in line with our Equality Objectives.

A separate report is produced for York Teaching Hospital Facilities Management (YTHFM).

1.1 The Equality Act 2010 and the Public Sector Equality Duty (PSED).

The Equality Act 2010 introduced a general equality duty requiring organisations to have due regard in the exercising of their functions. These are to:

1. Eliminate discrimination, harassment, and victimisation.
2. Advance equality of opportunity between people who share a protected characteristic and people who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

We are required to do this by:

1. Removing or minimising disadvantages suffered by people due to their protected characteristic.
2. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
3. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
4. The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include steps to take account of disabled person's disabilities.
5. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard to the need to tackle prejudice and promote understanding.

The Protected Characteristics covered by the Equality Act 2010 are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

The PSED places additional specific duties on public authorities, including NHS Trusts, these are to:

- Publish sufficient information to demonstrate compliance with the general duty by 31 January 2012 and thereafter annually, and

- Prepare and publish 1 or more equality objectives by 6 April 2012 and no more than 4 years thereafter.

1.2 The NHS Equality Delivery System (EDS 2022).

The EDS 2022 replaces the EDS2 and is a new and revised approach which supports meeting the PSED. Therefore, it is advised that the EDS2 is now disregarded.

Implementation of the EDS is a requirement on both NHS commissioners and NHS providers.

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, Staff Networks, community groups and trade unions - to review and develop their approach in addressing inequalities in health access, experiences, impact and outcomes through three domains: Services, Workforce health and Wellbeing and leadership. It is driven by data, evidence, engagement and insight and has been amended to be brought into line with the NHS Long Term Plan, and in response to COVID-19.

2022/23 has been used as a transition year, for organisations to use this period to get used to applying the EDS 2022 in a new way, in a new system.

EDS 2022 has 3 Domains and 11 Outcomes which are:

EDS Domain 1: Commissioned or provided services:
Outcome 1A: Patients (service users) have required levels of access to the service.
Outcome 1B: Individual patients (service users) health needs are met.
Outcome 1C: When patients (service users) use the service, they are free from harm.
Outcome 1D: Patients (service users) report positive experiences of the service.

EDS Domain 2: **Workforce health and well-being**:
Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.
Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
Outcome 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.
Outcome 2D: Staff recommend the organisation as a place to work and receive treatment.

EDS Domain 3: Inclusive leadership:
Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
Outcome 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

Organisations must work with partners and stakeholders across the Domains. Each Outcome is to be scored based on the evidence provided. Once each Outcome has a score, they are added together to gain Domain ratings. Domain scores are then added together to provide the overall score, or the EDS Organisation Rating.

2. Our Commitment to Workforce Equality and Diversity.

York and Scarborough Teaching Hospitals NHS Foundation Trust is dedicated to encouraging a supportive and inclusive culture where all our patients can receive high quality, person-centred healthcare which meets their needs. It is within our best interest to promote diversity and eliminate discrimination amongst our workforce in the development of services and our hospital environments.

York and Scarborough Teaching Hospitals NHS Foundation Trust are dedicated to creating a supportive and inclusive culture in line with our Trust Values. We are dedicated to our patients receiving high quality, person-centred healthcare which meets their needs and our staff being able to feel valued, listened to and respected so they can bring their whole selves to work.

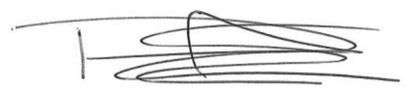
We are committed to taking our responsibilities seriously in providing equity and fairness to all our staff, ensuring we provide no less favourable treatment on the grounds of the 9 protected characteristics.

The 9 protected characteristics are what is covered by the Equality Act 2010 but it is important for the Trust to not only comply with legislation but to move beyond it, in seeing the 'whole person' by focusing on creating a culture of inclusion, as we know that when you do this, equality and diversity should naturally follow. We also acknowledge that there are vulnerable health groups that our staff may belong to and our staff might experience health inequalities too, so our work will endeavour to address their needs too.

We recognise the Trust has a long way to go, but we are dedicated in making the required changes and recognise that everyone has a responsibility to ensure that we are diverse, inclusive and equitable in all our practices.

York and Scarborough Teaching Hospitals NHS Foundation Trust commits to:

- Being an organisation that is welcoming and accessible to all.
- Ensuring that there are no barriers to accessing jobs, training or promotion.
- Engaging with patients, communities and colleagues, whilst working collaboratively with our partners and stakeholders.
- Not tolerating any forms of discrimination and will challenge it safely wherever we see it, ensuring that Equality, Diversity and Inclusion is everybody's business – continuing to embed our values and behavioural expectations; a 'Just Culture' and learning environment for all.
- Acting on staff feedback.
- Developing interventions which help our staff to understand and support one another for the benefit of each other and patients in our care.



Polly McMeekin
Director of Workforce and OD

Simon Morritt
Chief Executive

3. Progress made with our Workforce Equality Objectives – Equality, Diversity and Inclusion Activity.

The Trust is required to publish its equality objectives every 4 years, therefore the objectives cover the period of 2020-2024. These are:

Patients:

To engage with patients, visitors, carers, governors and local stakeholders and organisations to listen and understand their needs and experiences across the protected characteristics.

To engage internally with services to discuss how the needs of patients and visitors can be met to ensure that:

1. Health inequalities are reduced.
2. Discrimination is eliminated.
3. Patients are provided with the appropriate support to meet their needs.

To achieve compliance with the Accessible Information Standard 2016*.*

Buildings Environment:

- To monitor progress against the Trust inclusive built environment policy and strategy.

Workforce:

To be regarded as a fully inclusive employer by:

- Continuously reviewing our recruitment processes to remove any unintended bias.
- Continuing to undertake activity which ensures we maintain our disability confident status.
- Engaging with members of our community, local charities and internal stakeholders to become a fully diverse employer that is reflective of society.

To contribute to the overall Trust's retention strategy by:

- Working to reduce inequalities experienced by staff from across the protected characteristics by engaging with key stakeholders to fully implement the Trust's EDI action plans, which include Gender Pay Gap, Disability Confident, WRES, WDES and also, the annual staff survey action plan.
- Providing a voice to our workforce through the development and implementation of Staff Networks.
- Fully equipping our workforce through training and development to proactively support staff to work in an equal, diverse and inclusive manner and environment.
- Ensuring that our HR policies and procedures support the needs of a diverse workforce.
- Supporting our staff to work flexibly wherever possible.

The Trust currently has 2 reports which focus on the PSED. 1 relates to Patients and Buildings Environment, which provides a summary of the progress made against the corresponding objectives. The other (this report) focuses on Workforce.

Below is a thorough but not exhaustive overview of the work that has been carried out within the Trust in line with our Equality Objectives. In June 2022 an External Consultant worked with the Trust to conduct a review of where the Trust was in progressing the EDI agenda. This led to the employment of a Head of EDI who has strategic responsibility for EDI with an operational focus on workforce issues. A Trust wide workforce action plan has been created which will support the Trust in becoming more a more inclusive employer.

EDI Governance:

The Trust has a Fairness Forum which is chaired by Simon Morritt, Chief Executive. The Forum has an overview of EDI and discusses areas relating to patient and workforce EDI. Representatives from the Care Groups, Corporate Services, the Staff Networks, Staff Side, Trust Governors and external partners and stakeholders attend the meetings to ensure that there is partnership working and collaboration in addressing issues raised.

In 2023 the Head of EDI will be implementing an EDI Workstream which will consist of a group of representatives that have operational responsibility for focusing on EDI at a local level; creating action plans to address specific local issues as well as Trust wide issues.

This Workstream will update the Fairness Forum but will report to the People and Culture Committee for workforce issues and Quality and Safety Assurance Committee for patient issues. Both of these committees are sub-committees to the Trust Board.

Communication and Engagement:

In October 2022 the Trust's latest Communications and Engagement Strategy was approved by the Board of Directors. At its core, there are several communications principles which are rooted within the organisation's values and behaviors and aim to ensure that equality, diversity, and inclusion influence our communications approach and activities.

Within with the Trusts Values, these principles include:

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).

We previously conducted workshops with staff and the feedback we received confirmed that we needed a set of Values which provided a strong foundation for the organisation we want to become, and which will help us to create the future we want to experience. The Trust Values say who we are and what we stand for. The framework provides examples of the behaviours we love, the behaviours we expect and the behaviours we don't want. We started to embed the new Values in 2021 through annual appraisals and introducing the role of Values Ambassadors, who

explore what values mean and how they can be lived out in real life i.e. how they can be integrated into everyday work.

Celebration of Achievement Awards:

The Trust's annual recognition awards took place in 2022 for the first time since 2019 due to the pandemic. The awards recognise a wide range of staff for their achievements across several areas. In 2023 a new category will be included to recognise staff who have done significant work to champion diversity and inclusion and challenge discrimination, making a difference to patient and staff experience as a result. The Communications Team, working with the Head of EDI, will also review the annual and monthly awards process to identify ways of improving diversity amongst the nominations and winners, and increasing participation from all parts of the workforce including those with protected characteristics.

Events Planner:

The Communications and Workforce and Organisational Development teams are developing a calendar of events and awareness days for 2023. This will enable proactive planning to deliver several campaigns to highlight EDI priorities across the year, focussing on areas where the Trust needs to raise further awareness and/or take action to improve. Taking a campaign-style approach and using existing national and international awareness initiatives/days (e.g. Disability History Month, International Women's Day, Black History Month etc.) creates the opportunity to maximise impact and provides a platform for the Trust's local messages and priorities.

Recruitment and Selection:

The Trust continues to emphasise the importance of a Values-based recruitment (VBR) approach through its recruitment strategy. All recruitment campaigns which are centrally supported by the Human Resources (HR) team utilise VBR methodology. The VBR approach relies on the attraction and selection of new staff according to their motivations and drivers and ensures that experience and qualifications are not given a disproportionate level of attention in the selection process. Research has shown that values-based recruitment increases workforce diversity as it takes a much broader view, not only of applicants, but of the attributes which make someone suitable to undertake a particular role.

We undertake our recruitment via a system called Trac, which ensures that candidate's details, other than those required to evaluate the application against the role requirements, are not available to the shortlisting panel until shortlisting has been finalised.

The Trust's Recruitment & Selection training, which is available to all staff, promotes a Values-based approach. The content of this training course is continually under review to ensure that it reflects current legislation and best practice. Due to the pandemic this course was developed to enable the Recruitment Team to deliver it remotely when necessary, and we are working with our Staff Networks and our Head of EDI to help make further improvements both in our Recruitment & Selection Training and in our recruitment practices generally.

We are a Disability Confident employer and eligible candidates are offered a guaranteed interview if they meet the essential criteria for the role.

All applicants who are invited for an interview via Trac are encouraged to make us aware if they require any adjustments to be made to their interview arrangements.

Careers Events:

We continue to attend careers events and link with Universities, Colleges and Job Centre Plus to attract a diverse range of candidates to apply to our Trust.

International Recruitment:

We continue with our project to recruit Nurses from overseas to work in both York and Scarborough. On arrival they work as Band 4 pre-registered nurses while they study for the exam which will enable them to register with the NMC and ultimately work as a Band 5 Nurse in the Trust.

Over 400 International Nurses have arrived at the Trust since inception of the project in 2019, and a vibrant Stay & Thrive network now operates in the Trust.

Over the past year we have also welcomed several international colleagues from professions such as Medics, Allied Health Professionals and Midwives. We continue to host the training programme for internationally trained Midwives for our region.

All international arrivals receive the same wrap around pastoral care from our International Recruitment Team.

We have started to help recruit and train internationally trained nurses for the Social Care sector.

Recruitment Website:

During 2022 a dedicated recruitment website was built and is now up and running. We are currently working to ensure that the site is representative of our diverse workforce.

Disability Confident and a Mindful Employer:

Disability Confident is a government scheme that encourages employers to think differently about disability and take action to improve how they recruit, retain and develop disabled people. There are 3 levels of in the scheme.

1. Disability Confident Committed.
2. Disability Confident Employer.
3. Disability Confident Leader.

During 2021 we achieved Disability Confident reaccreditation; this means that we have assessed ourselves against the framework as an employer that goes the extra mile in getting the right people for the Trust and keeping and developing those people. There is always more that we can do, and the associated actions are incorporated within the Trust Workforce Disability Equality Standard action plan, which was developed in consultation with our Staff Network, Enable. As a Trust we have an aspiration to be a Disability Confident Leader which is the highest level Disability Confident accreditation and this means that we will be acting as a champion in our local area for recruiting, retaining and developing disabled staff.

After submitting a wealth of information to Mindful Employer on its wide-ranging suite of health and wellbeing offerings for staff, we were successful in retaining Mindful Employer status. We have a group that meets regularly to discuss our current strategy and forthcoming health and wellbeing initiatives to ensure that the needs of our staff are met. Staff councils, which are designed to be safe space for employees to voice their views and co-produce ideas with their local management teams, are also being established in the Trust some of which have a specific focus on health and wellbeing.

The Trust has invested in training Mental First Aiders and are rolling out training on the effects of burnout which has a focus on supporting teams with their mental and physical wellbeing; through all of these initiatives, we aim to provide a gold standard of support for the entirety of our workforce.

The Mindful Employer charter sets out that all staff who are involved in recruitment activity should be trained on the Equality Act 2010. It is expected therefore, that recruitment and selection panel members have undertaken the recruitment and selection training; this training includes information on what it means to be a Disability Confident and Mindful Employer. It provides examples of how and where to apply the Disability Confident scheme, the legal framework of the disability legislation and how to make appropriate reasonable adjustments. These important schemes are also a key component of our recruitment and selection policy.

We have intranet pages dedicated to supporting disabled individuals in the workplace and the operational HR team have recently received bespoke EDI training. Our people professionals proactively support and provide appropriate challenge where required to our managers in the application of the equality legislation across our people management processes.

Staff Survey:

40.7% of eligible staff completed the 2021 Staff Survey. Several questions specifically relate to the WDES and WRES. Where the responses to these questions indicated that staff who either identified as Black and Minority Ethnic (BME) or having a long-term condition / illness had a less favourable experience than either staff identifying as white or not having a long-term condition / illness, specific actions have been identified and these are included in the Trust's 2022 and 2023 WRES and WDES action plans.

In addition, the Trust identified several actions as part of its Staff Survey improvement plan (2022-23). This will further support the actions to increase staff voice and change the culture:

- Refresh our leadership approach.
- Implement a Just & Learning culture.
- Launch the Behavioural Framework that supports the Trusts Values.
- Review our processes for addressing experiences of bullying and harassment.
- Appointment of Head of EDI for the Trust.
- Increase the profile of the Freedom to Speak Up Guardian (FTSUG).
- Listening events for BME staff with the CEO and Race Equality Network.
- Reintroduce CEO drop-in surgeries.
- Introduce Director of Workforce & Organisational Development staff surgeries.
- Review and increase two-way engagement opportunities for staff.

Further work is being delivered by several workforce-focused workstreams:

- Culture & Engagement.
- Health & Wellbeing.
- Flexible Working.
- Retention.
- Attraction & Workforce Planning; to improve staff experience generally.

Freedom to Speak Up and the Fairness Champions:

The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment for staff and to promote learning and improvement.
A FTSUG within every NHS Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review in 2015. FTSU has also become part of the Care Quality Commission (CQC) Well Led inspection component since October 2016.

The Guardian is impartial, independent and reports directly to the Chief Executive. It is important that that the FTSUG is visible and accessible to all staff, therefore the Guardian has promoted the role, speaking up and the Fairness Champions via different mediums.

As well as a continuation of the above there are plans in place for the FTSUG and the Equality, Diversity and Inclusion Lead to conduct further “Speak Up and Inclusion Roadshows” in 2023 to help spread the message of speaking up and hopefully reach those staff groups who face barriers to speaking up.

Employee Relations Practices.

Just Culture:

We have continued to develop a Just Culture within the organisation, the HR team, work in line with the NHS England guidance and principles so we only commission formal disciplinary cases when all other options have been exhausted. We have updated our guidance for Investigating Officers and Panel Members over the last 12 months to ensure that we capture learning for all at every step of the process and ensure we have accountability for taking forward these actions. We are still developing a new disciplinary policy with Staff Side colleagues to develop this culture further within the Trust and this will be rolled out in 2023 with training for all line managers.

Policies:

We are reviewing all our HR policies to ensure that they are people focused and cater to the majority, not the minority, with the flexibility for managers to make decisions to meet the needs of the colleagues they are working with. We want our managers and leaders to have the autonomy and ability to meet the needs of individual staff members in the framework of our policies that are fair for all. A number of our policies are being re-written completely to ensure that they are fit to meet the needs of staff members and the organisation in these current times, to ensure they are easy for managers and staff members to follow and to ensure that they support staff members to achieve their best within the organisation.

Working with Staff Side:

We continue to work with our Staff Side colleagues on several improvements we are doing within the workplace. We have Staff Side representation within a range of meetings which address the workforce priorities. We regularly meet with Staff Side colleagues formally and informally to hear the employee voice and to try and find solutions to problems.

Organisational Development and Improvement and Learning:

The Trust continues to promote and embed the role of Values Ambassadors across all departments and roles. The Trust's Organisational Development Team continues to support the development of both new and existing Values Ambassadors. The Trust's Values and Behavioural Framework are also embedded in all internal leadership programmes and organisation development interventions.

The Development of its workforce has always been paramount for our Trust; the support and development of people maximises talent within the organisation, attracts and retains the best people and creates opportunities for career progression. This is key to the success in achieving our strategic goal of delivering safe and high-quality patient care as part of an integrated system.

There are development opportunities offered to all clinical and non-clinical staff regardless of background or level. Any programme or workshop ring-fenced for a

specific staff group has a clearly defined purpose. By engaging with and targeting the Trust's internal Staff Networks, our programmes support diversity and inclusion with equal access for all.

Leadership Framework:

The Trust has recently developed 'Our Leadership Framework'.
The ambition of our Leadership Framework is to support every leader, no matter their level across the Organisation, to recognise, reflect and role model 3 core principles of people centred leadership, which align to our Trust Values. A reflective tool supports and complements the framework and can be used by individuals to explore their behaviours and competency against the principles of the framework and allow others to give feedback on this.

It recognises that good leadership plays a vital role in improving services, building an inclusive and respectful culture where diversity and difference is valued and celebrated and one where staff are engaged and motivated. It will contribute to supporting both the attraction and retention of staff and ultimately a more positive patient experience and improved quality of care.

Reverse/Reciprocal Mentoring:

Following the evaluation of a successful pilot Reverse Mentoring programme which focused on pairing staff from a BME background with Executive and Senior Managers, a Reciprocal Mentoring Framework has been refined and developed in response to feedback from those who participated in the initial programme.

The Reciprocal Mentoring Framework can be implemented for any equality group and it is our intention to widen this participation. It is proposed that the Trust initially builds upon the success of the pilot programme and continues to focus on race with its next cohort in order to provide this significant learning opportunity for all our Executives and Senior Management. Recruitment for the next cohort will commence in January 2023.

By creating opportunities for staff from minority groups to share their experiences we are demonstrating our willingness to listen and learn in line with our Values and to shape a culture where every member of staff can thrive, belong, develop and perform.

Training:

Generic and specific EDI training and development ensures that our staff have the knowledge and skills to support them in the delivery of care and enables them to work cohesively with colleagues. Training has occurred at Trust Board level, locally and through accessing the EDI section of our Trust's Website. The EDI component of the Core Skills Framework is now mandatory training for all staff.

We know that we need to enable our colleagues to access a wider range of learning interventions and have plans to address this in 2023.

So far, the learning interventions that are to be delivered are:

- Trans Awareness and Gender Diverse Communities.
- Conscious Inclusion.
- Neurodiversity in the workplace for Managers.
- Race Conversations at Work for Leaders.

Chaplaincy:

The Trust's chaplaincy service provides pastoral, spiritual and religious care to patients, carers and staff. They play a huge role in helping people find strength and meaning in their experience of illness, anxiety, dying or bereavement regardless of their faiths and beliefs, including those with no faith.

The service has been stretched over the last year but a business case for support will help support delivery. Investment in the chaplaincy service would enable a more diverse team to offer support to a wider group of staff and patients, particularly those from a Muslim, Roman Catholic and non-religious background. Chaplaincy continues to recruit volunteers from diverse backgrounds and develop links with local faith groups and communities.

At Scarborough hospital the chapel is now a shared space for Muslim daily and Friday prayers thanks to the purchase of a curtain and a privacy screen.

The building work on a permanent ablution room at York Hospital has commenced and is due to be open soon. The department recently hosted the New York Imam who was very pleased with the work done on the facilities and the recent provision of Halal food for staff.

Staff Networks:

The number of Staff Networks has increased in the past 12-18 months, and their work continues to be promoted, alongside encouraging increased membership and involvement. **We have 5 Staff Networks, which are**:

- Enable (Disability)
- Women's Network
- LGBTQ+
- Caring for Carers
- REN (Race Equality Network)

All Networks are open to all staff and are included in the decision-making process of the Trust.

To progress our Staff Networks the Head of EDI will implementing Protected Time for Committee Members, exploring a permanent budget, having Executive Director Sponsors and intersectionality and how the Networks can work together.

Staff Benefits:

Staff Benefits aims to offer a wide variety of benefits and wellbeing initiatives accessible to all staff.

Financial Wellbeing:

A financial newsletter outlining all relevant help towards the cost of living issues is available and was translated into Polish on request from YTHFM who have a large proportion of Polish staff. This can be translated into any language upon request. Financial help and savings opportunities via Leeds Credit Union helping staff to save and gives access to ethical loans and debt consolidation with the option to pay direct from salary.

Cost of living initiatives:

A range of cost of living initiatives are available to support staff, from free feminine hygiene products, uniform swaps to prize draws.

Staff Wellbeing:

The Trust offers a wide range of Occupational Health (OH) and Staff Wellbeing offers and initiatives. The aim of the Health and Wellbeing services is to work with our staff to integrate health and wellbeing into day-to-day activities to enable us to create positive and healthy working environments across the Trust. This is achieved through wellbeing initiatives, employee support mechanisms and joint working with staff and their representatives. We also work with local partners such as the Integrated Care Board to identify and address areas of improvement. The OH and Wellbeing Team are proactive in empowering our staff to prioritise their wellbeing and support those around them in doing the same. The team works closely with the Communications Team to promote the wellbeing offer and collaboratively with a wide range of stakeholders across the Trust to ensure a robust health and wellbeing offer is provided.

A celebration of world cultures:

Team members from different parts of the world came together at Scarborough Hospital to create the first ever Festival of Culture where staff spent a week sharing, enjoying and learning about their colleague's cultures.

York and Scarborough Teaching Hospitals NHS Foundation Trust has over 400 international nurses who play an essential role and contributions came from staff from India, Pakistan and Nepal, Philippines and Africa and the rest of the world. The week involved food, music and dancing, and culminated in a huge beach party at Scarborough's North Bay with around 200 people joining in.

A quote from our Associate Chief Nurse at Scarborough Hospital: "*Sharing our cultures is such an important part of helping our international colleagues thrive, and we're proud to see it done so well in Scarborough. The full week event, which was driven by our international nurses in their own time, was amazing and really built the team spirit. The staff loved learning about different cultures and the beach party was extraordinary - full of joy and happiness. We look forward to having a similar event annually to continue to embrace our cultural differences and understanding."*

The International Nurse Project Manager at the Trust added: *"We are really proud to have hosted this festival. It's a wonderful acknowledgement of how welcome our international nurses have felt at Scarborough Hospital and a real testimony to the team spirit in Scarborough. The beach party was incredible and I'm sure it will stay in people's minds for a very long time."*

(The cover photo was taken at this event).

York Theatres Cultural Celebration Afternoon:

In the last two years, our Theatres Team have received 98 new starters, many of whom are international Nurses. It had been identified that staff needed to understand differences in intercultural communication, so a cultural celebration event was organised. The afternoon was brilliant, so much positive feedback and a real sense of joy in the department. The event will be replicated on a regular basis focusing on a different culture to really appreciate and celebrate each other.

4. Gender Pay Gap Report.

The Gender Pay Gap (GPG) describes the difference between the average earnings of all the women in an organisation compared to the average earnings of all the men in that organisation. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same.

Our GPG Report was published in 2022 (the data is a snapshot taken at 31 March 2021) which provides an analysis of pay by gender. It also provides information regarding the areas of focus and the progress made against them. The report can be found here:

https://www.yorkhospitals.nhs.uk/seecmsfile/?id=6345

Progress:

- The Caring 4 Carers Network has been implemented along with the creation of a Carers Passport and a review of the Special Leave Policy which has given additional leave to benefit staff.
- EDI training has been implemented and is planned for 2023.
- The Leadership and Management Framework incorporates EDI.
- Recruitment adverts have been reviewed.

- Starting salaries guidance for staff on Agenda for Change terms has been updated.
- The Trust has completed the Flex programme and has a Flexible Working Workstream.
- The Family Leave Policy has been reviewed.
- The Retention Strategy has been incorporated into the Trust's Attraction and Retention Workstream.

The Trust's Women's Network has the Gender Pay Gap as a standing item on their meeting agenda's and have influenced policy change to support staff.

5. Workforce Race Equality Standard (WRES).

A review of our WRES metrics has enabled us to establish where we are with race equality. Progress has been slow across the metrics and dedicated actions have been created with internal stakeholders to address the issues that have been identified. It is important that we make more sustainable progress across the metrics and with race equality in general. The Head of EDI who is also the Trust's WRES Expert is working with staff to address local issues and the Care Groups and Corporate Services to look at the strategic process required to make change. The 2022 report and action plan can be found here:

https://www.yorkhospitals.nhs.uk/seecmsfile/?id=6816

https://www.yorkhospitals.nhs.uk/seecmsfile/?id=6820

6. Workforce Disability Equality Standard (WDES).

The Trust has reviewed data collected from the NHS Staff Survey and the Electronic Staff Record (ESR) in line with the 10 metrics of the WDES. The analysis shows that the Trust has made good progress with disability equality and was invited by NHS England to take part in a national focus group sharing best practice. We recognise that we cannot be complacent about our progress and our action plan shows the areas of focus for 2022/23. The documents can be found here:

https://www.yorkhospitals.nhs.uk/seecmsfile/?id=6817

https://www.yorkhospitals.nhs.uk/seecmsfile/?id=6819

7. Workforce Equality Monitoring Information.

This section focuses on internal demographics regarding staff employed by York and Scarborough Teaching Hospitals and has been extracted from Electronic Service Record (ESR) on a snapshot date of 30/11/2022. The 2021 Census data is being released in stages this year so a comparison with this will occur in the next reporting cycle. What we can ascertain from our data is that we employ a diverse workforce and this will influence the work that we carry out as a Trust.

In relation to gender, our workforce is heavily made up of females which is reflective of the NHS profile. The national ESR system does not yet enable organisations to collect data on other gender identities but information regarding this has been given to NHS Digital.

There is a significant proportion of staff that chose not to share whether they have a religious affiliation or not and this is their right. This will still be incorporated into our equality monitoring work.

Our age demographics show that there is an even spread of staff from ages 26-60, but below and above this, less staff are employed. This will influence our work on apprenticeships, retirement and workforce planning.

Our sexual orientation profile shows that many staff have not disclosed their orientation and there will be different reasons for this. This will influence our EDI work on engagement, culture, psychological safety, training and equality monitoring.

The staff ethnic profile of the Trust, whilst states BAME (Black, Asian and Minority Ethnic) in the pie chart is broken down further. This is important, to show the different ethnicities but also to acknowledge and recognise that different ethnic groups have a variety of different needs and therefore should not be treated as one homogeneous group.

The ethnic groups that are more represented that others are White, African, Asian and Indian. This is likely to be reflective of our localities with the non-white groups being in situ due to international recruitment and representation in certain professions.

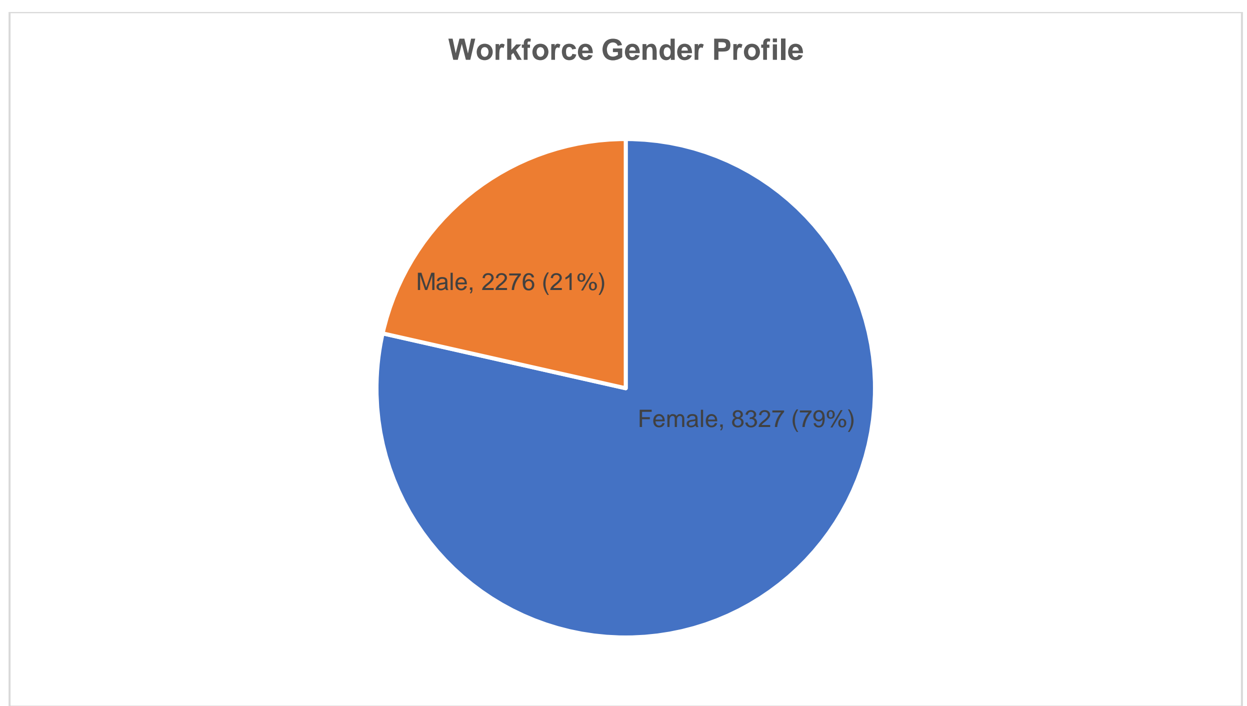
There has been an increase in staff sharing their disability identity and as it is important to continue to support staff, we have incorporated this in our equality monitoring work and WDES action plan.

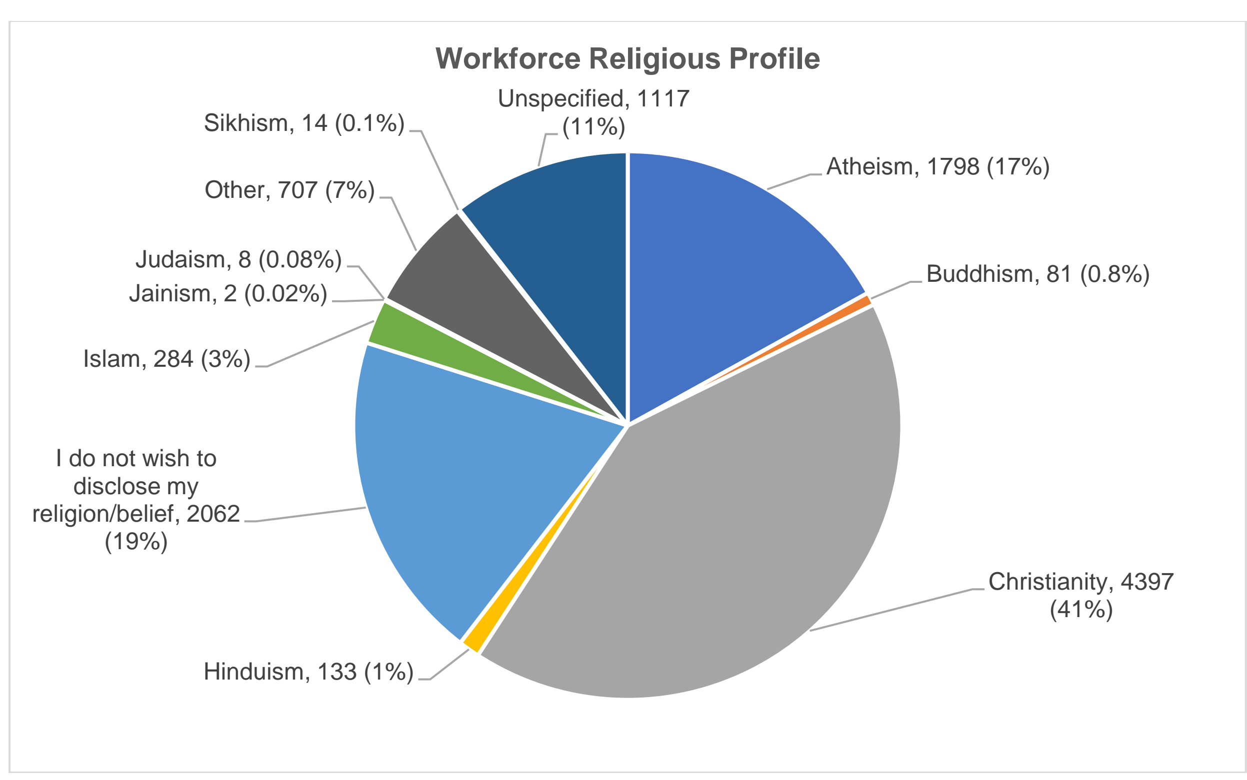
National population demographics tell us that as we become older, we are more likely to have a long-term health condition (LTHC). There will be various reasons why staff choose not to share whether they are disabled or have a LTHC but as an organisation we still need to offer support and talk about LTHC and the social and medical models of disability. This internal data will be monitored through our WDES data analysis.

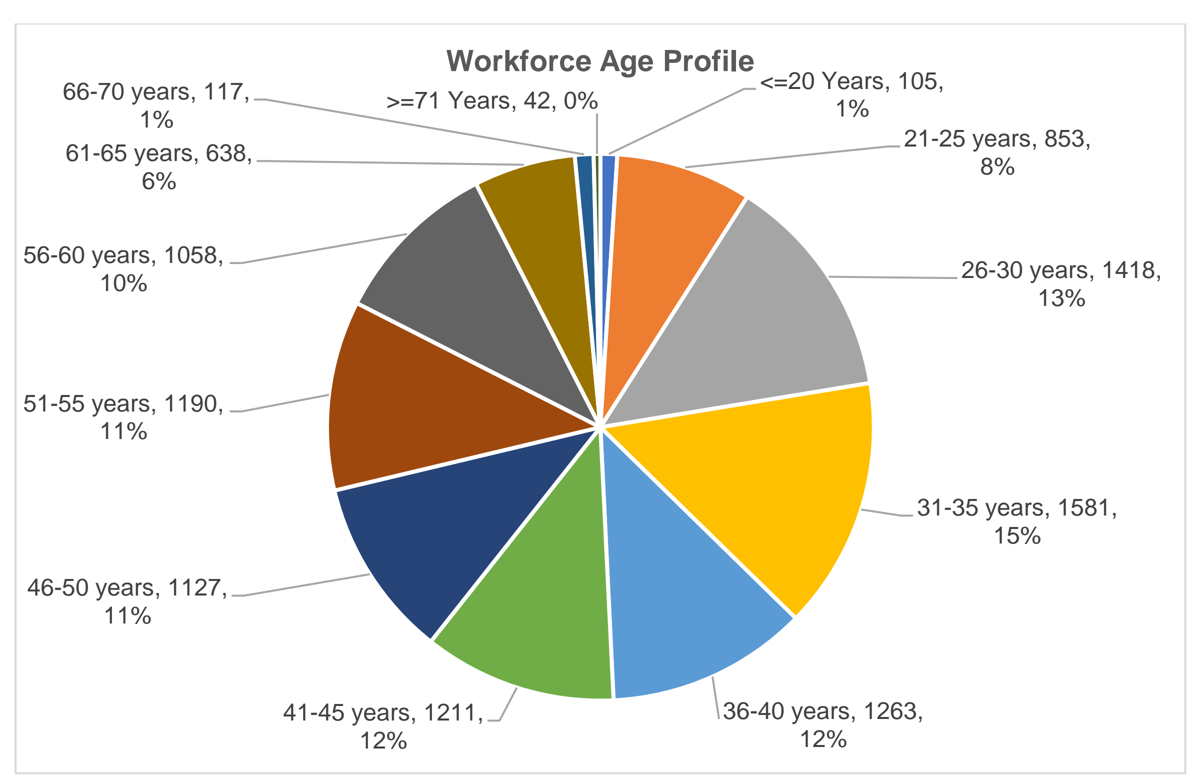
Our marital status and civil partnership data show that a high percentage of staff either identify as married or single. This will continue to influence the development of policies.

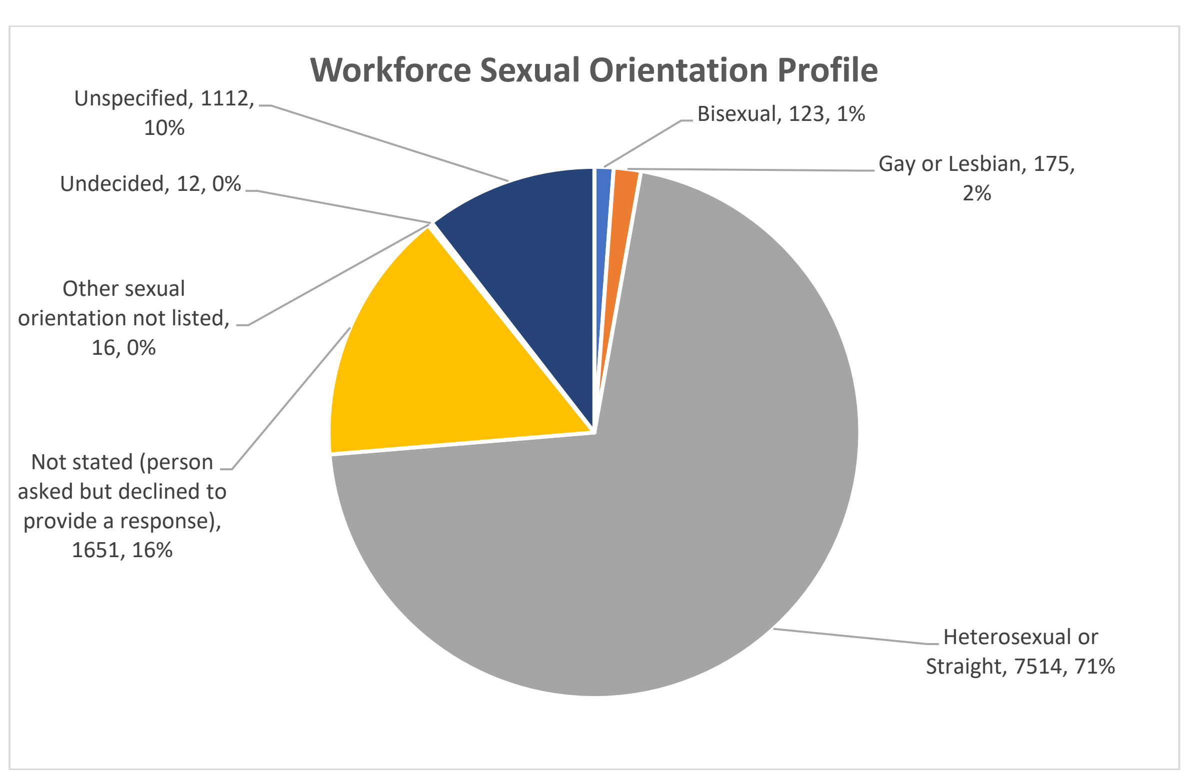
The below data covers York & Scarborough Teaching Hospitals only – bank, substantive and fixed term contract holders.

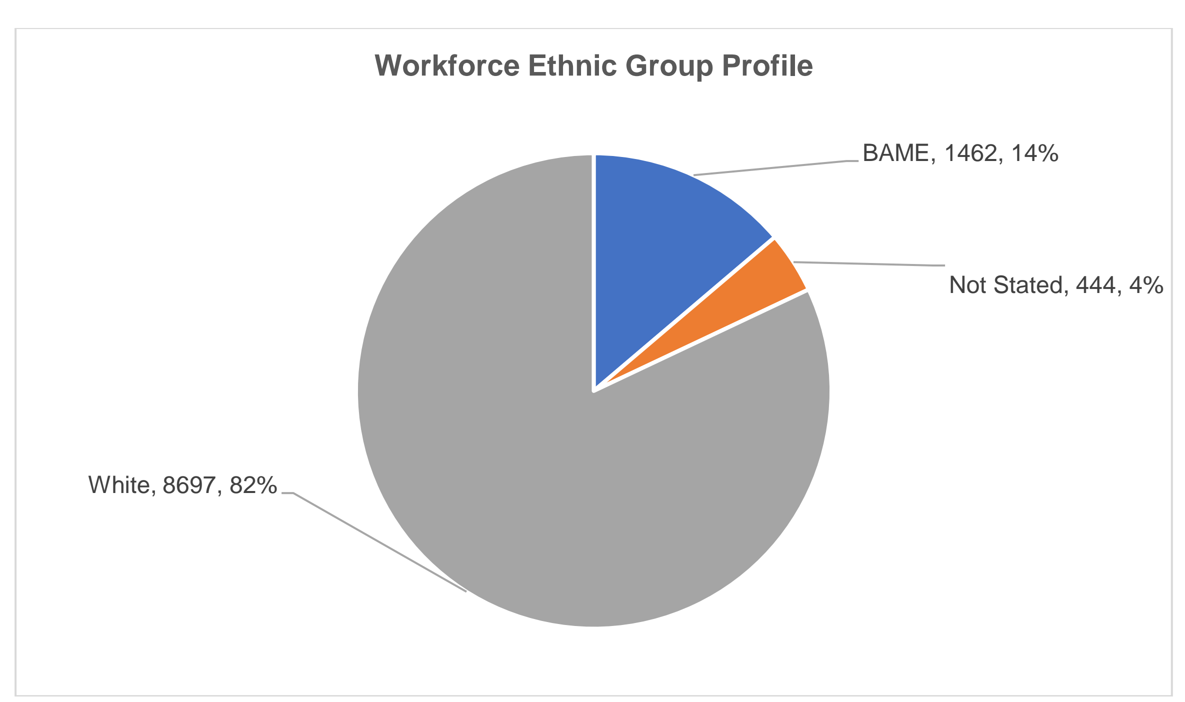
- **Staff in post headcount = 10,603**

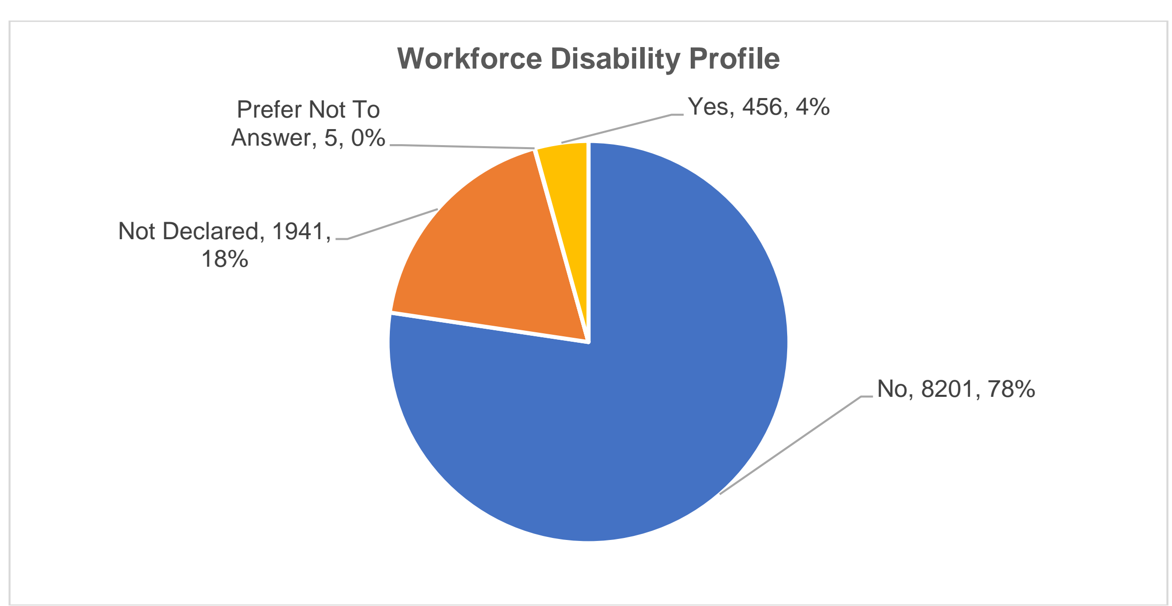


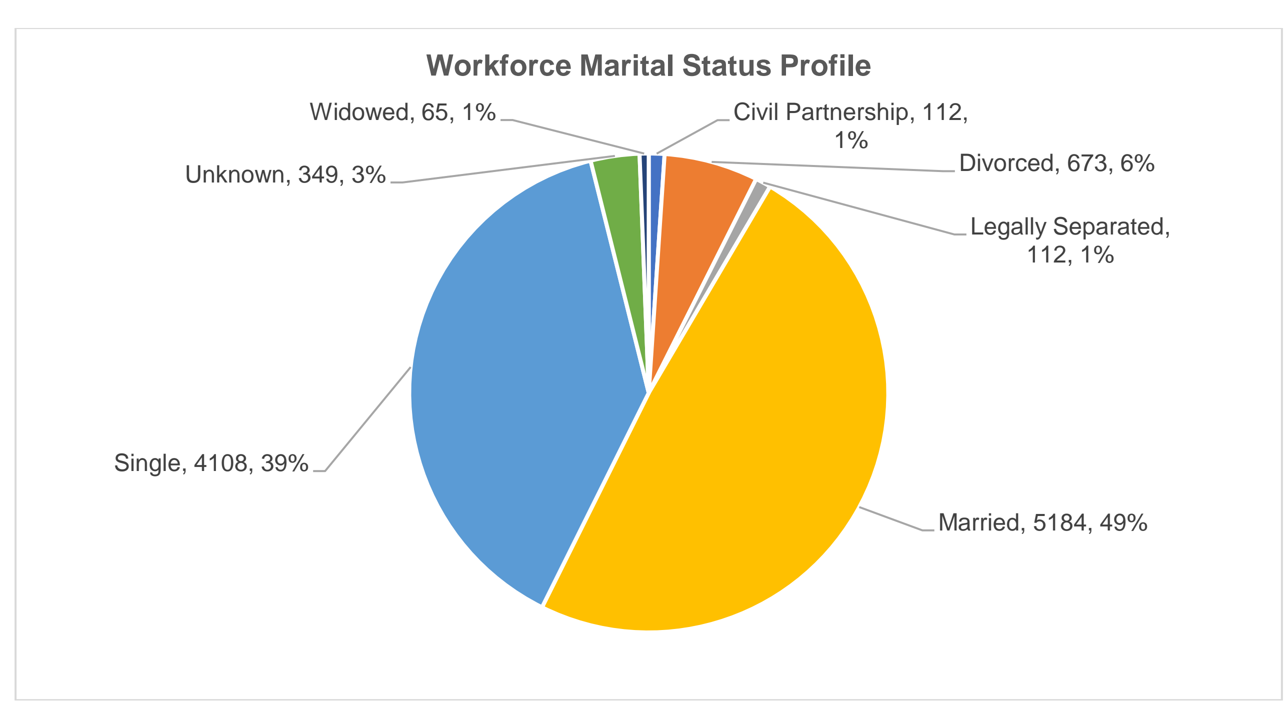



Workforce Age Profile
66-70 years, 117, 1%
>=71 Years, 42, 0%
<=20 Years, 105, 1%
21-25 years, 853, 8%
61-65 years, 638, 6%
56-60 years, 1058, 10%
26-30 years, 1418, 13%
51-55 years, 1190, 11%
31-35 years, 1581, 15%
46-50 years, 1127, 11%
41-45 years, 1211, 12%
36-40 years, 1263, 12%


Workforce Sexual Orientation Profile
Unspecified, 1112, 10%
Bisexual, 123, 1%
Gay or Lesbian, 175, 2%
Undecided, 12, 0%
Other sexual orientation not listed, 16, 0%
Not stated (person asked but declined to provide a response), 1651, 16%
Heterosexual or Straight, 7514, 71%


Workforce Ethnic Group Profile
BAME, 1462, 14%
Not Stated, 444, 4%
White, 8697, 82%


Workforce Disability Profile
Prefer Not To Answer, 5, 0%
Yes, 456, 4%
Not Declared, 1941, 18%
No, 8201, 78%



Employee ethnic origin	Employee headcount	Employee %
Any Other Ethnic Group	128	1.21%
Asian British	8	0.08%
Asian Mixed	3	0.03%
Asian or Asian British - Any other Asian background	240	2.26%
Asian or Asian British - Bangladeshi	17	0.16%
Asian or Asian British - Indian	347	3.27%
Asian or Asian British - Pakistani	64	0.60%
Asian Sinhalese	2	0.02%
Asian Sri Lankan	2	0.02%
Asian Tamil	1	0.01%
Asian Unspecified	4	0.04%
Black British	3	0.03%
Black Mixed	1	0.01%
Black Nigerian	13	0.12%
Black or Black British - African	343	3.23%
Black or Black British - Any other Black background	20	0.19%
Black or Black British - Caribbean	21	0.20%
Black Unspecified	1	0.01%
Chinese	49	0.46%
Filipino	50	0.47%
Malaysian	4	0.04%
Mixed - Any other mixed background	14	0.13%

Mixed - Asian & Chinese	1	0.01%
Mixed - Other/Unspecified	17	0.16%
Mixed - White & Asian	42	0.40%
Mixed - White & Black African	43	0.41%
Mixed - White & Black Caribbean	16	0.15%
Not Stated	336	3.17%
Other Specified	8	0.08%
Unspecified	108	1.02%
White - Any other White background	253	2.39%
White - British	7721	72.82%
White - Irish	58	0.55%
White Cypriot (non-specific)	1	0.01%
White English	392	3.70%
White Greek	3	0.03%
White Italian	2	0.02%
White Mixed	2	0.02%
White Northern Irish	9	0.08%
White Other European	71	0.67%
White Other Ex-Yugoslav	1	0.01%
White Polish	27	0.25%
White Scottish	18	0.17%
White Serbian	2	0.02%
White Turkish	2	0.02%
White Unspecified	131	1.24%
White Welsh	4	0.04%
Grand Total	**10603**	**100.00%**

Care Group Area vs Employee Gender	**Headcount of Gender**	**Percentage of Gender**
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
Female	1665	15.70%
Male	359	3.39%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
Female	776	7.32%
Male	205	1.93%
CG3 Surgery	**1640**	**15.47%**
Female	1235	11.65%
Male	405	3.82%
CG4 Cancer and Support Services	**1531**	**14.44%**
Female	1165	10.99%
Male	366	3.45%
CG5 Family Health & Sexual Health	**897**	**8.46%**
Female	843	7.95%
Male	54	0.51%

CG6 Specialised Medicine & Outpatients Services	1090	10.28%
Female	849	8.01%
Male	241	2.27%
CG Corporate Services	**2434**	**22.96%**
Female	1789	16.87%
Male	645	6.08%
CG Trust Estates and Facilities Management	**6**	**0.06%**
Female	5	0.05%
Male	1	0.01%
Grand Total	**10603**	**100.00%**

Care Group Area vs Religion	Headcount of Religious Belief	Percentage of Religious Belief
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
Atheism	321	3.03%
Buddhism	24	0.23%
Christianity	952	8.98%
Hinduism	33	0.31%
I do not wish to disclose my religion/belief	368	3.47%
Islam	54	0.51%
Judaism	3	0.03%
Other	138	1.30%
Sikhism	2	0.02%
Unspecified	129	1.22%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
Atheism	107	1.01%
Buddhism	12	0.11%
Christianity	451	4.25%
Hinduism	12	0.11%
I do not wish to disclose my religion/belief	196	1.85%
Islam	44	0.41%
Judaism	1	0.01%
Other	57	0.54%
Sikhism	1	0.01%
Unspecified	100	0.94%
CG3 Surgery	**1640**	**15.47%**
Atheism	264	2.49%
Buddhism	9	0.08%
Christianity	641	6.05%
Hinduism	22	0.21%
I do not wish to disclose my religion/belief	335	3.16%
Islam	39	0.37%
Other	98	0.92%

Sikhism	1	0.01%
Unspecified	231	2.18%
CG4 Cancer and Support Services	**1531**	**14.44%**
Atheism	315	2.97%
Buddhism	3	0.03%
Christianity	551	5.20%
Hinduism	12	0.11%
I do not wish to disclose my religion/belief	306	2.89%
Islam	34	0.32%
Judaism	2	0.02%
Other	115	1.08%
Sikhism	1	0.01%
Unspecified	192	1.81%
CG5 Family Health & Sexual Health	**897**	**8.46%**
Atheism	166	1.57%
Buddhism	3	0.03%
Christianity	360	3.40%
Hinduism	9	0.08%
I do not wish to disclose my religion/belief	162	1.53%
Islam	19	0.18%
Other	66	0.62%
Sikhism	1	0.01%
Unspecified	111	1.05%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
Atheism	168	1.58%
Buddhism	9	0.08%
Christianity	478	4.51%
Hinduism	17	0.16%
I do not wish to disclose my religion/belief	186	1.75%
Islam	18	0.17%
Jainism	1	0.01%
Other	62	0.58%
Sikhism	1	0.01%
Unspecified	150	1.41%
CG Corporate Services	**2434**	**22.96%**
Atheism	456	4.30%
Buddhism	21	0.20%
Christianity	961	9.06%
Hinduism	28	0.26%
I do not wish to disclose my religion/belief	508	4.79%
Islam	76	0.72%
Jainism	1	0.01%
Judaism	2	0.02%
Other	170	1.60%
Sikhism	7	0.07%
Unspecified	204	1.92%

CG Trust Estates and Facilities Management	6	0.06%
Atheism	1	0.01%
Christianity	3	0.03%
I do not wish to disclose my religion/belief	1	0.01%
Other	1	0.01%
Grand Total	**10603**	**100.00%**

Care Group Area vs Age	Headcount of Age	Percentage of Age
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
<=20 Years	40	0.38%
21-25 years	187	1.76%
26-30 years	290	2.74%
31-35 years	311	2.93%
36-40 years	243	2.29%
41-45 years	218	2.06%
46-50 years	213	2.01%
51-55 years	218	2.06%
56-60 years	179	1.69%
61-65 years	104	0.98%
66-70 years	13	0.12%
>=71 Years	8	0.08%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
<=20 Years	9	0.08%
21-25 years	96	0.91%
26-30 years	148	1.40%
31-35 years	173	1.63%
36-40 years	104	0.98%
41-45 years	104	0.98%
46-50 years	122	1.15%
51-55 years	98	0.92%
56-60 years	75	0.71%
61-65 years	39	0.37%
66-70 years	10	0.09%
>=71 Years	3	0.03%
CG3 Surgery	**1640**	**15.47%**
<=20 Years	5	0.05%
21-25 years	122	1.15%
26-30 years	208	1.96%
31-35 years	250	2.36%
36-40 years	186	1.75%
41-45 years	188	1.77%
46-50 years	190	1.79%
51-55 years	186	1.75%

56-60 years	179	1.69%
61-65 years	109	1.03%
66-70 years	13	0.12%
>=71 Years	4	0.04%
CG4 Cancer and Support Services	**1531**	**14.44%**
<=20 Years	7	0.07%
21-25 years	120	1.13%
26-30 years	187	1.76%
31-35 years	215	2.03%
36-40 years	226	2.13%
41-45 years	199	1.88%
46-50 years	173	1.63%
51-55 years	176	1.66%
56-60 years	128	1.21%
61-65 years	86	0.81%
66-70 years	10	0.09%
>=71 Years	4	0.04%
CG5 Family Health & Sexual Health	**897**	**8.46%**
<=20 Years	3	0.03%
21-25 years	73	0.69%
26-30 years	103	0.97%
31-35 years	140	1.32%
36-40 years	131	1.24%
41-45 years	125	1.18%
46-50 years	90	0.85%
51-55 years	100	0.94%
56-60 years	89	0.84%
61-65 years	40	0.38%
66-70 years	2	0.02%
>=71 Years	1	0.01%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
<=20 Years	2	0.02%
21-25 years	37	0.35%
26-30 years	103	0.97%
31-35 years	123	1.16%
36-40 years	118	1.11%
41-45 years	140	1.32%
46-50 years	117	1.10%
51-55 years	164	1.55%
56-60 years	157	1.48%
61-65 years	103	0.97%
66-70 years	18	0.17%
>=71 Years	8	0.08%
CG Corporate Services	**2434**	**22.96%**
<=20 Years	39	0.37%
21-25 years	218	2.06%

26-30 years	378	3.57%
31-35 years	367	3.46%
36-40 years	255	2.40%
41-45 years	234	2.21%
46-50 years	222	2.09%
51-55 years	248	2.34%
56-60 years	251	2.37%
61-65 years	157	1.48%
66-70 years	51	0.48%
>=71 Years	14	0.13%
CG Trust Estates and Facilities Management	**6**	**0.06%**
26-30 years	1	0.01%
31-35 years	2	0.02%
41-45 years	3	0.03%
Grand Total	**10603**	**100.00%**

Care Group Area vs Sexual Orientation	**Headcount of Sexual Orientation**	**Percentage of Sexual Orientation**
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
Bisexual	28	0.26%
Gay or Lesbian	39	0.37%
Heterosexual or Straight	1495	14.10%
Not stated (person asked but declined to provide a response)	332	3.13%
Other sexual orientation not listed	3	0.03%
Undecided	1	0.01%
Unspecified	126	1.19%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
Bisexual	13	0.12%
Gay or Lesbian	13	0.12%
Heterosexual or Straight	726	6.85%
Not stated (person asked but declined to provide a response)	126	1.19%
Undecided	1	0.01%
Unspecified	102	0.96%
CG3 Surgery	**1640**	**15.47%**
Bisexual	16	0.15%
Gay or Lesbian	15	0.14%
Heterosexual or Straight	1064	10.03%
Not stated (person asked but declined to provide a response)	312	2.94%
Other sexual orientation not listed	2	0.02%
Undecided	2	0.02%
Unspecified	229	2.16%
CG4 Cancer and Support Services	**1531**	**14.44%**
Bisexual	16	0.15%

Gay or Lesbian	48	0.45%
Heterosexual or Straight	1041	9.82%
Not stated (person asked but declined to provide a response)	225	2.12%
Other sexual orientation not listed	3	0.03%
Undecided	4	0.04%
Unspecified	194	1.83%
CG5 Family Health & Sexual Health	**897**	**8.46%**
Bisexual	5	0.05%
Gay or Lesbian	9	0.08%
Heterosexual or Straight	641	6.05%
Not stated (person asked but declined to provide a response)	129	1.22%
Other sexual orientation not listed	2	0.02%
Undecided	1	0.01%
Unspecified	110	1.04%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
Bisexual	6	0.06%
Gay or Lesbian	9	0.08%
Heterosexual or Straight	764	7.21%
Not stated (person asked but declined to provide a response)	161	1.52%
Other sexual orientation not listed	1	0.01%
Unspecified	149	1.41%
CG Corporate Services	**2434**	**22.96%**
Bisexual	39	0.37%
Gay or Lesbian	42	0.40%
Heterosexual or Straight	1778	16.77%
Not stated (person asked but declined to provide a response)	365	3.44%
Other sexual orientation not listed	5	0.05%
Undecided	3	0.03%
Unspecified	202	1.91%
CG Trust Estates and Facilities Management	**6**	**0.06%**
Heterosexual or Straight	5	0.05%
Not stated (person asked but declined to provide a response)	1	0.01%
Grand Total	**10603**	**100.00%**

Care Group Area vs Disability	Headcount of Disability	Percentage of Disability
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
No	1647	15.53%
Not Declared	282	2.66%
Prefer Not To Answer	1	0.01%
Yes	94	0.89%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
No	763	7.20%

Not Declared	187	1.76%
Prefer Not To Answer	1	0.01%
Yes	30	0.28%
CG3 Surgery	**1640**	**15.47%**
No	1227	11.57%
Not Declared	344	3.24%
Prefer Not To Answer	1	0.01%
Yes	68	0.64%
CG4 Cancer and Support Services	**1531**	**14.44%**
No	1108	10.45%
Not Declared	361	3.40%
Yes	62	0.58%
CG5 Family Health & Sexual Health	**897**	**8.46%**
No	680	6.41%
Not Declared	178	1.68%
Yes	39	0.37%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
No	795	7.50%
Not Declared	247	2.33%
Yes	48	0.45%
CG Corporate Services	**2434**	**22.96%**
No	1976	18.64%
Not Declared	341	3.22%
Prefer Not To Answer	2	0.02%
Yes	115	1.08%
CG Trust Estates and Facilities Management	**6**	**0.06%**
No	5	0.05%
Not Declared	1	0.01%
Grand Total	**10603**	**100.00%**

Care Group Area vs Ethnic Group	Headcount of Ethnic Group	Percentage of Ethnic Group
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
BAME	336	3.17%
Not Stated	71	0.67%
White	1617	15.25%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
BAME	247	2.33%
Not Stated	41	0.39%
White	693	6.54%
CG3 Surgery	**1640**	**15.47%**
BAME	278	2.62%
Not Stated	89	0.84%

White	1273	12.01%
CG4 Cancer and Support Services	**1531**	**14.44%**
BAME	150	1.41%
Not Stated	44	0.41%
White	1337	12.61%
CG5 Family Health & Sexual Health	**897**	**8.46%**
BAME	68	0.64%
Not Stated	17	0.16%
White	812	7.66%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
BAME	84	0.79%
Not Stated	35	0.33%
White	971	9.16%
CG Corporate Services	**2434**	**22.96%**
BAME	299	2.82%
Not Stated	147	1.39%
White	1988	18.75%
CG Trust Estates and Facilities Management	**6**	**0.06%**
White	6	0.06%
Grand Total	**10603**	**100.00%**

Care Group Area vs Marital Status	Headcount of Marital Status	Percentage of Marital Status
CG1 Acute Elderly Emergency General Medicine and Community Services York	**2024**	**19.09%**
Civil Partnership	22	0.21%
Divorced	142	1.34%
Legally Separated	18	0.17%
Married	972	9.17%
Single	807	7.61%
Unknown	50	0.47%
Widowed	13	0.12%
CG2 Acute Emergency and Elderly Medicine-Scarborough	**981**	**9.25%**
Civil Partnership	14	0.13%
Divorced	53	0.50%
Legally Separated	15	0.14%
Married	486	4.58%
Single	368	3.47%
Unknown	40	0.38%
Widowed	5	0.05%
CG3 Surgery	**1640**	**15.47%**
Civil Partnership	13	0.12%
Divorced	97	0.91%
Legally Separated	18	0.17%

Married	823	7.76%
Single	609	5.74%
Unknown	71	0.67%
Widowed	9	0.08%
CG4 Cancer and Support Services	**1531**	**14.44%**
Civil Partnership	12	0.11%
Divorced	84	0.79%
Legally Separated	11	0.10%
Married	715	6.74%
Single	655	6.18%
Unknown	43	0.41%
Widowed	11	0.10%
CG5 Family Health & Sexual Health	**897**	**8.46%**
Civil Partnership	8	0.08%
Divorced	55	0.52%
Legally Separated	6	0.06%
Married	485	4.57%
Single	322	3.04%
Unknown	19	0.18%
Widowed	2	0.02%
CG6 Specialised Medicine & Outpatients Services	**1090**	**10.28%**
Civil Partnership	14	0.13%
Divorced	78	0.74%
Legally Separated	9	0.08%
Married	633	5.97%
Single	319	3.01%
Unknown	31	0.29%
Widowed	6	0.06%
CG Corporate Services	**2434**	**22.96%**
Civil Partnership	29	0.27%
Divorced	164	1.55%
Legally Separated	35	0.33%
Married	1069	10.08%
Single	1023	9.65%
Unknown	95	0.90%
Widowed	19	0.18%
CG Trust Estates and Facilities Management	**6**	**0.06%**
Married	1	0.01%
Single	5	0.05%
Grand Total	**10603**	**100.00%**

8. Conclusion and Next Steps.

Our PSED report provides a thorough account of the work undertaken by the Trust to promote equality, equity, diversity and create an inclusive culture for staff and ultimately patients.

A substantial amount of work has been carried out in order to meet our Equality Objectives and this demonstrates the Trust's commitment in working towards creating an inclusive environment in support of the Trust Values, which show kindness, openness and excellence and how we value the identity of all of our staff. We acknowledge that there is still work to do and that we are always on a journey.

This report provides assurance that the Trust is continuously making progress against its Equality Objectives. The next step for reporting will be to combine the Patient and Workforce reports into one to demonstrate the correlation between the two portfolios of work.

Virginia Golding
Head of Equality, Diversity and Inclusion, Workforce.

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Item 9.2

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Public Sector Equality Duty Annual Report - Patient Equality, Diversity and Inclusion April 2020 – June 2022

Summary

This report is intended to summarise the current position against our equality objectives. This report outlines progress, changes and limitations during the period 2020-2022, against the backdrop of the COVD-19 pandemic. It also begins to identify a number of key priorities and areas for review and development during 2022-23.

Our Commitment to Patient Equality and Diversity

York and Scarborough Teaching Hospital NHS Foundation Trust is dedicated to encouraging a supportive and inclusive culture where all our patients can receive high quality, person-centred healthcare which meets their needs. It is within our best interest to promote diversity and eliminate discrimination amongst our workforce, in the development of services and our hospital environments.

We are committed to promoting equality, diversity and human rights for all our patients, visitors and staff and ensuring we provide compassionate care for all, with no less favourable facilities or treatment on the grounds of age, disability, race or ethnicity, sex, gender re-assignment or identity, marriage and civil partnership, pregnancy and maternity, religion or belief, or sexual orientation.

We are opposed to all forms of unlawful and unfair discrimination and we will ensure that all patients are treated fairly and with respect. York and Scarborough Teaching Hospitals NHS Foundation Trust commits to:

- ✓ being an organisation that is welcoming to all,
- ✓ not tolerating any forms of discrimination and will challenge it wherever we see it, ensuring that equality, diversity and inclusion is everybody's business,
- ✓ ensuring that there are no barriers to accessing our services,
- ✓ engaging with our communities, in a bid to ensure we meet the needs of the people who use our services.
- ✓ listening to our users, particularly those from "seldom heard" groups in our community (for example, the travelling community and people with learning disabilities),
- ✓ developing initiatives which help our staff to understand and support one another for the benefit of patients in our care, and
- ✓ working with partner organisations to reduce inequality within our local area as part of the Humber and North Yorkshire Integrated Care Partnership

Heather McNair Chief Nurse	Jim Taylor Medical Director	Simon Morritt Chief Executive

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1. Equality Objectives 2020-24

1.1. Our Objectives and workstreams

In April 2020, the trust identified three patient equality objectives for the next four years and these were set out in our previous annual report (2019-2020):

Objective 1
To engage with patients, carers, governors, and local stakeholders and organisations, including Humber and North Yorkshire Integrated Care Partnership and Healthwatch, to listen and understand the needs of our patients.

Objective 2
To engage internally with services to discuss the needs of patients to ensure the reduction in health inequalities, that discrimination is eliminated, and patients and staff are supported with appropriate tools.

Objective 3
To achieve compliance with the Accessible Information Standard 2016

There are three workstreams to support our approach, each with a responsible executive director and operational lead:

Work stream	Executive Director	Operational Lead
Patient Equality	Chief Nurse	Patient Equality and Diversity Lead
Built Environment	Chief Nurse	Access Adviser for Inclusive Built Environment
Workforce	Director of Workforce and Organisational Development	Care Group 3 Workforce Lead and, HR Business Partner *

* From late 2022 it is intended this workstream will be led by the new Head of Equality, Diversity and Inclusion, who will also be the strategic lead for the trust's equality work, overall.

Some of this work is also supported by the trust's Patient and Public Involvement Lead.

2. Performance April 2020 - June 2022

This report is intended to summarise the current position against our objectives and to indicate changes and priorities for 2022-23.

2.1 Overview and context

During 2020-22 some work was started towards these objectives in several key new areas. Unfortunately, due to the COVID-19 pandemic some progress has been limited and work in some areas necessarily paused until 2022. In line with national expectations, no annual report was prepared in 2020-21 and work on the Equality Delivery System was also paused. During this period, many staff were redeployed and seconded to support the changing demands of the pandemic. This has also meant that the Patient Equality Lead and the Patient Involvement Lead posts have been vacant for some months and specific work has been limited.

However, work has continued where possible, including in the patient equality, built environment and workforce workstreams. Workforce equality and diversity work is covered in separate workforce equality reports. Patient equality and built environment work is covered in this report.

During 2021-22, as services began the recovery process, the Trust took the opportunity to carry out a number of key actions to support future delivery of our equality objectives. This has included;

- Formal review of the trust *Fairness Forum* with input from a range of key stakeholders – this helped identify priorities to share with the trust board.
- Trust board development session facilitated by Deputy Chief Nurse and workforce / access equality leads to present patient and staff experiences and current challenges. This led to;
- The Trust Chief Executive becoming Chair of the Fairness Forum and board members each making an individual pledge to support and champion the wider equality, diversity, inclusion agenda;
- Creation of a new Head of Equality, Diversity, Inclusion role for the trust and recruitment to the Patient Equality, Diversity and Inclusion Lead and Patient and Public Involvement Lead posts, to cover vacancies due to secondments (all due to start summer 2022);

- Commissioning of an External Review of the current equality, diversity and inclusion arrangements in relation to meeting our public sector duties. The review report and recommendations were received by the Fairness Forum in July 2022, with an initial action plan;
- Securing funding for three new roles to start in Summer 2022 in the Safeguarding team to support identified areas;
  - An Autism Service Lead - to develop support for autistic people and training for staff and;
  - Two Mental Capacity Advisors – two posts to support patients and staff with capacity assessments and decisions.

Together, these actions will strengthen resources and governance structures for patient equality and diversity work across the trust.

2.2 Progress against Equality Objectives 2020-2024

Below is a summary of progress towards our equality objectives, with actions completed to end of June 2022.

Where activity has been paused or changed due to the pandemic, our intention is to review and restart during the second half of 2022, following the external review and appointment of key personnel. We aim to align our equality priorities with key strategic objectives and future changes. We anticipate that Equality Impact Assessments, Quality Improvement projects, (and a refreshed approach to the Equality Delivery System) will likely be a key tool for embedding many of the equality objective actions, into our future ways of working.

During 2022-23, we plan to align reporting of progress against our patient equality objectives with our reporting on workforce equality, in a single report.

Objective 1: To engage with patients, carers, governors, and local stakeholders and organisations (including Humber and North Yorkshire Integrated Care Partnership and Healthwatch), to listen and understand the needs of our patients.

During 2020-22 our work towards this objective has included:

- ✓ Continuing to engage with stakeholder groups, such as Healthwatch North Yorkshire, Healthwatch York, Scarborough Disability Action Group, Healthwatch East Yorkshire to listen to feedback provided by patients and services users, to help understand how to shape our services (ongoing).
- ✓ Reviewing the reports published by Healthwatch partners on services in respect of equality and diversity and develop action plans to address, as far as practicable the concerns identified (ongoing). Engaging with our patients across the protected characteristics to understand their needs and concerns and engage with them on service developments and improvements. This has included support for complaints investigation where there is an equality and diversity or, accessible information standard concern. The trust Access Adviser continues to engage with disabled peoples' organisations, carry out access audits, and provide advice to capital planning and minor works teams on all new build development to address our accessibility and inclusivity needs (ongoing).

Actions for review/restart in 2022-24:

- Reviewing feedback provided from the inpatient surveys to identify any themes for equality and diversity improvements and take action on these. Engaging with Humber and North Yorkshire Integrated Care Partnership colleagues in the local area on shared actions for improvement. Working with partner organisations and the LGBTQ+ community, to develop appropriate processes to ensure that the health records of the transgender community are appropriately maintained, reflecting the wishes of the patient (paused due to pandemic).
- Working with our Facilities Management Compliance team on the process for Patient-led Assessments of the Care Environment (PLACE) assessments to ensure appropriate involvement and engagement of our patient and service users and respond to the outcomes of the assessments to deliver quality improvement (paused due to pandemic).
- Support the analysis of patient feedback to understand the experiences of people with different protected characteristics and identify areas for improvement.

- Working with patient groups/advocates to ensure that a wide range of communities have the opportunity to inform our service development and help us understand how and what we can do differently to make a difference (paused due to pandemic).
- Working with patient groups, develop the arrangements to introduce the Hidden Disabilities Sunflower Lanyard Scheme to the trust, to provide support to patients with hidden disabilities. (Paused due to pandemic).
- Exploring the feasibility of the trust signing up to the *Safe Places Initiative*, where organisations agree to provide a safe and supportive space if someone who is vulnerable asks for help. (National programme paused due to pandemic – due for restart).

Objective 2: To engage internally with services to discuss the needs of patients to ensure the reduction in health inequalities, that discrimination is eliminated, people are treated with compassion and patients and staff are supported with appropriate tools.

During 2020-22 our work towards this objective has included:

✓ Work to review and strengthen the trust's Fairness Forum meetings, with the Chief Executive becoming Chair and commissioning an external review. With representation from across care groups, governors and non-clinical services, this group oversees progress on our objectives. (ongoing, for review)

✓ The trust has also continued work with *AccessAble* and York Hospital Charity to publish access guides for staff, visitors, and patients for our hospitals at Malton Community Hospital, and New Selby War Memorial Hospital and York Hospital, to add to the guides developed for the Scarborough Hospital site in 2019-20. *AccessAble* is a web-based directory of venues which provides photos and detailed information about physical access facilities, to enable people with access needs to plan a visit.

✓ Improving access to ablution facilities for patients and staff of differing faiths - work completed at Scarborough hospital and capital and charity funds identified for similar improvements at York hospital (planned for Nov 2022).

✓ Work has been completed to install a Changing Places toilet on the Scarborough hospital site (June 2022)

✓ Ongoing improvements to physical design or features to improve accessibility including;

- Ensuring sufficient hearing loops and wheelchairs are available across the trust premises to support our patients' needs
    - Dementia-friendly refurbishment work on Chestnut Ward at Scarborough Hospital site and a dementia-friendly environment audit in the Emergency Department at York.
    - Improvements to access at entrances at Scarborough Hospital including North entrance, X-ray entrance and occupational health department, for example new ramp and steps added.
    - The accessible toilet facilities at main reception at York hospital have been refurbished (with York Wheels).
    - At Scarborough and Bridlington, improvements have been made to access for the Blue Badge accessible parking bays and to create additional parking spaces.
    - Following feedback from disabled people's organisations, we have improved road access at York hospital by removing some traffic calming measures at South entrance to provide a level surface.
    - At York Hospital, improvements have been made to improve visual contrast and accessible features for toilet facilities in the Neurosciences Department, to better meet the complex needs of these patients.

- ✓ Continuing the work of the *Dementia Improvement Group* - supporting dementia awareness week across hospital sites and delivering our dementia strategy implementation plan to better support people living with dementia and their families and carers.
- ✓ Establishing a new *Learning Disability and Autism Steering Group* which in time will have oversight of our developing work on supporting autistic people (and recognise where the needs of autistic people and people with a learning disability are separate).
- ✓ Establishing the *Mental Health working group*, with a strategy and action plan in development.

Actions for review / restart in 2022-24:

- Introducing a policy for assistance dogs across the trust, which recognises and supports the valuable contribution assistance dogs provide for their owners to lead independent lives. We developed a draft policy for assistance dogs within trust premises during 2020, which was paused due to the pandemic, before completion - to be finalised during 2022.

- Reviewing patient experience and patient safety information which relate to equality and diversity issues to understand the circumstances, identify improvements, and share best practice (Ongoing, for review)
- Exploring the development of 'Patient Equality Champions' across our hospital care groups and LLP to help drive the agenda (not started, for review).
- Working across services to promote health screening for seldom-heard or under-served patient groups (ongoing, for review).
- Promoting the trust as an organisation that respects the rights of parents to breastfeed their children within our open spaces, should they choose to do so (ongoing).
- Developing appropriate systems to ensure that a patient's identification details match their gender identity (started and paused).
- Ensuring that our workforce is educated about the needs of our patients living with dementia, d/Deaf people, autistic people, people with visual impairment or other sensory or learning disabilities or communication needs. Learning from patients with lived experience to help improve staff education and awareness (started and paused – also links to objective 3).
- Ensuring that our patients are supported irrespective of their marital or civil partnership status and their partners are afforded the same respect, care and compassion.
- Improving access to appropriate menu choices for patients of differing faiths.
- Providing a safe place for patients to be open with us about their gender identity.
- Increasing awareness and understanding of the health needs of the LGBTQ+ community.
- Ensuring that LGBTQ+ patients/people feel safe in our environment and feel safe to be open with us, without fear of victimisation, harassment or bullying.
- Introducing a system for patients to feel confident to share information about sexual orientation with us on a voluntary basis, to help us carry out equality monitoring, in line with national standards.
- Discussions with local partner organisations began during 2019/20 on supporting transgender men and women when accessing health services to ensure that health records presented their acquired, rather than their assigned at birth identity. We suspended this work in March 2020 due to the pandemic.

- Ensuring that hospital passports for people with a learning disability (which help staff understand people's individual needs), are stored and appropriately accessible on the hospital electronic patient record system. More than 1000 passports are now uploaded into the system. Work continues to make these and other types of passports more accessible to staff.
- Working to move closer to having access to specialised Learning Disability teams seven days a week across our York and Scarborough sites. From having a single staff member split between the two sites (before 2020), this has increased to 3 days per week of Learning Disability Liaison Nurse support at each of the York and Scarborough hospitals sites, plus 6 hours of learning disability support assistant time on each site. Support from the team is now also spread more evenly throughout the week, which is more effective. Planning is underway to further increase the service to 4 days per week from September 2022.
- Continuing to improve access to hospital buildings and services, in line with our Access Strategy and Plan. Reviewing the trust's Equality Impact Assessment process to ensure that it remains robust and is implemented across all services (to ensure it meets our legal obligations and supports service improvement.
- Providing an advice and support service to colleagues reviewing policies, procedures, guidance to consider equality, diversity and inclusion.
- Working with LLP colleagues to create a physical environment that meets the needs of our patients with impairments, such as dementia and learning disabilities.

Objective 3: To achieve compliance with the Accessible Information Standard 2016

During 2020-21 our work towards this objective has included:

- ✓ Implementing our Accessible Information policy that seeks to ensure that all patients with a disability, impairment or sensory loss have the appropriate written and communication support to understand and consent to the healthcare being provided to them and can be supported in making decisions about their care including informed consent.
  - ✓ Engaging with patients to improve the range and access to patient information in appropriate formats, which meet their needs. (ongoing).
  - ✓ Improving the range and access to interpretation services for patients, including British Sign Language (BSL) and spoken language support.

A remote British Sign Language service started in 2020 to provide access to an interpreter 24 hours a day, 7 days a week via a video link. Four digital tablets were made available to support this, across our two main hospital sites. Plans to roll-out further tablets to support video interpreting in relation to spoken languages also, were paused during 2020-21 and will be reviewed as part of our work to support accessible communication. We recognise this is a key area for further development, to improve access across services during 2022.

Actions for review / restart in 2022-24:

- Expanding staff training resources and access to the tools. Continuing to increase staff awareness and skills to support accessible communication and information by expanding the training resources and, access to the tools and support available is a key priority for 2022-24 (work started and paused due to pandemic).
- Ensuring that hospital appointment letters are clear, relevant, and available in a range of formats. Letters should tell patients how to inform the trust about their written and verbal communication needs and how to request information in different formats (work started and paused due to pandemic).
- Working with colleagues within Systems and Network services to develop and improve effective capture and flagging of patient communication needs. This includes improving how we meet people's needs when we provide letters and written information.
- Producing revised guidance on written patient information to ensure that any patient information produced is inclusive, meets our patients' needs, and is available in a range of formats, both online and in hard copy.
- Exploring opportunities for using appropriate technology to improve patient access to patient information.
- Improving the availability of information in an *Easy Read* format.
- Working towards the requirements outlined in the Website Content Accessibility guidelines autumn 2020 - currently partially compliant and working towards full compliance, as per our accessibility statement.
- Monitoring the performance of our interpreting, translation and transcription services, including for British Sign Language (BSL) and spoken languages due for review and restart in 2022.

2.3 Equality Delivery System

The Equality Delivery System, known as the EDS was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, whilst complying with the Equality Act 2010.

In line with national expectations, work on the Equality Delivery System was paused across the NHS in 2020-21 due to the pandemic. An updated version of the Equality Delivery System with a revised range of standards and future expectations is due to be published in Summer 2022, with a revised range of standards.

Our external review in Summer 2022 will help us refresh our approach to EDS from 2023, in line with local system partners and national expectations.

3.Patient and Public Engagement

3.1 Partnership working

During 2020-2022, the Trust has continued to engage with the following organisations where possible, to understand further the needs of patients across the protected characteristics:

- York Human Rights City Network
- Scarborough Disability Action Group
- York Disability Rights Forum
- Healthwatch York
- Healthwatch North Yorkshire
- York Dementia Action Alliance
- My Sight York
- York LGBTQ Forum

Colleagues from Healthwatch have supported us by attending trust Fairness Forum meetings and sharing feedback on equality and diversity themes.

The Patient Equality and Diversity Lead and Access Adviser have continued to listen to the views of patients and partner organisations to support the needs of our patients.

Thank you to all our partners who have supported us during this time.

3.2 Patient Complaints

During 2020-2021 and the peak period of the COVID-19 pandemic, the Trust received 11 complaints and 3 concerns from patients and families which were recorded as complaints or concerns about inequality or discrimination. This was higher than in previous years with 7 such complaints or concerns received in 2019.

Of these, 10 related to disability and 1 was related to religion / faith / belief. Following investigation, 3 complaints were upheld, 3 were partially upheld and 4 were not upheld.

In addition, we also received 1 concern relating to disability (mental health), 1 relating to gender identity or reassignment, and 1 relating to age (concerns are not a formal complaint). Each of these were considered and contact was made with the individuals to resolve their concerns and identify learning.

During 2021-22, we received 6 complaints, 2 concerns and 1 enquiry from patients and families which were recorded as complaints or concerns about inequality or discrimination. This was similar to 2019, when we received 7 complaints.

Of these, 5 related to protected characteristics - 2 related to disability; 2 related to race / ethnicity; and 1 related to harassment based on sexuality and gender reassignment. Following investigation, 1 complaint was upheld, 4 were partially upheld and 1 was not upheld.

In addition, we also received 1 concern (not a formal complaint) and 1 enquiry, both related to disability, specifically people's communication needs due to sensory impairment. Each of these were considered and contact was made with the individuals to resolve their concerns and identify learning.

There was also 1 complaint and 1 concern raised about prejudice towards people affected by drug or alcohol misuse which were resolved and upheld. These issues fall outside the remit of the Equality Act 2010, however they are noted here as they help us understand the wider issue of inclusion.

During 2021-2022, the most common complaint themes overall were;

- Communication with relatives, carers, patients
- Care needs not adequately met
- Appointment availability
- Delay or failure in treatment or procedure
- Discharge arrangements

We recognise some of these themes can potentially have a greater impact on some people with protected characteristics, including people with specific communication needs and people who have lived experience of discrimination.

Accessible Information Standard Complaints

During the period of the COVID-19 pandemic, accessible communication has become an increasing area of focus. More information about our work on accessible communication is covered in Section 2.2. Objective 3.

During 2021-2022, we received 6 concerns/complaints specifically about accessible communication. This is compared with 1 complaint and 1 comment about accessibility in 2019-2020 and 1 concern and 2 enquiries in 2020-2021.

We recognise that many disabled people who have made a complaint or concern, are likely to have experienced repeated problems with accessing information in their preferred format from a variety of health and care providers.

We have processes in place to support staff in meeting patient requirements including a transcription service which can put information into a variety of formats and video tablets to support BSL interpreting. We recognise these systems are not fully embedded across all parts of our organisation.

The trust is committed to ensuring that we communicate with patients in their chosen format and accessible information continues to be a key priority in our equality objectives 2020-24.

3.4 Other public and patient involvement and engagement

We note that face-to-face patient engagement work and some analysis of patient surveys has been paused or suspended due to pandemic and staffing challenges (as per Section 2.1) and is due to review and restart in 2022-2023.

Responding to information people share with us about their lived experiences, continues to be an area for development during 2022-24.

A new role of Patient and Public Involvement Lead has been created through a restructure of the Patient Experience Team to increase the support for patient engagement and involvement in service improvement. In addition, a Patient Experience Facilitator role has been created to support front-line staff with improving the use of patient engagement and a range of feedback initiatives, including local surveys.

4. Inclusive Built Environment

The inclusive built environment agenda across our the trust has a primary objective to make our built environments more inclusive and accessible to everyone including, patients, staff and visitors.

The approach to improving the inclusive built environment is twofold and includes:

1 Undertaking accessibility audits of our buildings and **e**state. The Equality Act Code of Practice states that the completion of an Access Audit by a, “suitably qualified person” [who] will ‘help service providers to meet their obligations under the Act’

2 Ensuring that any refurbishment works or new building development that takes place across our sites has principles of inclusive design embedded at the start of the project and throughout the project development stages.

The age of our buildings means that much of our estate does not meet current regulatory or good practice guidance in terms of access to, and the use of, buildings for people with a range of mobility, sensory and neurological impairments. Our completed access audit reports and prioritised recommendations are used to inform our trust access plan, which provides a framework to improve improvements to the built environment. Our Patient-Led

Assessments of the Care Environment (PLACE) also inform our access strategy. he PLACE assessment programme was suspended nationally during the pandemic and is due to recommence in Autumn 2022.

Access audits at the Trust have continued wherever possible and around 70 audits have been completed across our sites, during 2020-2022. This work highlights areas for action and prioritisation with the trust's estates and capital planning teams.

However, funding constraints mean there is a significant backlog of unaddressed accessibility issues across the estate which may limit patient and carer access to care. We continue to identify a recurrent funding stream in order to progress remedial work at a greater pace.

Work has been undertaken to secure a Changing Places toilet on the Scarborough Hospital site, which is due to open in Summer 2022.

Our Built Environment Lead has also given input on accessibility into the several proposals for new developments, including the new Emergency Department developments at York and Scarborough due to open in 2023/4.

The role of the Access Advisor will change in Summer 2022. The aim is to continue this work with the LLP and Capital Planning teams to advise on environmental improvements and to focus on design appraisals for new build developments; completing access audits and delivering staff training during 2022-2023.

5. Conclusion and next steps

This report is intended to summarise the current position against the equality objectives 2020-2024. This report outlines progress, changes and limitations during this period, against the backdrop of the COVD-19 pandemic. It also identifies a number of key priorities and areas for review and development during 2022-23.

We anticipate that over the next two years to 2024, the actions set against our objectives will evolve as the needs of our patients change, services are developed and technology changes, following the pandemic.

We will align our equality priorities with key strategic objectives and future changes, including changes in our local health and care system due in 2022-

23.For example looking at the opportunities for aligning our work on embedding the Accessible Information Standard, with new technologies. We anticipate that Equality Impact Assessments (and a refreshed approach to the Equality Delivery System) will likely be a key tool for embedding many of the equality objective actions, into our future ways of working.

We will continue to monitor progress against our equality objectives, via the Fairness Forum and our trust Board and we will respond to the recommendations of the external review due in Summer 2022.

5.1 Further information

For further information, questions about this report or if you require a different format, please contact:

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Appendix: our responsibilities

As an NHS healthcare provider, the NHS Constitution requires us to support our communities and wider society to reduce health inequalities and address imbalances for minority or diverse groups of people.

At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where health inequalities are seen in relation to access, experience and outcomes e.g. where life expectancy rates are poorer for some people with protected characteristics.

Legal and Regulatory Framework

In addition, the trust is required to meet a number of legislative and regulatory frameworks. These include:

- Human Rights Act 1998
- Mental Capacity Act 2005
- NHS Act 2006
- Autism Act 2009 and the national strategy for autistic children, young people and adults: 2021 to 2026 and statutory guidance for NHS trusts
- Equality Act 2010, including the Public Sector Equality Duties
- Health and Social Care Act 2012, 2014
- Children and Families Act 2014, Children Act 1989
- Care Act 2014
- Health, public health and social care outcomes frameworks
- CQC five key questions, framework and key lines of enquiry
- Care Act 2014
- Special Educational needs and disability (SEND) Code of practice 0-25 years 2015, Learning disability standards for NHS trusts 2018
- NHS England's long-term plan
- British Sign Language (BSL) Act 2022
- Health and Care Act 2022

Public Sector Equality Duty

Under the Equality Act 2010, all public sector bodies must abide by the Public Sector Equality Duty (PSED). The PSED has three key aims, which are to:

1. Eliminate discrimination, harassment, and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and people who do not
3. Foster good relations between people who share a protected characteristic and those who do not.

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

York and Scarborough Teaching Hospitals NHS Foundation Trust

Item 10.1

Minutes

People and Culture Assurance Committee
23 November 2022

Attendance:
Jim Dillon (Chair), Lorraine Boyd, Matt Morgan, Polly McMeekin, Jim Taylor, Lucy Brown, Mike Taylor, Gail Dunning, Rachael Snelgrove, Lucy Glanfield, Virginia Golding, Will Thornton

Apologies:
Heather McNair, Stef Greenwood

Welcome and Introductions

The Chair welcomed all members to the new Committee and meeting was declared quorate.

22/26 Declaration of interest

There were no declarations or conflicts of interest arising from the agenda.

22/27 Minutes of the meeting held on 12 September 2022

The Committee acknowledged receipt of minutes from the 12 September 2022 meeting.

The Committee:
- **Received the minutes of the 12 September meeting.**

22/28 Matters arising from the minutes and any outstanding actions

Action 45 - Polly McMeekin ("PM") confirms that the Workforce and OD report is structured in line with the operational plan and will provide updates as to how we are delivering on together with any relevant issues. PM states this is evolving and is now not an outstanding action. Jim Dillon ("The Chair") agrees and states that from reading through the agenda items that fall under that heading this action is covered.

Committee agreed to close this action.

22/29 Escalated Items

Two items were escalated from the Board.

Action 79 - Medical training and education update including medical appraisal evaluation - item 10 on the agenda

Action 81 - Freedom to Speak Up Guardian Annual Report recommendations

The Chair questioned whether the Freedom to Speak Up Guardian Annual Report been postponed as Stef Greenwood ("SG") is not in attendance.

PM states the report was brought to Board in September and had thirteen recommendations which the Board did not discuss at length and was allocated to this Committee to go through the detail. PM was keen to make progress with the recommendations as the Committee will not meet again until January but questioned whether SG would need to be present for her feedback. If the committee agreed PM would like to cover the recommendations today. Lorraine Boyd ("LB") agreed that some can be agreed in SG's absence and do not need further discussion. The Chair asked for sight of the recommendations, which PM shared and suggests they are covered at the end of the meeting.

James Taylor ("JT") queried the Terms of Reference of the committee and also queried whether this committee should be approving recommendations from the Freedom to Speak Up Guardian. The Chair confirms that the Board has requested the Committee to consider the detail of the report. LB understands the work of the Freedom to Speak Up Guardian is to be independent of the Board which would steer it away from the Executive Committee to other forums, which The Chair confirms.

The Chair confirmed confirmation will be sought from Mike Taylor ("MT") as to whether the committee can approve the recommendations.

22/30 Workforce Planning

Will Thornton ("WT") introduced himself and confirmed he commenced this role at the end of March and was asked to develop an approach to workforce and planning in the Trust. WT presented an update on the workforce planning activities.

On commencement of his role WT confirmed that the organisation was not planning the workforce effectively and consistently which put us at a disadvantage in terms of our

resourcing and workforce development activities and also did not fully understand the size of our workforce gaps. Our deficit was being measured against our budgets and, in some places, these have not changed for quite some time.

WT implemented a cyclical approach which provides annual planning which they are now part way through. A dual approach is being used by the staff groups and are looking at how many staff are required and how that compares with their current budget. They are conducting an exercise with speciality teams to deal with any changes to workforce over the short, medium and long term. Teams are being asked to consider changes to national guidance, patient pathways, technological developments and activity trends.

There are three stages for the main clinical groups. Nursing teams have completed a review of requirement of all inpatient wards and it has been determined that 464 staff over and above our existing budgeted levels including York, SGH and Brid are required in patient areas which represents a significant uplift from our establishment baseline.

With regards to AHP, medical and dental staff WT states there are limitations on data making it a difficult exercise and in particular AHP roles are made harder by a lack of guidance around staffing ratios. However, the Chief AHP Team have appointed a member of staff to lead and their initial focus is to develop and cleanse activity data and provide a new baseline. We have the benefit of activity exercise in relation to medical and dental which will be matched with output from the next job planning round which the Deputy Medical Directors are looking at.

With regards to the speciality lens, submissions made by Care Groups are under review. Additional support is being given to Care Groups 1, 2 & 3 but it is deemed significant additional requirements are needed. Initial information received confirms that professionals are required in various roles including 56 more support workers, 44 more nurses outside of the adult inpatient areas, 35 more midwives, 30 scrub practitioners and approximately 23 allied health professionals.

Also highlighted is a requirement for training capacity. A role that features in plans across different departments/staff groups is a Clinical Indicator which will be required for a number of training roles required in the future.

In conclusion WT deems that our workforce needs are more significant previously articulated. WT understands the gap cannot be funded over above the establishment but hope that this will help the Board and the ICB contribute towards our long-term improvement plan. PM confirms that in the first instance it will be managing expectations.

In terms of assurance Matt Morgan ("MM") feels the Trust has a better understanding of workforce although the shortfall in number is alarming. MM questions whether there is something in place for the LLP and non-clinical roles and whether we have sufficient support staff? Also, is it clear whether we have sufficient staffing to support the nursing staff already in place?

Heather McNair ("HM") raised at the last meeting the issue of transition of advance practice roles and raised concerns about how that is being understood in terms of the skill mix and what was needed. Appreciate HM is not present but how are those concerns being addressed?

WT confirmed the scope of work will include YTHFM and corporate directors with the latter being a simpler exercise. Each care group is in receipt of a data pack to enabling them to

have informed discussions with their teams. It is hoped YTHFM will be in receipt of their data packs by the end of the year.

With regards to the advanced practice roles it is hoped that plans will be put to a panel of professional lead delegates to confirm their requirements which will touch on the advanced practice elements. WT understands that we are in the process of appointing a professional lead and PA's and there is definite scope to work with clinical leadership teams to develop the process. It will almost be a quality risk assessment.

LB agreed that it is a step forward in increasing the visibility of our staffing challenges and helping staff to accept we understand their frustration.

PM states it needs to be communicated in a clear and concise way which she believes the organisation is improving on, however, feels the staff need to be engaged and be part of the journey rather than this is a problem we have to solve without their support.

MM asks when it will be presented at Quality and Resources as it has significant implications about service delivery and establishing how far below real staffing levels should be in terms of what is needed. MM also questions how it feeds into the BAF and the risk register? MM refers to "Risk 4" and our inability to manage our vacancy rates predominantly due to insufficient domestic workforce, MM asks whether what we are alluding to is we are so far away from where our workforce should be, we have no resource to get there; how does this then feed into those risks and how we are monitoring them?

A discussion was had by PM and LB regarding governance escalation to the committees. LB queried the significance of escalating it sideways to other committees as it was felt this would only increase visibility and not be assured either. LB feels it should be presented to the Board as both the Quality and Resources Committee will also agree it is unacceptable.

MM feels as there are gaps in terms of resources it should be presented to the Quality Committee and although the committee is not assured what are the identifiable issues. LB confirms that the Quality Committee has considered it numerous times but to no avail.

MT agrees with both MM and LB's comments in that an understanding on the impact from a quality and safety perspective and also from a performance perspective. However, MT concludes that it is something that needs to be discussed at Board and carried forward as an action that is tasked to individuals as this committee will be reporting on it every quarter. MT will discuss with Alan Downey prior to the Board Meeting on 30th November. MT confirmed the role of this committee is to escalate onwards.

JT pointed out that some of issues we face are not just purely workforce, for example, acute and urgent care is sitting in outpatient bays causing inefficiencies in delivering outpatient capacity, old dilapidated theatres with broken ventilation and workforce problems in theatres due to the number of support staff in theatres and anaesthetists. JT understands workforce is a key issue but states all the issues are interlinked.

The Chair agrees with all comments but questioned if the numbers and capacity cannot be resolved then what would be the solution?

Lucy Brown ("LB") highlights the importance of making staff aware of the real pressures the organisation faces and ensure our next steps are clearly articulated albeit it may not be achievable for years to come.

The Chair concludes that it will be a continuous evolving issue but we need to be realistic with the plans and measures and have alternatives in place.

22/31 Leadership Framework

Gail Dunning (GD) made introductions to the Committee and gave her presentation regarding the Leadership Framework and the 360 Feedback Tool.

GD outlined the three values and the three leadership behaviours. The aim of the framework is to set standards whatever the role. Based on feedback GD confirms people are keen to understand more about being a leader. Ambition of the framework is to reflect the three core principles of people centred leadership in line with Trust Values. The values and the behaviour framework are very different to leadership behaviours and there needs to be a clear connection. Currently the organisation has no framework in place other than that of the external Leadership Academy Framework

Three values compassionate, collaborative and professional are deemed to be the best practice for leadership which are what the more detailed leadership framework and 360 feedback tool are based upon.

GD discussed the support which would be available to compliment the leadership development. Included would be coaching and mentoring, psychometric tools, a development centred approach to look at leadership development, a values ambassador who will be promoted as leaders, internal leadership and management programme and access to external programmes and apprenticeships. Other opportunities will be created, for example, shadowing which sits alongside coaching and mentoring.

GD believes it will enhance the appraisal and talent management process and not be reliant on external leadership behaviour assessment tools and feel it will help to analyse training needs for leadership and management throughout the organisation.

GD understands there will be challenges but seeks clarity on the implementation and how we encourage its use. GD is aware of the sensitive nature regarding feedback and the need for it to be handled sensitively. GD spoke of the most suitable platform to access the framework and explained that Learning Hub is unable to accommodate it, however, the relevant forms can be accessed from learning hub but not the whole process.

The cost implication was discussed in relation to providing external leadership programmes. GD states that a face-to-face environment is preferred but securing venues problematic. Furthermore, the coaches and mentors within the organisation do not have the capacity to give 360 feedback due to work pressures.

LB commends GD on the framework and feels that leadership is cited across the organisation with every risk we have. LB applauds the idea that we are all leaders and would like for it to become part of job roles, rather than in addition to.

The Chair asks how confident we are that we will have the resources to use a more complex system requiring commitment from individuals to which GD appreciates the technical side requires support. GD favours a central source i.e. Learning Hub but in the absence of that consideration is being given as to piloting it within existing programmes.

The Chair sought clarity on whether it is voluntarily or applied to a leader or who is considered to have leadership potential. GD has spoken with a Care Group Director and he would like it included in the medical 360 appraisal as this is more about their individual leadership abilities and was very keen to pilot it with his medical consultants in his Care Group. GD states that further clarity is needed as to how the framework will be put into practice.

The Chair spoke of his concerns in that the framework could be seen as hugely aspirational and unless we have the capacity to support it people will not want to commit to the process. The Chair feels that more time should be given until we have the IT system to support the process which will make it easier to implement and engage people in the long term.

GD confirms at present there is nothing in place and we have leaders that are unaware of their expectations and the framework gives some clarity in what is expected of them. Simon Morritt, Polly McMeekin and Alan Downey have signed this off as to the expectation of being a leader in our organisation. GD appreciates that it is very early days to have a robust system but it can be used in a more simplistic way which has been piloted.

MM agrees that as an organisation something needs to be in place but questions how it is implemented. MM queried the comparative costs on providing the framework externally compared to internally – would that be a genuine cost saving or should we just be making use of the resources that are external. MM questions that if we are to find the resource are we not better trying to use a process that is already in place rather than developing the framework internally and replicate it?

GD confirms the 360 tool from the Leadership Academy costs £50, which is done externally and not set against our framework and not fed back into the organisation. They would receive feedback but from someone independent who is not set within our organisational context. MM and The Chair understand the need for leadership and the development tool within the organisation, but query how it can be realistically delivered for the best value for money.

JT supports the tool but also questions how we get to it. JT confirms that all the senior medical team have two appraisals a year in any event (mandatory medical appraisal and leadership management appraisal) and a five yearly cycle for medical appraisal which includes medical feedback which is a 360 of sorts. JT would like the process to be streamlined to make it achievable and deliverable but supports the direction. GD states that when it is being piloted it can sit with the appraisal process.

PM confirms that in terms of assurance, commitment has been made to the operational plan and developing a leadership framework and the importance of it being brought to this meeting. The next stage is for it to be presented at the executive committee. It will continue to evolve and will be rolled out as much as possible whilst navigating the limited resources.

22/32 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report and Action Plan

VG made introductions and explained that the action plans have already been presented at Board on 2nd November but in normal circumstances the information would be before the committee in the first instance.

VG understands that all members present have seen the presentation to which MM confirms and asks The Chair and MT what the committee is being asked to do with the information if the papers have already been before the Board meeting.

PM states that the People and Culture Committee do not meet every month and the Board meeting was postponed to 2nd November, which was after the publication date but it was felt that it needs to be presented to the People and Culture Committee to work through the detail from an assurance perspective. MM states that the recommendation on the front sheet is for the Board of Directors to note the report. There is no ask of this Committee. The coversheet needs to be clear as to what is actually needed. The Chair confirms that from reading the papers the view is that the Committee would consider it in more detail, for example, improving the declaration rate "trying to embed a culture of civility".

VG explains that information which comes from the workforce team and ensuring staff are aware of updating their ESR information whether that is via the app or whether that's self-service. Using disability history month to promote that. Having conversations with teams around why people may not share their declarations and demystifying the reasons why people may not share their disability status. In terms of civility and respect ensuring policies are inclusive and promoted in the organisation and cascading the behavioural framework throughout the Trust.

The Chair asks if the only time people are asked to declare their disability is at recruitment which is possibly the least likely time someone would feel comfortable declaring it, later in the employment would seem more sensible as they would feel less prejudice towards them. VG confirmed that many disabilities come later in life so using different platforms to share that information is important throughout their employment not just at recruitment. The Chair asks whether staff are not asked to update their data annually to which PM confirmed there is not a system in place, however, the annual appraisal process would be an opportunity to review it if VG would be supportive of this to which VG confirms. VG is working with Stef Greenwood on inclusive speaking up which will hopefully provide an opportunity to ask why staff are not declaring information.

LBoyd asks from an assurance point of view if VG feels she is getting the right levels of support and engagement to which VG confirms she is. VG states she has received a positive response and people have sought advice and support enabling them to make a difference. VG is keen to coach people so they will be in a position to provide help and support which is how inclusion is embedded so people naturally think of it.

LBoyd asks how positive changes get implemented so others do not share the same experience. VG confirms if a recurring pattern around experiences became apparent that is when she would start to tackle the underlying theme and put procedures in place.

MM asks from an assurance point of view where it fits into the wider context and ensuring we are not in position where this work is operating in silo without making use of staff networks. MM states that it is great to see an action plan regarding culture change and leadership practices.

VG confirms it takes time to change the culture of an organisation and these plans only look at disability and race and not other protected characteristics. Changes are made by everyone taking responsibility for inclusive practices. The standards of the WRES have been in place longer than the WDES but not as much progress has been made and this needs to be questioned.

PM states a new starter choosing not to declare any disability tends not to be reflective of our culture but be reflective of where they have come.

22/33 Workforce and OD Update

PM confirms she has spoken to those in attendance about aspects referenced in the paper. PM updated the committee regarding the real living wage issue and also an update on some of the "fix the basics" which are referenced on page 95 of the pack which is totally reliant on finances and cannot be accessed via charity funds. PM states a discussion at Board is required as to how we can deliver people's priorities if we are so financially constrained. PM would like to escalate that finances are becoming a real challenge in order to be able to deliver many of the "fix the basics".

LBoyd questioned how are we monitoring the impact on the wellbeing initiatives and do we have the evidence to support the effectiveness which we could then argue should take precedent. PM states that the initiatives came from staff either via the staff survey narrative, previous surveys or the Clever Together outsourcing work. A few of the initiatives are in place i.e. the brunch trolley but are unable to assess the effectiveness/value for money as they have not been in place long enough.

LBrown describes a number of curtailments but states we have now reached a point when it comes to prioritising and we have placed people as our priority but the financial implication is the problem. LBrown states there is not a direct link in higher staff engagement/retention in organisations where free tea and coffee is provided, it does seem to correlate with better retention of staff, however, this is not definitive.

PM gave an update on the strike action which is due to take place before Christmas and confirmed our Trust and Harrogate were the only two hospitals that balloted in favour of strike action. Because of the nuances and the extra criteria which is applied in the legislation for public services frustratingly had those ticked "no, I do not support strike action" and just not responded, the RCN would not have met the threshold to make the ballot. Unison is currently out to ballot together with the Chartered Society of Physiotherapy balloting.

Responding to The Chair's question PM states the impact will not go to Board level, because the nature of industrial action is that it will not fall into Board cycles and we will receive very limited information of what the level of discontinue is. PM confirms the Trust is ready to respond and is also maintaining good industrial relations with our union colleagues.

22/34 Medical Training and Education Update including Medical Appraisal Revalidation

JT introduces Rachael Snelgrove ("RS") and Lucy Glanfield ("LG") who will be presenting the paper today.

RS explains the highlights/challenges that are being experienced across medical education in both undergraduate and postgraduate training.

Face to face training has been reintroduced in the last twelve months and also hybrid training. HYMS medical students are in branded scrubs giving them more of an identity in the organisation. A pastoral lead has been appointed in the medical school and more

medical students are seen with concerns and disabilities. The medical school is going through expansion and expect to expand our foundation training as of next year and 27 foundation posts have been successfully accrued in York and Scarborough over three years and then looking towards core and registrar training.

It was deemed there were “no concerns” following the recent GMC national training surveys and are one of the Trusts in the area that has not had any conditions imposed. However, there are local concerns where measures have been implemented to support local provision of teachers through the care groups which has been challenging during covid. A new role has been created to support the alternative workforce of the Trust.

LG confirms that the GMC survey did not highlight any concerns regarding postgraduate medical education, however, we are 150/200 Trusts so it is clear work needs to be done. The survey is due to end in November and feedback will be received a few months thereafter.

LG states that supervision for the trainees is challenging as all trainees should have an educational supervisor. Support and training courses are provided but the consultants need to work with the care groups and meeting the demand of our activities. A further challenge is space for training and education in both undergraduate and postgraduate which is presently having the biggest impact.

MM questions postgraduate training and although the GMC see no concern, it is clear we are just below or significantly below on a national level on most measures. Regarding assurance on delivering education and training, how are we addressing those specific issues?

LG advises that the appropriate training courses are being provided and refresher courses to support trainees. LG states consideration is being given to formalise the education supervision process to include letters of appointment to care groups so they are aware this is an official role that needs to be job planned and to enable care groups being held accountable.

JT responds to MM’s question and states the reason for the consultants not delivering is not a lack of willingness it is fitting it into job plans and other demands. Within the HYMS network funding has been used to bring in training fellows and expand capacity.

The Chair acknowledges there is clearly work to be done but, in any event good progress has been made to date.

The Chair would like to request that any future papers have names in full and not abbreviated.

22/35 Risk Management report: Board Assurance Framework and Corporate Risk Register

MT summarises the report and where we are in relation to management of risks predominantly around workforce. John Bynoe, Risk Manager, is working with the care groups to populate further any workforce risks in relation to this committee and ensuring we are identifying, analysing and implementing meaningful actions. Future reports will be more robust once there is more of an understanding of the risks across the care groups.

MM quotes from page 118 that our current risk level is “significant”. MM queries whether it ties in with workforce planning in that the Trust does not have sufficient staff, knowledge nor skills so it is not necessarily a risk it is the position we are actually in. MT understands MM’s concerns and confirms workforce planning needs to be considered but feels a conversation outside of the committee needs to be had between himself, John Bynoe and PM.

22/36 Issues to escalate to Board, other Committees, BAF or CRR

The Chair queried whether MT could confirm whether the issues raised by the Freedom to Speak Up Guardian should be addressed by this committee.

MT clarified this as a Board escalation regarding the recommendations contained in SG’s report. SG will attend the meeting in January to discuss the recommendations. LBoyd reminded the committee of PM’s earlier suggestion that some do not need further clarification and can be actioned.

PM suggests the escalation gets added to the Executive Committee agenda and SG is invited to discuss as some need further clarification.

MT confirms this will be formally escalated to the Executive Committee.

22/37 Reflections on the Committee and Any Other Business

LBoyd feels the meeting was helpful and there is a clear indication that the Committee is beginning to understand the direction. The Chair asked if a discussion could be had at the next meeting as to whether a bi-monthly meeting is correct, as the agenda is quite lengthy.

22/38 Date of next meeting

18th January 2023, 2pm

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 11

Report to:	Board of Directors
Date of Meeting:	25th January 2023
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 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:

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

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.
Board of Directors	2nd November	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. Group disestablished due to the work done to put in place the infrastructure to support progressing our people priorities, with workstreams and working groups established to support these. Clear overlap between these and the workforce working group, therefore group stood down as remit superseded.
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	Complete – Leadership framework/360 socialised with stakeholder groups including Exec Committee. Shadow Board programme designed-start date agreed, participants have been invited. Staff stories being used at Board meetings & being

				collected to use on development programmes
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	Face to face Staff brief launched. Staff surgeries underway. On-going.
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. Quarterly analysis of centrally received leaver forms now shared with the JNCC.
1.7 Embed the 'Just & Learning Culture' Programme	Chief Executive	Corporate Directors	September 2022	On-going. 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	Strategy drafted. Has been delayed due to operational pressures. Due to go to QPAS and Quality Committee in Feb 23.
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	Completed. Communications and Engagement strategy approved by the Board of Directors at the October 2022 meeting.
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	Complete – The next stage of this work will be to create a workstream to enable the recommendations to be taken forward.
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. YTHFM being chased for the quotation to be able to take forward the application for charity funding.
2.2 Develop and implement a food and drink plan for out of hours staff and shift workers across our sites.		Finance Director	Malcolm Veigas	November 2022	Delayed. Provision provided 24/7 at SGH and BDH but yet to be provided at YH. Meeting delayed with provider due to industrial action.
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	Complete. The Strategic Outline Case (SOC) was presented and agreed by the Board in August 2022. The related Outline Business Case, and then Full Business Case are the next steps in this process.
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. Outstanding issue to be resolved regarding solution for policies and procedures. Revised launch date to be confirmed once a

				solution is identified and timelines adjusted accordingly.
2.7 Deliver transparent and equitable local medical pay agreements.	Director of Workforce and OD	Lydia Larcum	December 2022	Agreed equitable extra contractual payments (ECP) in line with WLIs and ICS. Long standing local pay arrangements which deviate from the national contract remains outstanding. Seeking new Medical Director input.

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	Director of Workforce and OD / Medical Director	Care Group Directors	September 2022	Departmental tours have occurred for individuals post advert. Recruitment open events are 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	Completed. Corporate messaging has been consistently clear from finance.
3.4 Pay the Real Living Wage for employees	Director of Workforce and OD	Lydia Larcum	July 2022 – achieved. New RLW	With Board of Directors for final decision. Analysis provided in paper to Exec Committee in 2022.

			announced Sept 2022.	
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 began 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. Reconciled recruited numbers with NHSE and confirmed 131 nurses arrived against a 22/23 target of 130. Plan for additional 130 during 23/24 (96 RN posts offered following recruitment event in Kerala). Numbers to include first time recruitment of 12 paediatric nurses
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	All on track, plan is out for all the upcoming apprenticeships for CUS and UoY. Retention work continues. Career clinics now established and start Weds 22 Jan. This includes interview and application techniques. Plan for legacy mentors on going and NHSE funding approved to run the programme. In November we celebrated the first HCSW recognition day across all sites of the trust. Recruitment event set for Feb 13 2023 at York Stadium.

				HCA RRG continues and led by a Matron for workforce with a timeout planned for Jan 25th and NHSE.

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	Nursing inpatients completed, AHP dependency on AHPpro tool (in test phase and expect to be utilised throughout 23-24). Medical pending discussion with new MD on 9 Jan.
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, though actual figure likely to be lower due to pattern of disbursements.
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 appointed. Intake of 11 staff commenced training for ACP roles in September.
4.5 Procure activity planning software to support job planning and assessment of capacity gaps.	Medical Director	Nicola Topping	March 2023	Draw down option has been built into the Allocate contract. Lack of approval of the eRoster business case a set back. New MD to review.

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	Delayed. CNIO met with DIS to develop plan mid-Jan.

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	CQC Update Report
Director Sponsor:	Heather McNair – Chief Nurse
Author:	Caroline Johnson – Deputy Director of Governance and Patient Safety

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

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

Trust Priorities	**Board Assurance Framework**
☐ Our People ☒ Quality 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:

This report provides the Quality Assurance Committee with an updated position in relation to the action being taken to address the CQC regulatory conditions.

On the 23rd December 2023 the Maternity action plan in response to the section 31 was submitted and a further update will be provided to the CQC on 23 January 2023 and every 23rd of the month thereafter.

Progress continues with the delivery of the actions from the Section 29A for Medicine. However, the dashboards to monitor risk assessment compliance require further development work to ensure that assurance can be provided via the dashboards.

Recommendation:

For the quality Committee to receive the assurance provided in this report.

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

Meeting	**Date**	**Outcome/Recommendation**

CQC Report – January 2023

1. Introduction and Background

The trust has received 4 inspections between 2019 and 2022 and as a result the following enforcement action is in place:

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

The purpose of this report is to provide assurance of action plan delivery and their impact. In addition, risks to delivery of the required improvements are also outlined.

2. Governance and Shared Learning

In order to ensure robust governance of the improvements required to address the CQC conditions of registration, the governance structure shown in figure 1 below has been established.

The Quality and Regulatory Assurance Group oversees the delivery of action plans and has a programme of themed assurance to ensure evidence is reviewed for the delivery of actions (table 1). To ensure that learning is not limited to the care group where the inspection occurred all care groups must submit assurance reports. The only area that has not participated is maternity and this will be addressed from January 2023, when they will commence attendance.

In addition, the overall corporate and clinical governance of the trust is being reviewed with the support of Lorna Squires from NHSEI, who will be in the organisation for 2-days 26-27 January to commence this work.

Figure 1: Governance Structure

Table 1: Quality and Regulatory Assurance Report timetable

Assurance Topic	Date
Nutrition & Hydration	11.11.22 - complete
MCA/DOLS	24.11.22 - complete
Clinical Risk Assessments	08.12.22 - complete
Deteriorating Patients	22.12.22- complete
Workforce	05.01.23 deferred due to operational pressures
Infection Prevention and Control	19.01.23 deferred due to strike action

The deteriorating patient theme highlighted several areas for improvement across all care groups. VTE assessment/prophylaxis was a common theme that emerged, in relation to gaps in assurance. This correlated with an escalation raised by the Chief Pharmacist – Stuart Parkes at the December QPaS. A report will be presented to QPaS in February 2023 to further highlight the actions required.

3. Section 29A – Scarborough Hospital - PEM Consultant

The PEM consultant position is now filled in Scarborough; therefore, we are now able to request the removal of this warning notice.

4. Section 31 – York and Scarborough Emergency Departments – Mental Health Risk Assessments

Over the last 2-years the Mental Health Steering group have been working to address the performance of the ED departments in relation to mental health risk assessment completion. As can be seen in tables 2 and 3 there have been considerable improvements, particularly in York, however, performance is still not at the level required to apply for the conditions being lifted. The TEWV team have been supporting the ED departments to improve performance and it is hoped that the introduction of the risk

assessment on Nucleus (anticipated January 2023) will assist in improving performance. It is important to note that the SBARD is the responsibility of TEWV to complete.

Table 2: Scarborough Mental Health Audit

Month	Page 1 Safeguarding	Page 2 Initial Triage Risk Assessment	Page 4 Behavioural Observations Levels Agreed Initially Due to Presentaion Complete?	Page 5 SBARD Complete?	Page 6-7 Review of Changes and Consideration to Maintain Safety complete?
Aug-21	50%	59%	24%	24%	46%
Sep-21	50%	47%	21%	39%	39%
Oct-21	50%	45%	40%	58%	39%
Nov-21	50%	36%	22%	42%	17%
Dec-21	77%	71%	28%	75%	22%
Jan-22	79%	70%	29%	66%	34%
Feb-22	75%	68%	19%	81%	23%
Mar-22	79%	69%	50%	58%	30%
Apr-22	73%	68%	59%	67%	41%
May-22	76%	71%	55%	59%	41%
Jun-22	74%	87%	50%	76%	34%
Jul-22	73%	74%	60%	80%	23%
Aug-22	77%	87%	50%	87%	37%
Sep-22	72%	79%	56%	68%	24%
Oct-22	57%	67%	47%	60%	30%

Table 3: York Mental Health Audit

Month	Page 1 Safeguarding	Page 2 Initial Triage Risk Assessment	Page 4 Behavioural Observations Levels Agreed Initially Due to Presentaion Complete?	Page 5 SBARD Complete?	Page 6-7 Review of Changes and Consideration to Maintain Safety complete?
Mar-21	88%	67%	56%		
Apr-21	88%	77%	56%		
May-21	94%	96%	74%		
Jun-21	80%	100%	87%		
Jul-21	89%	89%	57%		
Aug-21	95%	93%	68%		
Sep-21	87%	87%	68%	71%	8%
Nov-21	83%	85%	67%	78%	10%
Jan-22	89%	87%	72%	85%	20%
Feb-22	92%	92%	69%	85%	35%
Mar-22	95%	90%	97%	81%	31%
Apr-22	88%	87%	60%	83%	30%
May-22	82%	84%	64%	63%	13%
Jun-22	90%	84%	65%	80%	0%
Jul-22	91%	84%	44%	66%	10%
Aug-22	95%	84%	76%	87%	29%
Sep-22	86%	85%	53%	84%	11%
Oct-22	90%	92%	67%	78%	31%

5. York Hospital Medicine Inspection (March 2022)

5.1 Section 29A (Hydration and Nutrition and management of Risk)

Thirty-two actions were identified in response to section 29A warning notice. The delivery of the section 29A actions is well progressed as evidenced below in table 4 with 2 actions currently at risk of exceeding the delivery timescales (table 5).

Table 4: Overview of section 29A action progress

Overview – Section 29A		
	0	Off Track
	2	At risk of exceeding timescale for delivery
	0	On Track
	30	Complete

Table 5: Actions at risk of exceeding delivery timescales

CQC section 29A Requirement Off Track	Actions Taken to Mitigate	Mitigation in Place
Nutrition & Hydration Visiting Policy scoping Exercise – promote family and carers to support care delivery	Existing policy was revised and approved by Executive Committee Consultation exercise underway with carers and external agencies to inform further revision to the policy Final Policy due for ratification 30.4.23	John's Campaign carers card pilot initiative in place to encourage carers to visit at mealtimes to support care.
Risk Assessment Bumpers and Crashmats	Bumpers have been ordered for both ED departments. 3 suppliers have been identified that can provide the trust specification. Awaiting feedback from procurement re date.	

5.2 Must Do Actions

Overall, there were 5 Must do recommendations and 25 actions have been put in place to address the recommendations. As can be seen below in table 6, 21 actions are complete with 3 actions at risk of being at risk of delivery (table 7).

Table 6: Overview of must do action progress

Overview – Must Do's		
	0	Off track
	3	At risk of exceeding timescale for delivery
	1	On track
	21	Complete

Table 7: Must Do actions at risk of exceeding delivery timescales

Must Do Requirement - At Risk of Exceeding Timescale	Actions Taken to Mitigate	Mitigation in Place
Mental Capacity Act MCA Advisors – Recruitment and Implementation	Attempts to recruit on two occasions. York post filled but Scarborough post has not been successfully recruited to. Interim Agency expert in place in Scarborough until April 2023.	Recruitment deferred until January/February to enable interim agency and substantive post holders to establish a service and robust operating procedure.
Information Governance Review storage and location of medical records on wards	With the introduction of Nucleus, the number of paper nursing records will reduce. As more clinical information is recorded electronically this again will reduce the number of paper records. The IG team carry out regular walk rounds on ward areas giving advice on the security of information. Recently a visit was undertaken in York ED by the Head of Information Governance to discuss the security of records and advised on the storage of records particularly in the reception area.	The clinical lead for Elderly Medicine has agreed that records will only be requested where necessary and not for all admissions. The storage of paper records on wards will continue to be monitored
Information Governance Scope requirements for medical records on wards	As above	As Above

5.3 Should Do actions

As can be seen in table 8 below one action was in place to address the should do action '*The trust should ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.*' However, this action was to establish the Trust training sub-group, which does not completely address the action required.

Table 8: Overview of Should do action progress

Overview – Should Do		
	0	Off track
	0	At risk of exceeding timescale for delivery
	0	On track
	1	Complete

5.4 Impact of Improvements

In this section the impact of the improvements made to date is outlined.

5.4.1 Risk Assessments

Nucleus

Risk assessments for falls, nutrition, pressure ulcers and bed rails are completed on the Nucleus system. Currently there are 40 areas using Nucleus and performance can be tracked via the Signal BI dashboards. The dashboards capture the total numbers of assessments completed per month and whether they were compliant or non-compliant with the required scheduling of assessments. The data for November and December is shown in table 9 below.

Table 9: Nucleus Data (November and December 2022)

Assessment	November	December
Falls assessment 6 hrs	66.2%	60.6%
Falls assessment 24 hrs	89.4%	85.4%
Falls reassessment 7 days	73.8%	67.3%
Bedrails assessment 6 hrs	64.3%	58.2%
Bedrails assessment 24 hrs	88.2%	84.5%
Bedrails reassessment 7 days	72.2%	66.2%
MUST assessment 24 hrs	63.1%	59.6%
MUST reassessment 7 days	61.7%	57.4%
Purpose T assessment 6 hrs	69%	64%
Purpose T assessment 24 hrs	Not available	Not available
Purpose T reassessment 7 days	80%	75%

Table 10 below, show the initial assessment compliance in the 5 areas with highest number of admissions (>50% of admissions) AMU, AMB, Lilac, Ward 14, Maple.

Table 10: Nucleus data the 5 wards accounting for >50% of admissions

Assessment	November	December
Falls assessment 6 hrs	82.5%	77.6%
Falls assessment 24 hrs	92.1%	93%
Bedrails assessment 6 hrs	79.9%	77.6%
Bedrails assessment 24 hrs	90.9%	89.8%
MUST assessment 24 hrs	72.5%	76.5%
Purpose T assessment 6 hrs	76.3%	71.9%
Purpose T assessment 24 hrs	Not available	Not available

When the user completes an assessment, and a risk is highlighted a care plan is automatically created. The care plan contains guidance and care tasks. The care tasks show on a care task list, they are scheduled to be completed within a timeframe and show as overdue when they become overdue. The care tasks include regular comfort checks, repositioning, lying and standing blood pressure etc.

The first iteration of the Nucleus dashboard was designed to look at assessment compliance on admission and does not yet report on care plan compliance. Some issues with the first iteration of the dashboard have been identified, and these are currently being addressed, before the next phase is developed. The data is most meaningful in areas with high numbers of admissions. Some areas with very small numbers of admissions will skew the initial assessment compliance data. For example, if an area only has 4 admissions and they do three of the admission assessments at 6 hrs 5 minutes this would be non-compliant, and they would score 25%.

The assessment currently only takes account of the ward the patient is on, so if the initial assessment was completed on another ward before transfer and is still applicable, it does not pull through to the dashboard and it is shown as non-complaint. Currently the dashboard does not provide visibility for patients who have no assessments recorded. This is visible on the ward whiteboards where there is a dynamic operational view of falls, MUST and Purpose T assessments, whether they are completed or overdue and what the outcome is.

There are a few areas where we are still working through anomalies in the data. This is due to how and when inpatient spells are created and what happens in the system when a patient goes to a different location temporarily or starts their inpatient journey in pre assessment which is an ambulatory area and does not have a requirement to carry out these assessments.

The Business Intelligence team have been provided with an outline of the requirements to enable them to further develop the Nucleus dashboard to provide more meaningful ward level data and greater assurance. These requirements are as follows:

- View of patients with no assessments completed
- Compliance dashboard to show compliance/non-compliance to ward where the patient was when the assessment was due
- Patient level view to show assessments completed – even if they are outside of compliance schedule
- Skin assessment and skin checks compliance
- Weight compliance
- Care task compliance – the care plans generate tasks, some of which are completed only once and some are scheduled for repeat – for example repositioning is scheduled for every 2 hrs with a red (high-risk) Purpose T pathway (pressure ulcer). It is our ambition for the dashboard to report on tasks but the scheduled tasks reporting needs careful consideration to ensure the data is meaningful.
- Evaluation of care tasks compliance

Tendable data

Two metrics in relation to nutrition and hydration are assessed within the monthly matron audits in Tendable. These are as follows:

1. Is there evidence that the Oral Nutrition Support Care Plan has been started?
2. Is there evidence that at least two suggested actions from the Oral Nutrition Support plan have been Implemented for patients with a MUST score of 1 or higher?

It is important to note that these metrics are not assessed in Tendable for the emergency department, those are assessed through a bespoke audit, which will be discussed in section 5 of this report.

As can be seen in figure 4, despite the introduction of Nucleus performance has remained broadly static, in relation to the starting of nutritional support care plans; with the most improvement seen in November. However, this was unfortunately not sustained in December.

Figure 4: Is there evidence that the Oral Nutrition Support Care Plan has been started?

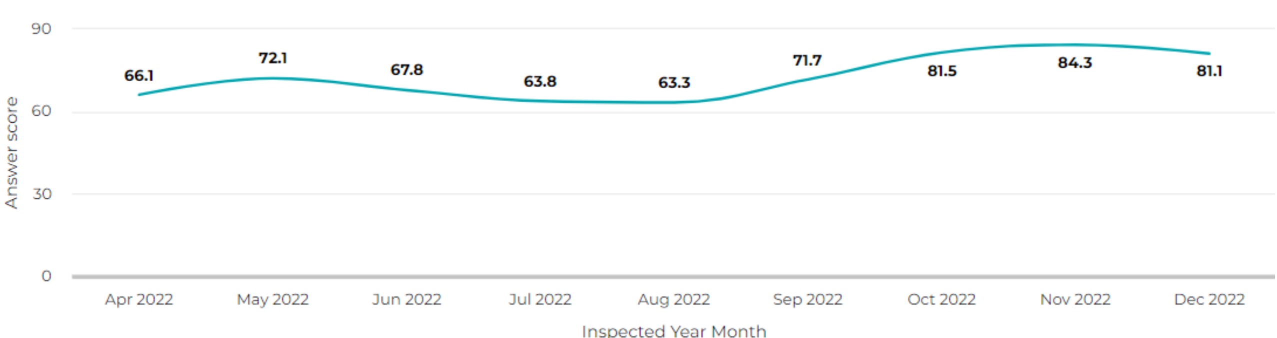
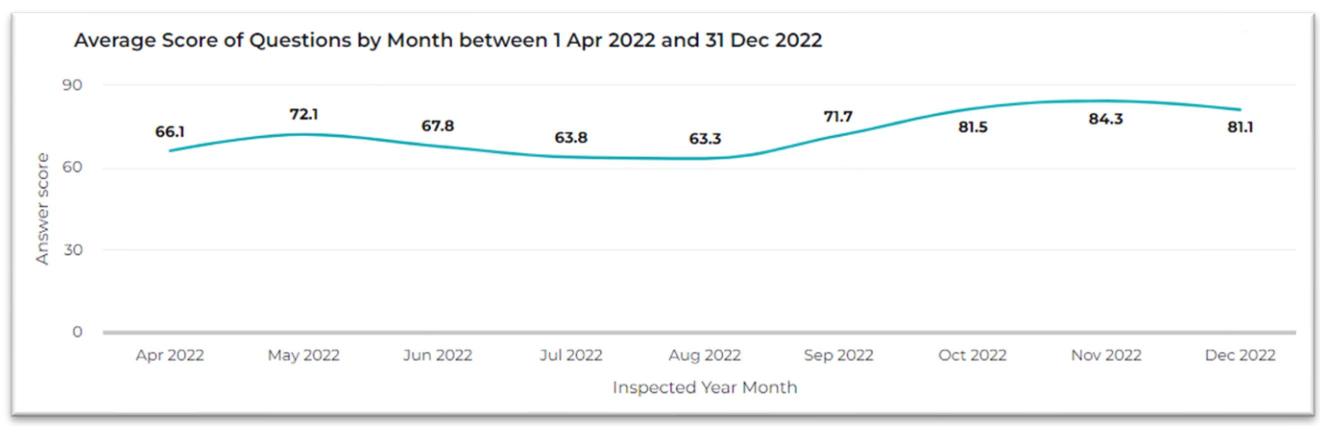


Figure 5 does demonstrate an overall improvement in the delivery of actions from the nutritional support care plan, although again improvements in November were not sustained in December.

Figure 5: Evidence if at least 2 suggested actions from the oral nutrition support plan implemented



Two audits are planned – fluid balance and snapshot mealtime. The snap-shot mealtime will be available in the February report and the Fluid Balance in March. This is to allow for review by the Nutrition Steering Group.

5.4.2 Mental Capacity Act and DOLS

The MCA Improvement Group has overseen several service developments over the last quarter: For example:

- Non-compliance identified is now reported via Datix
- MCA Policy reviewed and awaiting consultation and include patients from aged 16.
- Developed Terms of Reference for link staff attending MCA Education Forum group.
- MCA compliance included in Tendable.
- Datix Dashboard now in place for MCA– to monitor/chase DOLS and contact Local Authority to increase priority.

- Established and reporting schedule with Care Groups and the Quality and Regulations Group

Table 11 below shows the current training compliance for MCA/DOLS. All training compliance is reported to individual Care Group compliance via Quality/Governance Forums. Care Groups have been asked to address where compliance is below 85% as a matter of priority. Non-compliant staff list is available for them to target key staff.

Table 11: Training compliance (Jan 2023)

Certification Name	Overall Trust %	% diff on last mth
Core Stat/Mand - Deprivation of Liberty Safeguards/DoLS Level 1 3years	72%	-1%
Core Stat/Mand - Deprivation of Liberty Safeguards/DoLS Level 2 3years	74%	2%
Core Stat/Mand - Mental Capacity Act Level 1 3years	81%	-1%
Core Stat/Mand - Mental Capacity Act Level 2 3years	79%	0%

Audit/Quality Assurance Outcomes

There had been a routine ask of ward managers to complete in the moment quick audits. On review we were not gaining assurance of improvement of quality in these audits and were indicating 100% compliance but did not reflect the quality of the assessments or paperwork. We have therefore moved to a qualitive audit approach from January - results will be available for next Assurance report. Tendable data is not available for this month's report due to technical difficulties encountered with the system.

5.5 Staffing

The actions in relation to workforce are ongoing and reported via the workforce paper. However, this report provides assurance in relation to the impact of staffing on safety and quality. The process for deploying the nursing workforce and how it is escalated and mitigated has been 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.

A SOP has been developed entitled 'Daily Nursing Escalation 'Adult Inpatients Wards, 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.

5.5.1 Red Flags

The Trust has implemented the red flags system in Safe Care, to augment the escalation processes described above. An audit carried out in November highlighted a need for further training from ward to matron level to ensure the flags are raised appropriately and

mitigated effectively**.** As result a train the trainer model has been adopted to ensure trainers are allocated to each ward/department area to support with education. This will commence in February.

In York a total of 1093 red flags were reported in November and 645 for Scarborough and Bridlington. As can be seen from figures 10 and 11 below most of the red flags related to the provision of enhanced care. This is a broad category; therefore, consideration is being given to removing this category to ensure that staff choose categories that accurately reflect the nature of the enhanced care affected.

Figure 10: Red Flags – York site

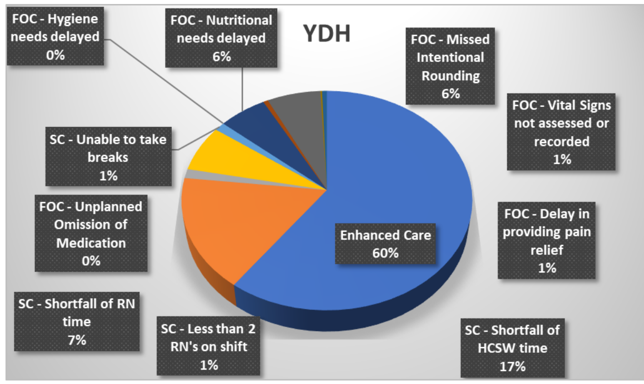
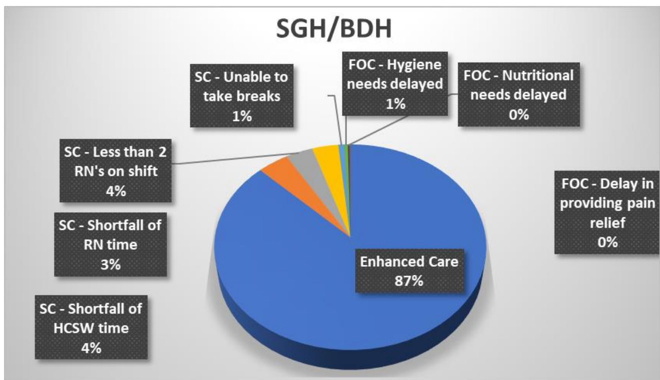


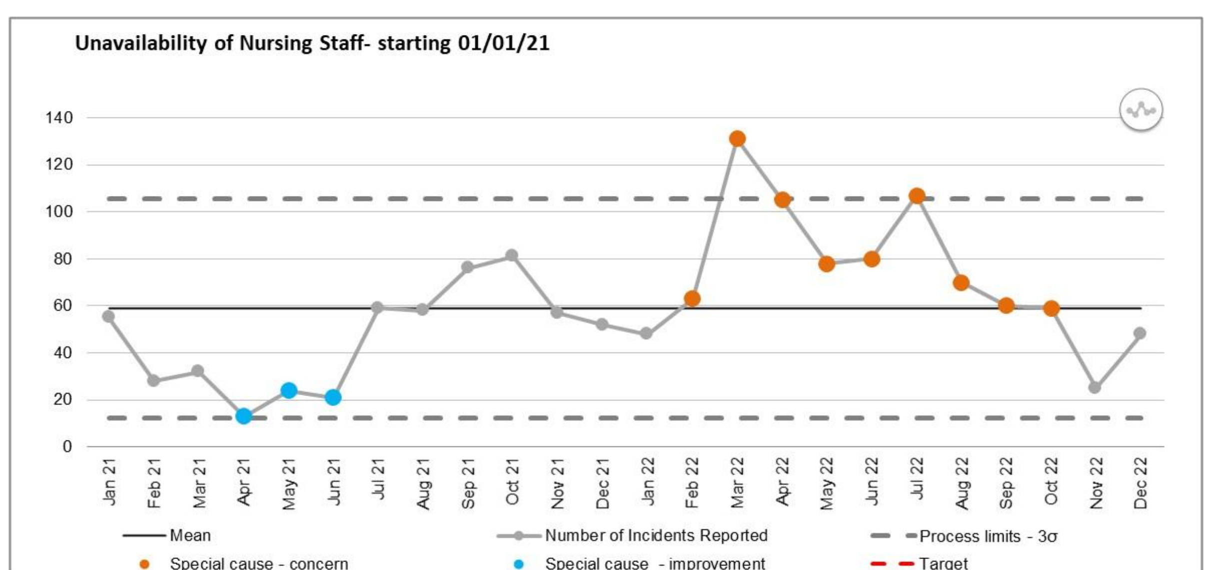
Figure 11: Red Flags – Scarborough Site



When a red flag cannot be mitigated, it is escalated to either the Head of Nursing or 1st on-call out of hours to support with actions to mitigate the risk. A datix is completed when the red flag remains unmitigated.

Datix reported incidents in relation to staffing deficits and impacts on safety have reduced since March 2022 as shown in figure 12.

Figure 12: Datix reported Incidents 1.1.21 – 31.12.22



6. Section 31 Maternity and Midwifery services (November 2022)

The trust response to the section 31 was returned in line with the required deadline (23 December 2022). The submission was comprehensive and is attached in Appendix A. As can be seen in the response a considerable amount of work has been undertaken since the inspection to address the issues identified. An independent consultant has led most of this work and engagement from the team has been positive.

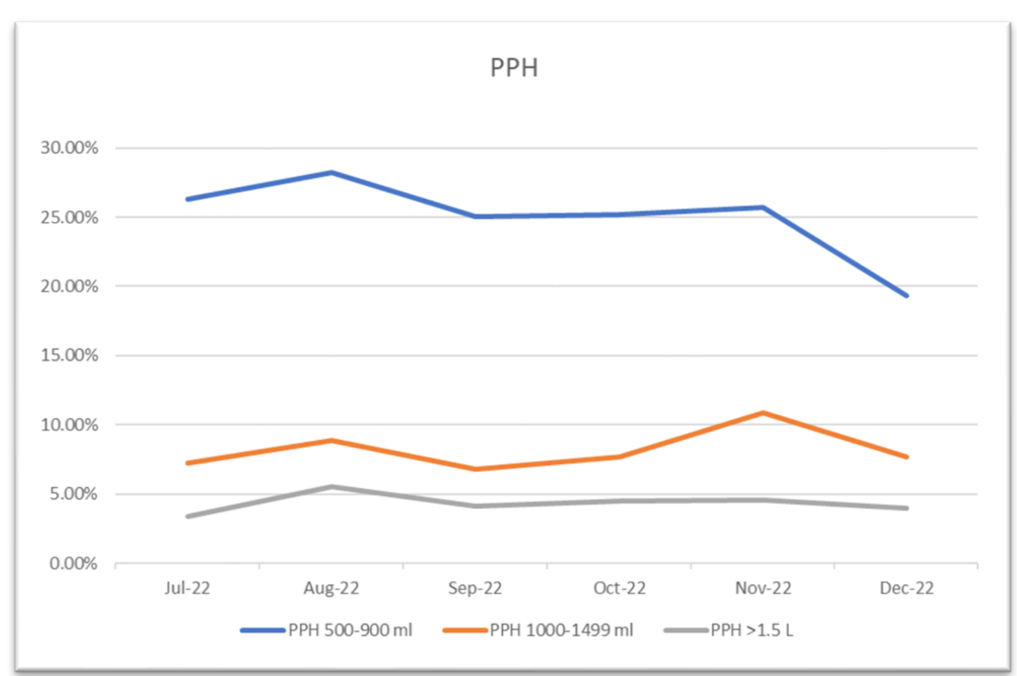
In addition, to the improvements outlined in Appendix A, two further reviews were commissioned to inform the improvement workstreams – A review of PPHs and a review of stillbirths. Both reviews were completed by independent consultants. The findings were presented to the maternity and obstetric team on 6th January and the required actions to address the findings are being developed. The delivery of these will be overseen by the PPH/Stillbirth steering group that has been established. Both reports with their associated action plans will be presented to QPaS and the Quality Assurance Committee in February 2023.

The improvement dashboard is in development to provide evidence of the impact of improvements. In the interim two key metrics can be provided in this report, PPH and training are shown below.

PPH

Figure 13, demonstrates an improvement in PPH since November, arising from the improvements that were introduced following a walkthrough of PPH cases facilitated by the independent consultant.

Figure 13: PPH performance



Training

Table 12 shows the level of compliance with essential training within the maternity department. As can be seen the training compliance is below the required levels particularly in the medical workforce. The Clinical Director is overseeing the improvements and all staff are being booked on the training. Training compliance is being monitored through the Specialty Governance meeting. The fetal monitoring compliance has been impacted by the requirement to undertake e-learning after the face-to-face training. The e-learning is often not completed. Therefore, a change to the training programme has been instigated to ensure the e-learning is completed within the training day to ensure completion.

Table 12: Maternity Training Compliance

York %	PROMPT	NLS	Fetal Monitoring	SBLv.2 (5x e-learning courses)	Public Health presentation	Perinatal Mental Health	Bereavement	Learning from incidents claims & complaints
Midwives (137)	97% (135/139)	94% (130/139)	96% (133/139)	61% (85/139)	88% (122/139)	97% (135/139)	81% (113/139)	95% (132/139)
HCA/MSW (28)	90% (26/29)	N/A	N/A	N/A		N/A	62% (18/29)	N/A
Obs Cons (14)	100% (14/14)	N/A	100% (14/14)	86% (12/14)	100% (14/14)	93% (13/14)	N/A	100% (14/14)
All other Obs Drs (19)	53% (10/19)	N/A	58% (11/19)	53% (10/19)	58% (11/19)	58% (11/19)	N/A	53% (10/19)
ODP (53)		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anaes Cons (11)		N/A	N/A	N/A	N/A	N/A	N/A	N/A
All other Anaes Docs (21)		N/A	N/A	N/A	N/A	N/A	N/A	N/A

Scarborough %	PROMPT	NLS	Fetal Monitoring	SBLv.2 (5x e-learning courses)	Public Health presentation	Perinatal Mental Health	Bereavement	Learning from incidents claims & complaints
Midwives (61)	90% (55/61)	87% (53/61)	89% (54/61)	51% (31/61)	66%	97% (54/61)	57% (35/61)	79% (48/61)
HCA/MSW (19)	74% (56/61)	N/A	N/A	N/A	N/A	N/A	68% (13/19)	N/A
Obs Cons (8)	88% (7/8)	N/A	63% (5/8)	63% (5/8)	88% (7/8)	75% (6/8)	N/A	88% (7/8)
All other Obs Docs (13)	54% (7/13)	N/A	54% (7/13)	69% (9/13)	77% (10/13)	77% (10/13)	N/A	85% (11/13)
Anaes Cons (6)		N/A	N/A	N/A	N/A	N/A	N/A	N/A
All other Anaes Docs (12)		N/A	N/A	N/A	N/A	N/A	N/A	N/A
ODP (15)		N/A	N/A	N/A	N/A	N/A	N/A	N/A

7. The Emergency Department – York

In response to the concerns raised by the CQC during their inspection of ED in October 2022, a comprehensive action plan was implemented. As can be seen in table 13 below, there are no overdue actions.

Table 13: Action plan progress (York ED)

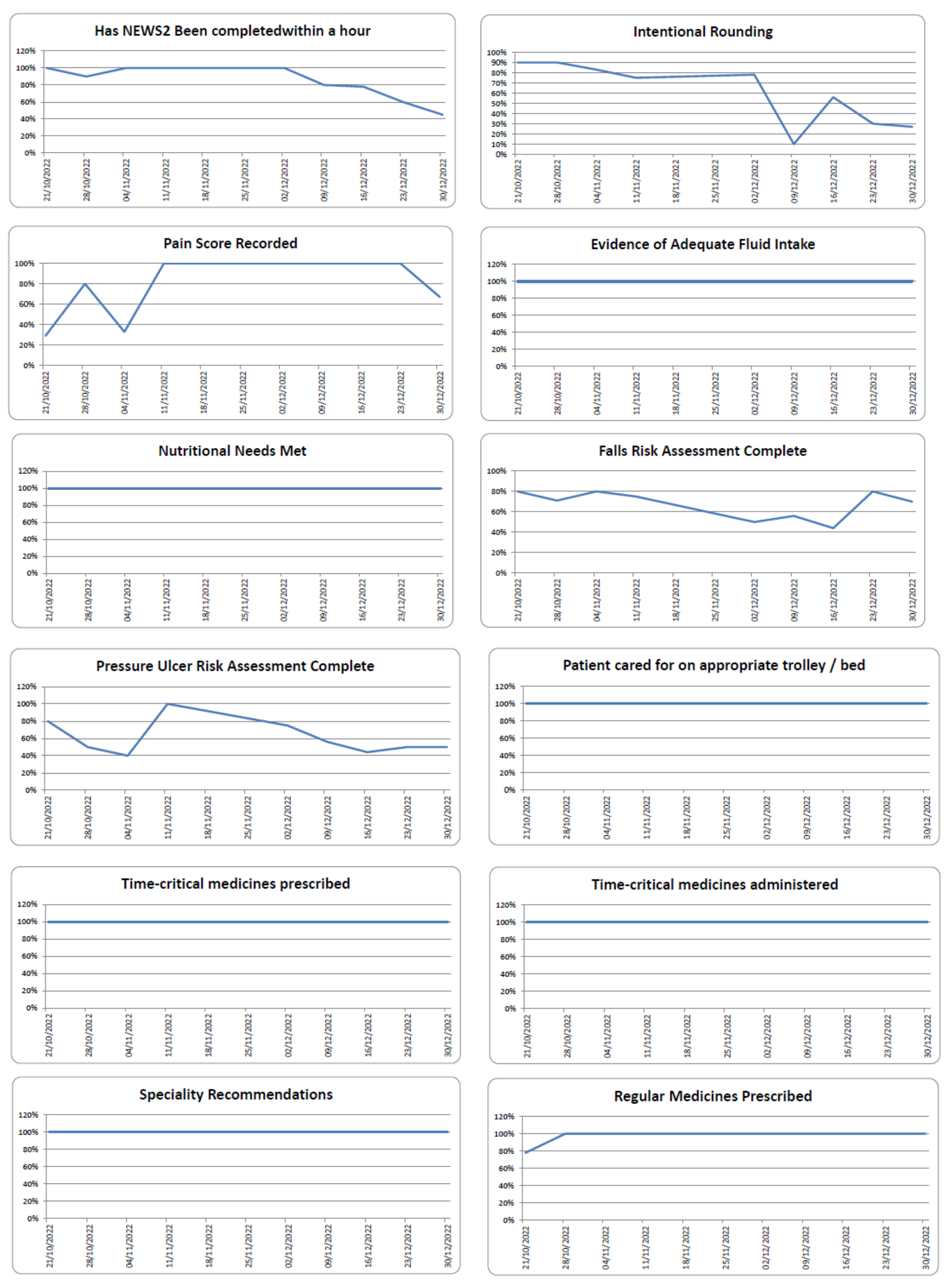
Overview of Actions		
	0	Off track
	0	At risk of exceeding timescale for delivery
	13	On track
	13	Complete

An independent Consultant (Professor Matthew Cooke) was commissioned to undertake a review of the emergency department, and this took place in December, with the report provided 21 December 2022. The review consisted of a two-day observation period. The findings of this review will be shared with Exec Committee in January and an action plan to address his findings developed accordingly. A further update will be provided in this report in February 2023.

7.1 ED delays (including 12 Hour Stays)

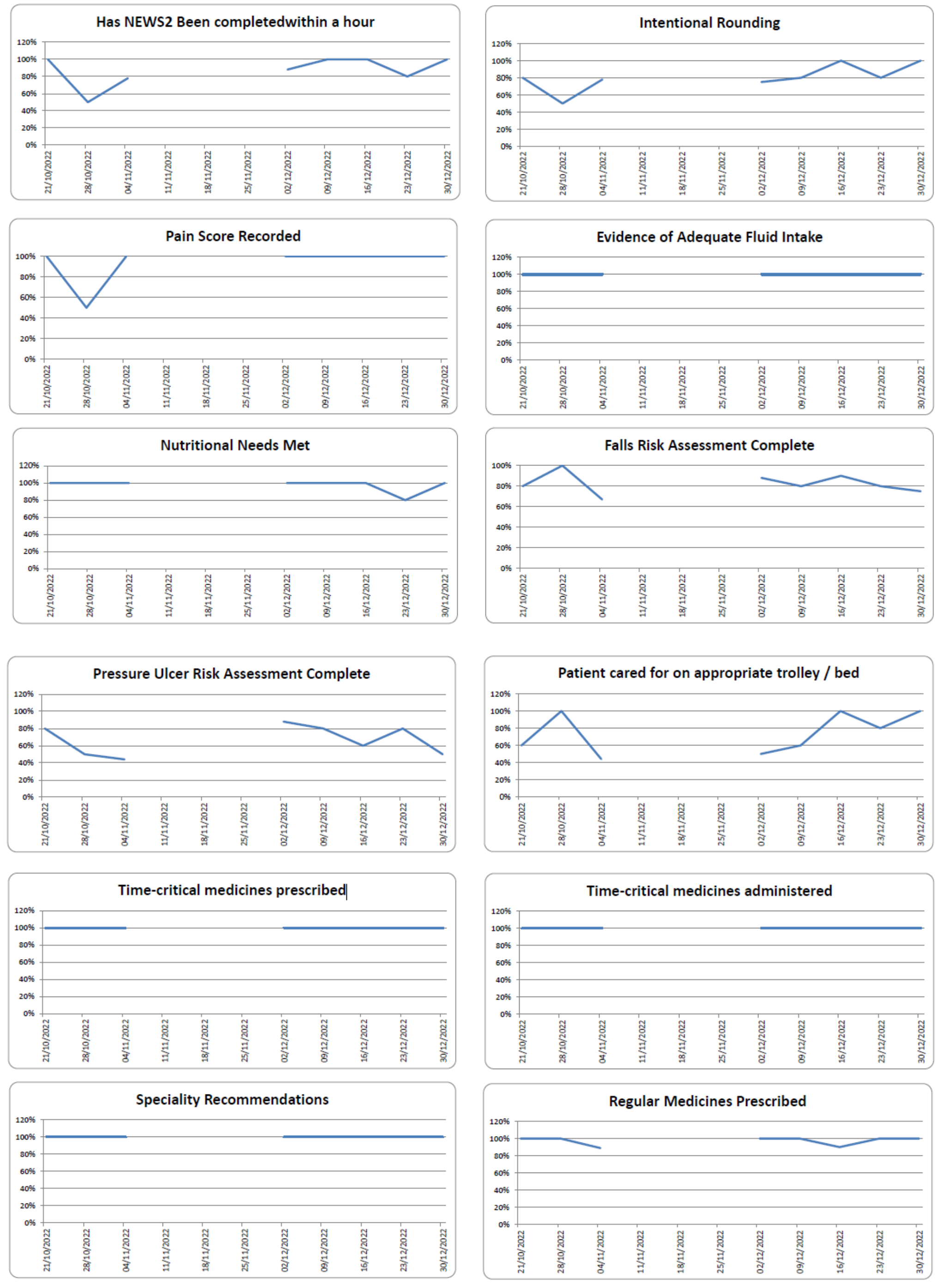
On a weekly basis the ED team undertake audits of key safety metrics for the 10 longest waits in both ED departments. The most recent audits are shown in figures 14 and 15. It is important to note that the Scarborough ED have not completed several audits during November and December. The gaps in audit completion are due to one person being assigned the task and when she is off work no-one else completes them. This is being addressed to ensure more than one person completes the audits.

Figures 14: York ED – 12-hour stay audit



As can be seen in the York ED audit; performance in relation to NEWS2, intentional rounding and falls has deteriorated across November and December. The Quality and Safety Group oversee this performance and have been informed that due to the volume of patients in the department timescales between intentional rounding have been increased to 4-hourly from 2-hourly at times and NEWS2 is done within 2-hours. Audits of performance specifically in relation to NEWS2 are undertaken and will be available in the February report.

Figures 15: Scarborough ED



Performance is largely impacted by overcrowding in the department. Throughout December the length of time that patients have waited in the department has increased. This indicator has been showing an increasing trend from June 2021, with December 2022 showing a new high of 1234 (figure 16). In addition, ambulance handovers after more than 30 minutes (figure 17) show special cause variation (deterioration). This is the result of a combination of increased attendances in December particularly for York in comparison to the previous 3 years (table 14), alongside a high number of patients who do not meet the criteria to reside.

Table 14: ED attendances by site December 2019, 2020, 2021 and 2022

Site	December 2019	December 2020	December 2021	December 2022
York	7080	5942	6753	7375
Scarborough	3453	2895	3601	3413

Figure 16 – 12-hour trolley waits

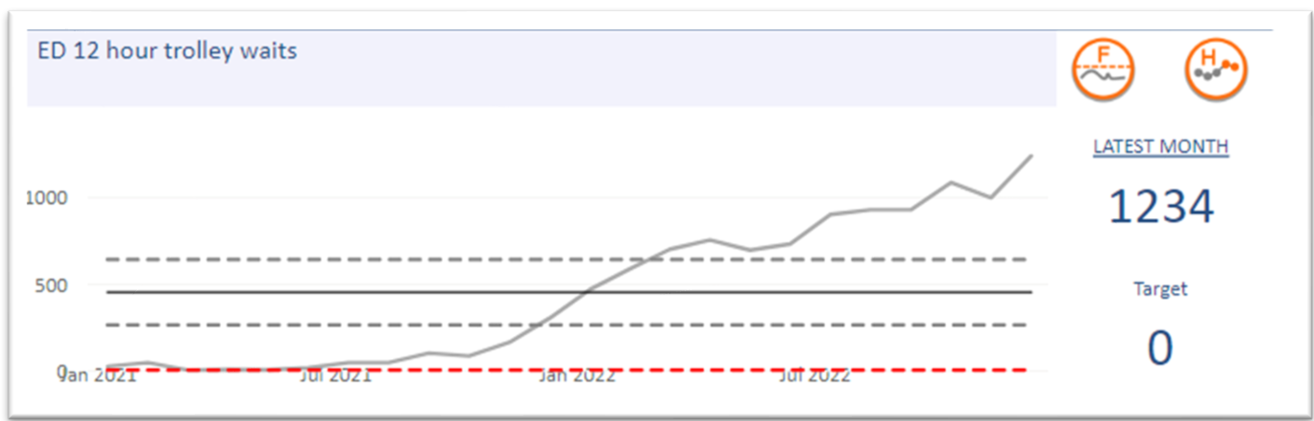
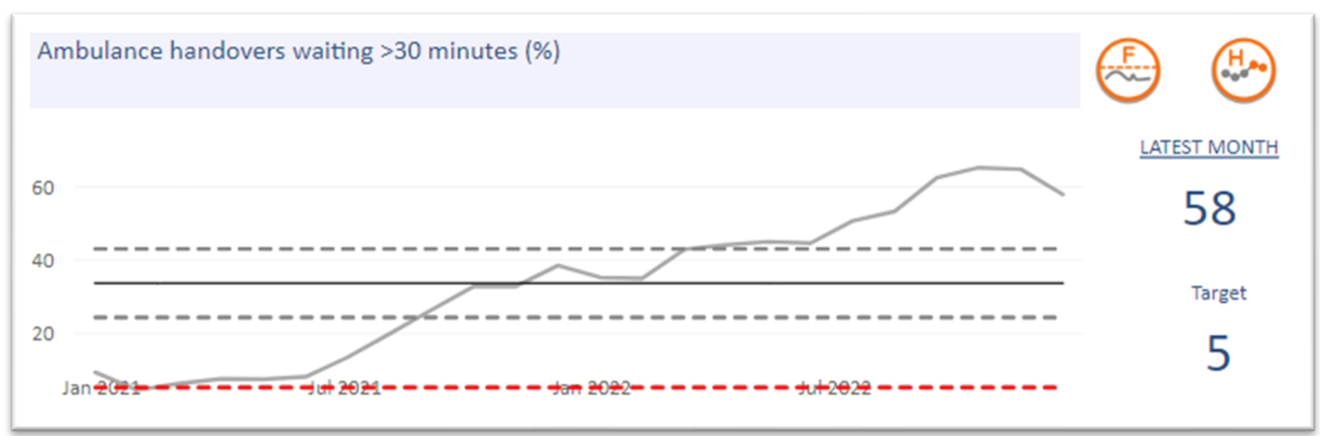


Figure 17 – Ambulance handovers greater than 30 minutes



In his review Professor Cooke asserts that based on national evidence the overcrowding in ED will result in 3-4 excess deaths in York. Unfortunately, the SHMI data works 4-months behind (national restriction) so there would be a wait for January data to pass through and see our expected/actual deaths split by diagnosis group. The information team are undertaking analysis of the number of deaths particularly in light of the recent enhanced OPEL 4 position and strikes (YAS and RCN), this will be provided in the February report.

7.2 Development of Nucleus for ED

An ability to see the ED ward list on Nucleus was finished and Nucleus went live in ED York on the 15th of December and ED Scarborough on the 20th of December.
This included mobile devices and charging stations. This includes the ability to record observations, blood glucose levels and the current nucleus risk assessments and care plans (falls, bedrails, MUST, Purpose T, skin checks).These are full assessments so more than exists on the current PAD – however in the case of the purpose T the digital assessment stops at part 1 if the patient is on a green pathway so it is broadly the same as

the paper. As described earlier activity over the Christmas and New Year period in ED was extremely challenging and there was a P1 (IT) incident which affected CPD and Nucleus, this did cause some issues.

The functionality within Nucleus to schedule observations for ED is being worked on by the DIS team and current progress indicates that it will be ready for implementation in early February. Nucleus enables staff to acknowledge escalations where a patient has a high NEWS2 score.

The Signal dashboard does not currently provide ED data but as the system develops this functionality will come online. However, it is essential that we first iron out the way the data pulls for the wards before we move to the data from ED being added to the dashboard.

8. Risk to the Delivery of Actions

The pressures experienced within the emergency departments over the Christmas and New Year period were significant with at the peak of the demand approx. 75 patients waiting for a bed on the York site alone. The ambulance corridor queue at York reached 27 at its peak. Both sites were under intense pressure, resulting in the declaration of enhanced OPEL4 on 2 January. Additional flex capacity was opened across the entire Trust with ward 25 (York) and Haldane (Scarborough) being opened to provide extra capacity. When the CQC inspected in March, we were in a similar position with all available additional capacity open which stretched the staffing levels thinly. There is a risk that opening new capacity will again impact on staffing levels and the delivery of the fundamentals of care. The additional wards opened during surge have all been closed at the time of writing this report.

The next report in February will provide further analysis of the actual impact of the significant overcrowding which peaked on 2nd January

9. Recommendation

The Quality Assurance Committee are asked to consider the update within this report and receive assurance of the delivery of key actions.

Date: 12.1.23

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	Perinatal Clinical Quality Surveillance Update
Director Sponsor:	Heather McNair Chief Nurse
Author:	Sue Glendenning Director of Midwifery

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:

Maternity Services had an unannounced Care Quality Commission (CQC) 3-day visit in October 2022 , with a follow up visit in November 2022 and a culmination of a Section 31 Notice served under the Health and Social Care Act 2008 on the 25th of November at York Hospital. A rapid improvement plan and a longer-term action plan was submitted to the CQC on the 23rd of December 2022.

Maternity Services are being supported by the National and Regional Maternity Teams as part of the Maternity Safety Support Programme and a Strategic Improvement Director who has recently supported Sheffield Maternity Services. Maternity Services are formally entered onto the programme if rated requires improvement or inadequate in the well led and or safe domains by the CQC.

The Maternity Services have received sign off from Trust Board regarding the paper presented for the Maternity Incentive Scheme (MIS) and is included as appendix D This has now been forwarded to the LMNS for discussion at ICB Board in January.

It is acknowledged that Ockenden and MIS are key workstreams alongside the 5 Key Lines of Enquiry and plans need to incorporate the embedding as key workstreams in conjunction with the Maternity Improvement Plan and be monitored via the Maternity Transformation Committee. A Transformation Lead Midwife has been appointed to commence in post February 2023, a 12-month post funded by the LMNS who will be able to support progress of the Maternity Improvement Plan.

Review of the midwifery structure is on-going and will be reported to the Board in February within the biannual maternity staffing paper.

The CG5 Governance Team have undertaken a review supported by their line manager the Associate Director of Midwifery and Deputy Director of Governance, roles and responsibilities of the team require clarification and the Director of Midwifery is requesting this with overall accountability for the service.

Midwifery staffing has improved slightly across the service but remain a challenge particularly within Community and Antenatal Services in York.

Recommendation:

The Board of Directors are asked to receive the report 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)

Quality and Safety Assurance Committee	**Date** 17th December 2023	**Outcome/Recommendation**

Perinatal Clinical Quality Surveillance Report – January 2023

1. Introduction and Background

This report provides monthly oversight of perinatal clinical quality surveillance reporting as per the minimum required dataset required by NHSE/I and highlighted in Appendix A ensuring a transparent and proactive approach to maternity safety across York & Scarborough Teaching Hospitals NHSFT. An introduction to Ockenden, Maternity Incentive Scheme (MIS), and Continuity of Carer (currently paused) is provided for context. The report intends to provide assurance surrounding any identified issues, themes, and trends to demonstrate an embedded culture of continuous improvement.

The MIS 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 in August 2021, paused in December 2021, a submission date of 5th January 2023 now revised to 6th February 2023.

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. The final Ockenden Report was published on the 30th March 2022 , resulting in a total of 49 standards and 92 safety recommendations to be addressed by providers of maternity services. The Trust has commenced this benchmarking in January 2023. The LMNS advised that this work would sit alongside the East Kent Report and a plan for the way forward from the LMNS and the DoM has contacted them for further information. The instability in the Midwifery Leadership Team throughout 2022 has caused difficulties with progressing this work alongside other key workstreams a risk has been raised to explain the issues.

Following the publication of the East Kent Report on the 19th of October 2022 the maternity service is working with the LMNS to evaluate current cultures and behaviours and the LMNS met on the 2nd of November 2022 to undertake preliminary benchmarking. The Maternity service has a culture and leadership work programme with MDT engagement, to date 3 engagement meetings have been held with a dedicated meeting on the 10th of January 2023 to discuss the report. Some key discussions included that It was felt that the CQC feedback has solidified what we already knew and we are actively working on addressing concerns. It was felt that most of the doctors have good relationships with the midwives and each other. However, the feeling was that this doesn't necessarily extend to junior doctors, or any new starter and the Trust was described as a '*weird place to join as a new starter'.* There was a discussion around how we need to ensure messages are clear and compassionate as the workforce are *'damaged'* and there is lots of mistrust.

2. Current Position/Issues

2.1 CQC Section 31 Inspection

The Trust submitted the response to the CQC on the 23rd of December following regulatory enforcement notice with a Section 31 to include immediate actions taken and a longer-term action plan as part of the Maternity Improvement Plan.

This submission will be shared at the Quality Committee on the 17th of January and the first update on progress will be provided to the CQC on the 23rd of January.

2.2 Moderate Harm & Serious Incidents

For December 2022 there were 10 O&G moderate incidents and 7 in November 2022, this is above the upper control limit. There is an increase in moderate harm incidents reported for several reasons, we have seen an increase in the number of incidents reported to HSIB over the last four months due to a slight increase in the number of intrauterine deaths, a working group has been set up to look at why this is and will be monitored through the speciality governance meetings. All moderate incidents are discussed at the weekly MDT maternity case review meeting and then taken to the Trust Quality & Safety meeting for wider discussion. A challenge is around workforce and the managers having the time to investigate incidents and SI's. Since the recent CQC visit it was requested that all Postpartum Haemorrhages >1500mls were declared as moderate harm and had a PSIR completed. This is still under review due to the large number and the ability to complete this additional review paperwork on top of the MDT discussions that already occur. Previously only the Postpartum Haemorrhages that raised concerns around prevention or management would be classified as moderate harm, this was infrequent. Therefore, many incidents of this nature were not declared as moderate harm, they were investigated by a governance midwife, consultant obstetrician and additional senior midwives/obstetricians who were also available for the meeting. If no concerns were highlighted, they remained at a harm level of minor/low. This is likely to have had a big impact on the moderate harm cases coming through due to a request by the CQC to change the classification for all of these incidents. Due to the large quantity of cases, they have not all had the associated PSIRs completed whilst it is decided what the most beneficial process is for review as the governance team don't have the capacity to complete them all.

There were five moderate harm incidents in December, all for postpartum haemorrhage of 2.5 litres or above. These have been reviewed by the Consultant Obstetric team as a cluster investigation and will be presented to the Trust Quality and Safety meeting on 16 January 2023. A PPH Scrutiny Panel has been established, an initial meeting was held on the 15th of December 2023 to agree TOR, the focus of this panel will be to reduce the rate of all PPH to below the national average using a Quality Improvement Methodology.

A walkthrough on the 14th of December 2023 identified the below key learning points with actions underway.

- reassessing risk of PPH just before the start of active second stage / at registrar review for delivery would help identify increased risk factors acquired during the later stages of labour - to amend risk proforma
- PROMPT scribe sheet has inadequate space to document blood loss and observations - to be modified
- delays in accessing emergency drugs locked away - sealed red emergency trolley (like cardiac arrest trolley) with non-refrigerated drugs accessible when seals broken
- practical difficulties with space in room and multiple trolleys - separate emergency trolley for PPH with suturing pack & drapes to be added to bottom drawer

- For bleeding due to trauma - Briony liaise with sterile services about packing 2 additional artery clips in with episcissors for clamping of vessels
- Increasing awareness - January to be PPH awareness month with bitesize highlights of changes shared via department Facebook page, email alerts, handovers, message boards

There were seven NICE Red Flags reported on Datix in December.

Scarborough: Four flags for delays of over two hours between admission and Induction of Labour and one for short staffing.

York: Two flags reported, one for delayed induction of labour and one for delayed recognition of sepsis in the community.

These are reviewed at the daily datix huddle for any immediate safety actions and discussed at the weekly Maternity Case Review meetings for any themes or trends, these are then fed back to staff in the weekly safety briefing.

Two Independent Clinical Reviews have been commissioned and undertaken to include Postpartum Haemorrhages and Stillbirths. A presentation to the Care Group via teams from the Authors, Michaelene Holder March, CQC Improvement Advisor and Professor Jaiyesimi Consultant Obstetrician and CQC Advisor occurred on the 6th of January and have been shared within maternity services. Both reports will be presented to Speciality Clinical Governance on the 13th of January and action plans will be agreed as an MDT.

Learning is disseminated to the teams in all areas at both sites using a daily safety briefing. This briefing is read at every MDT handover with the purpose of sharing any learning from incidents or patient safety messages to all staff groups for a week. There are also learning boards in the staff handover areas where important learning from patient safety incidents, including fetal monitoring are shared for staff to read and also highlighted during the daily handover.

2.3 Healthcare Safety Investigation Branch Reports (HSIB)

There were zero submissions to HSIB in December and no final reports received.

2.4 Perinatal Mortality Review Tool

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

A summary of the PMRT activity is detailed in Appendix B

2.5 Unit diverts and closures

Closure is recognised as both sites simultaneously being unable to facilitate 1:1 care in labour or no further bed capacity and therefore services are closed to admissions and all women are diverted across region. Diverts are when one-unit closes, York or Scarborough and women are transferred as needed within the Trust.

In December there were no unit closures or diversions from the York site. Scarborough there were 3 diversions to York with a total number of 11 women, the Associate Director of

Midwifery does review these cases and moving forward will be a key focus as part of understanding and improving patient experience.

Commencing in December the Senior Maternity Team led by the DHoM commenced a specific maternity on call on a voluntary basis., only 4 people were on this rota and it was unsustainable. A Standard Operating Policy has been developed and has been presented at Executive Committee in December to ask for support to commence as a permanent maternity on call and is still under discussion.

2.6 Training Compliance

The training figures for both SCH and York sites are presented in Appendix C, reporting on December data.

Obstetric CTG training leads are now tasked with regularly monitoring and chasing compliance, as well as ensuring that new starters are prospectively booked for the monthly face to face CTG training days.

There are now two Practice Development Midwives in post who are working on a plan to achieve compliance, for midwives we plan this trajectory for February 2023.

In addition, working with CLAD the Care Group, commencing with maternity are receiving core mandatory training specific compliance figures per identified metric for example IPC, Fire and will be included as part of Appendix C reporting on January data and included within the February Report.

In respect of the Maternity Dashboard there are plans to meet with the Chief Digital Information Officer on how this information is collated as currently reliance on manual submission and very limited resource, in addition looking at an option to change the format to SPC charts to make the data more meaningful.

2.7 Safe Staffing

The Department are undertaking a project around roster management working closely with the Band 7's and roster creators, the unregistered workforce now sits separately within the rosters. The aim is to ensure that all staff are sitting within the correct team and that budgets are aligned, this includes a large piece of work with the Finance Business Manager to separate budgets and allocate new codes e.g., YH Triage.

We have included the roster fill rates but until more work is undertaken around the rosters validity cannot be confirmed, however we are aware of the pressures in the York based community teams

Area	Roster fill rate 5 Dec – 1 Jan
COMM MIDWIFERY YH	36%
COMM MIDWIFERY SGH	60%
UNIT SGH	77%
UNIT YH	78%

The Maternity Services are suggesting undertaking another Birthrate Review as the current report is outdated and does not reflect the current plan and workforce model.

Birthrate + recommended establishment 185.74

WTE budgeted establishment 167.73
WTE Clinical Midwives in post 155.34 (7 new starters)
WTE Clinical Midwife Vacancies 5

3.0 Service User Feedback

The Maternity Services are in communication with the MVP to request regular feedback into this report and a request to undertake the 15 steps.

Through a recent complaint the maternity services are engaging with a complainant who would be happy to participate in future improvements.

The monthly report from the Patient Experience Team can also provide a forum for sharing learning and improvements.

5.0 Safety Champions Feedback

A presentation has been prepared for the meeting on the 17th of January to determine a new agenda and the way forward.

Next Steps

The focus for our maternity service is the monitoring of the CQC Rapid Improvement Plan / Long Term Action plan through the Maternity Transformation Committee.

Induction of new staff, bank and agency staff and probation periods continues to be a key focus review. In addition, acknowledging the importance some of the key HR processes to included recruitment, roster management and managing absence is a key focus for the new senior leadership team and the Director of Midwifery has discussed with the Care Group Workforce Lead to acknowledge and support with this and currently undertaking some anonymous case reviews that can be for leaning.

Date: 12th January 2023

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

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

	2022								
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Number of reviews completed using the Perinatal Mortality Review Tool	0	4	0	1	0	1	1	3	1
Number of cases notified to MBRRACE	2	2	1	1	3	2	2	2	2
Number of cases referred to HSIB as per eligibility criteria	1	0	1	0	3	1	0	1	0
Number of received HSIB final reports	0	2	0	1	0	1	0	0	0
Number of incidents with a harm rating of Moderate or above	4	5	1	1	3	4	7	10	10
Number of Maternity Unit Diverts	4 SGH 4 YDH	0 SGH 2 YDH	1 SGH 3 YDH	1 SGH 8 YDH	SGH 0 YDH 7	SG 1 YH 5	4	SGH 2 YDH 1	SGH 5 YH 0
Number of Maternity Unit closures	0	0	2	11	14	13	7	0	0
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	0	2 (CQC)	1 (CQC)	1 (CQC)	1(CQC)	1(CQC)	CQC Inspection	CQC Inspection	CQC Inspection
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0
Continuity of Carer									
Percentage of Continuity of Carer bookings	37%	34%	35%	paused	Paused	Paused	Paused	Paused	paused
Of those booked for Continuity of Carer - Black, Asian and mixed ethnicity backgrounds	28%	2%	64%	paused	Paused	Paused	Paused	Paused	paused
Of those booked for Continuity of Carer - Postcode for top decile for deprivation	92%	8%	90%	paused	Paused	Paused	Paused	Paused	paused
Intrapartum Continutiy of Carer received - Overall	25%	25%	19%	paused	Paused	Paused	Paused	Paused	paused
Intrapartum Continutiy of Carer received - Scarborough	24%	25%		paused	Paused	Paused	Paused	Paused	paused
Intrapartum Continutiy of Carer received - York	11%	0.00%	11.00%	paused	Paused	Paused	Paused	Paused	paused
Intrapartum Continutiy of Carer received - Black, Asian and mixed ethnicity backgrounds	0%	0%	8%	paused	Paused	Paused	Paused	Paused	paused
Intrapartum Continutiy of Carer received - Postcode for top decile for deprivation	15%	23%	50%	paused	Paused	Paused	Paused	Paused	paused
Safe Staffing									
1 to 1 care in Labour - Scarborough	95%	98%	100%	100%	99%	100%	99%	100%	Not provided
1 to 1 care in Labour - York	94%	100%	100%	100%	100%	98%	100%	100%	Not provided
L/W Co-ordinator supernumary % - Scarborough	84%	95%	99%	94%	73%	91%	100%	83%	Not provided
L/W Co-ordinator supernumary % - York	100%	100%	100%	76%	90%	67%	Not avail.	100%	99%
Vacancy Rate - Scarborough (excluding maternity leaves)	3%	4.60%	1.55%	0.15%		1.89% (1.13 WTE)	1.13WTE	1.97%	0.73%
Vacancy Rate - York (excluding maternity leaves)	15%	13%	12%	13.75%		14.77% (16.11 WTE)	16.11 WTE	10.97%	2.35%

PMRT – Appendix B

PMRT Summary from Q3 2022

Quarter 3

There were four reports completed in quarter 3 which related to three antenatal stillbirths, and an intrapartum stillbirth. In two incidences, there was a delay in obtaining an ultrasound scan where indicated. Subsequently, there has been work to develop a further room for scanning, as well as the development of three midwife ultra-sonographers. The benefits of these implementations have been immediate, and as of November 2022, there was a zero- day wait for required ultrasounds. There were no highlighted concerns within the antenatal cases. The intrapartum stillbirth presented many missed opportunities for better care provision, escalation and communication. Two of the cases also did not have a Kleihauer test taken post delivery as per the guidance. This was escalated to the laboratory and communication sent to all staff reminding them of the need for this to be done.

On two occasions, there was no evidence to indicate the parents were offered the opportunity to take their baby home. A suitable action for this was for the bereavement midwife to be present on the wards to support staff in caring for women experiencing loss, so that they aware this option can be offered. Recently 15 hours have been allocated at each site for a bereavement champion, who can support the lead midwife for bereavement in supporting staff, and families, as well as disseminating learning.

Training Compliance – Appendix C

Midwifery Staff – York

	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Neonatal Life Support	Annual	% of staff trained	≥85%	61%-84%	≤60%	77	73	74	87	92	93	92	92	92	92	88	94
Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	77	75	66	64	81	84	91	94	94	92	93	95
Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	84	84	85	86	89	92	94	97	95	95	96	97
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	90	91	89	90	92	94	93	95	96	95	96	97
Public Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	20	22	33	44	50	56	56	63	72	69	82	88
Personalised Care - Year 1 (2021/2022)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	20	23	33	44	51	56	60	64	77	73	79	76
Personalised Care - Year 2 (2023)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	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	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	64	72	82	91	92	90	92	94	93	93	93	97
PROMPT - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	60	54	64	77	77	81	79	79	90	86	93	90
COVID in pregnancy - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	84	67	68	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COVID in pregnancy - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	80	71	64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	78	70	75	83	84	85	84	85	83	88	89	92
Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	27	27	34	46	53	62	68	68	77	75	88	95
Substance Misuse	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	89	89	91	90	89	89	88	91	92	92	88	93
Mentorship	Annual	% of staff trained	≥85%	61%-84%	≤60%	26	26	33	45	52	60	56	56	63	62	71	74
Bereavement update	Annual	% of staff trained	≥85%	61%-84%	≤60%	60	54	49	70	72	76	75	81	79	79	82	81
e-lfH National Bereavement Care Pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	21	19	18	18	20	18	18	18	18	20	19	17
K2 - Full Midwife pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	63	60	57	61	66	66	70	72	79	72	66	70
SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	71	72	71	68	61	64	65	64	66	71	72	75
SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	≥85%	61%-84%	≤60%	81	61	59	61	61	60	62	66	71	73	75	76
SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	84	64	64	67	63	63	66	74	77	81	79	81
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	81	60	59	62	57	57	59	62	68	72	73	76
SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	87	66	66	68	62	63	66	70	73	76	80	80
Bereavement Workshop - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	80	71	64	69	69	69	61	66	62	62	61	62
2 day BFI - Midwives/MSWs/HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	83	83	83	92	81	82	82	79	87	87	87	86
Fetal Monitoring (with Rachel McCormack)	Annual	% of staff trained	≥85%	61%-84%	≤60%	83	87	90	89	91	94	94	94	95	93	93	96
BLS - Midwives	3yrly	% of staff trained	≥85%	61%-84%	≤60%	90	87	84	77	72	89	92	94	93	91	88	87

Midwifery Staff - Scarborough

	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Neonatal Life Support	Annual	% of staff trained	≥85%	61%-84%	≤60%	83	77	81	89	87	78	72	68	68	74	88	87
Infant Feeding	Annual	% of staff trained	≥85%	61%-84%	≤60%	73	73	83	77	80	71	59	59	69	79	80	82
Professional Midwifery Advocate	Annual	% of staff trained	≥85%	61%-84%	≤60%	81	82	87	89	90	79	74	74	77	76	83	85
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	91	93	93	96	94	94	91	93	92	89	90	89
Public Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	14	26	26	26	36	36	35	34	35	47	63	66
Personalised Care - Year 1 (2021/2022)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	13	23	31	31	33	36	34	32	37	35	59	57
Personalised Care - Year 2 (2023)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	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	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PROMPT - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	74	81	85	88	90	87	68	79	77	82	90	90
PROMPT - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	59	71	81	75	70	68	78	78	83	67	80	74
COVID in pregnancy - Midwives	Annual	% of staff trained	≥85%	61%-84%	≤60%	57	49	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COVID in pregnancy - MSW/HCA	Annual	% of staff trained	≥85%	61%-84%	≤60%	76	76	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antenatal and Newborn screening	Annual	% of staff trained	≥85%	61%-84%	≤60%	68	72	65	61	69	63	58	50	53	65	73	74
Maternal Obesity	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	90	87	85	85	86	86	86	N/A	N/A	N/A	N/A	N/A
Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	16	24	32	35	47	50	48	44	55	68	76	79
Substance Misuse	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	86	84	84	89	91	91	92	95	95	95	95	97
Mentorship	Annual	% of staff trained	≥85%	61%-84%	≤60%	16	5	19	22	33	36	36	33	44	52	61	59
Bereavement update	Annual	% of staff trained	≥85%	61%-84%	≤60%	61	56	45	42	54	53	52	50	52	53	61	57
e-lfH National Bereavement Care Pathway	One off	% of staff trained	≥85%	61%-84%	≤60%	12	11	11	13	13	13	13	14	15	15	15	7
K2 - Full Midwife pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	62	49	45	49	67	67	67	62	66	61	63	56
SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	65	58	71	64	64	64	68	68	69	71	76	72
SBLCB - Detection and surveillance of growth restriction	Annual	% of staff trained	≥85%	61%-84%	≤60%	67	46	41	50	41	54	59	62	68	69	73	74
SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	65	46	53	65	63	68	71	71	74	73	75	77
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	71	46	41	50	41	41	52	55	58	60	61	62
SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	67	45	51	58	58	62	68	71	70	74	76	80
Bereavement Workshop - HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	88	82	57	57	75	74	74	72	61	57	53	68
2 day BFI - Midwives/MSWs/HCAs	One off	% of staff trained	≥85%	61%-84%	≤60%	96	96	86	88	89	92	92	93	93	90	91	91
Fetal Monitoring (with Rachel McCormack)	Annual	% of staff trained	≥85%	61%-84%	≤60%	93	87	97	92	94	91	91	91	89	79	90	89
BLS - Midwives	3yrly	% of staff trained	≥85%	61%-84%	≤60%	97	97	90	91	90	87	90	91	95	81	85	85

Medical Staff - York

Course	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec
PROMPT	Annual	% of staff trained	≥85%	61%-84%	≤60%	50	53	61	71	90	97	100	87	74	74	73	73
COVID in pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	75	69	70	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antenatal Screening	One off exl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	13	31	45	45	59	62	61	60	61	71	79	67
Fetal Monitoring (with Rachel McCormack)	Annual	% of staff trained	≥85%	61%-84%	≤60%	75	72	64	71	71	87	89	80	61	65	67	76
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	19	36	52	55	60	64	67	65	74	70	73
Personalised Care - Year 1 (2021/2022)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	0	16	36	55	65	70	71	67	58	68	70	73
Personalised Care - Year 2 (2023)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	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	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Risk Assesment through pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	19	39	61	71	77	79	70	61	71	73	76
Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	22	42	48	55	57	64	63	58	68	70	73
SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	75	66	64	55	65	70	71	63	65	68	70	73
SBLCB - Detection and surveillance of growth restrictions	Annual	% of staff trained	≥85%	61%-84%	≤60%	69	56	55	68	68	77	75	73	68	68	73	76
SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	72	59	55	68	74	83	86	80	71	71	79	79
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	69	59	61	81	77	80	79	73	65	65	67	73
SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	72	59	55	71	74	83	86	77	71	74	79	79
K2 - Full Medical Staff pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	56	56	61	58	55	67	61	57	45	42	61	45

Medical Staff – Scarborough

Course	Frequency	Measure	No Concerns (green)	Of Concern (Amber)	Concerns (Red)	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec
PROMPT	Annual	% of staff trained	≥85%	61%-84%	≤60%	55	60	80	75	70	84	79	48	67	58	55	76
COVID in pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	60	60	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Antenatal Screening	One off exl F2 & GP	% of staff trained	≥85%	61%-84%	≤60%	10	10	10	0	0	11	37	42	48		55	52
Fetal Monitoring (with Rachel McCormack)	Annual	% of staff trained	≥85%	61%-84%	≤60%	75	75	75	75	55	58	63	37	48	37	55	57
Perinatal Mental Health	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	30	40	35	40	42	58	32	48	79	75	76
Personalised Care - Year 1 (2021/2022)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	0	15	25	20	35	37	53	26	48	84	80	81
Personalised Care - Year 2 (2023)	3 yrly	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	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	% of staff trained	≥85%	61%-84%	≤60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Risk Assesment through pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	15	20	25	40	42	58	32	52	84	85	81
Learning from Incidents, Complaints & Claims	Annual	% of staff trained	≥85%	61%-84%	≤60%	0	25	40	40	40	42	58	32	48	79	80	86
SBLCB - Supporting a smoke free pregnancy	Annual	% of staff trained	≥85%	61%-84%	≤60%	85	85	80	75	75	68	68	32	48	84	90	81
SBLCB - Detection and surveillance of growth restriction	Annual	% of staff trained	≥85%	61%-84%	≤60%	85	85	75	75	80	58	58	32	48	84	75	76
SBLCB - Reduced Fetal Movements	Annual	% of staff trained	≥85%	61%-84%	≤60%	85	75	85	75	70	63	53	26	43	74	70	76
SBLCB - Effective continuous fetal monitoring	Annual	% of staff trained	≥85%	61%-84%	≤60%	80	80	75	70	70	58	53	26	43	79	75	76
SBLCB - Reducing Pre-term birth	Annual	% of staff trained	≥85%	61%-84%	≤60%	80	75	75	70	70	58	58	21	38	74	70	67
K2 - Full Medical Staff pathway	Annual	% of staff trained	≥85%	61%-84%	≤60%	65	65	60	55	55	53	53	53	43		30	48

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Appendix D

Report to:	Board of Directors
Date of Meeting:	21 December 2022 (virtually considered)
Subject:	Maternity Incentive Scheme
Director Sponsor:	Heather McNair Chief Nurse
Author:	Sue Glendenning Interim Director of Midwifery

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:

This report provides the expected position of the Maternity Services at York and Scarborough Teaching Hospitals NHS Foundation Trust in relation to the Maternity Incentive Scheme (MIS) planned submission on Thursday the 2nd February 2023.

NHS Resolution is operating Year 4 of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer care. The scheme incentivises ten maternity safety actions which are outlined in section 3 of this report with more specific detail around the specific metrics for each safety action provided in section 4 of this report Trusts that can demonstrate they have achieved all the Ten Safety Actions will recover the element of their contribution relating to CNST. Trusts that do not meet the ten out of ten thresholds will not recover their contribution relating to the CNST MIS but may be eligible for a small discretionary payment to help make progress against actions they have not achieved.

This Trust will be declaring non-compliance against the scheme for this reporting period. Four safety actions will be compliant, three safety actions non-compliant and three safety actions partial compliant, there is no opportunity to make progress on these safety actions prior to the planned submission date.

An Improvement Plan will be commenced in January 2023 to monitor progress against all ten safety actions and it anticipated that full compliance will be declared in the next reporting period.

Recommendation:
For the Board to accept and approve this paper in preparation for submission to the Integrated Care Board in January 2023.

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

MATERNITY INCENTIVE SCHEME – YEAR 4
December 2022

1 Introduction and Background

The purpose of this report is to provide information following a review of the impact of Covid-19, and readiness to apply for a 10% reduction in the Maternity Incentive Scheme (MIS) formally known as Clinical Negligence Scheme for Trusts Maternity premium in 2021/22.

This report presents the following:

- **Background**
- **Covid-19 impact on reporting**
- **Review of the year four CNST safety actions**

2 Considerations

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the MIS, administered by NHS Resolution. The Maternity CNST rebate in 2019 was £470k with a further £21k allocation from Trusts who were not compliant with all ten-safety actions.

Following communication in May 2022, the members of the Maternity Incentive Scheme's Collaborative Advisory Group have further revised the scheme's standards to support Trusts to continue to work towards improving quality and safety.

The submission deadline has been extended to provide Trusts with extra time to achieve the standards. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023.

3 Current Position/Issues

The Ten Maternity Safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues
10. Reporting to HSIB and NHS Resolution

4. Summary

The current position at York and Scarborough Teaching Hospitals NHS Foundation Trust are outlined in table format below. Reporting periods for individual Safety Actions are identified within brackets for clarity under each separate Safety Action.

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool** **(6/5/2022 - 5/12/222)** **Compliant**	**Standard.** **Are you using the national Perinatal mortality Review Tool to review perinatal deaths to the required standard?** **Evidence.** All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter - **compliant** A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. - **compliant** At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. - **compliant** For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and /or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion - **compliant** Quarterly reports as part of the Perinatal Clinical Quality Surveillance Report will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust Maternity Safety and Board level Safety Champions. - **compliant**
2	**MSDS** **(6/5/2022 - 5/12/222)** **Compliant**	**Standard.** **Are you submitting data to the Maternity Services Data Set (MSDS)to the required standard?** **Evidence.** By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. - **compliant** Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. - **compliant**

		July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. - **compliant** July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. - **compliant** July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2). - **compliant** July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) - **compliant** Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics- **compliant** Midwifery Continuity of carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion -**currently paused so cannot be compliant** Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information) - **currently paused so cannot be compliant**
3	**Transitional Care Services (Pathway been in place since Year 2 and now business as usual if not by the 16th June at the very latest. Audits since Year 3 of the scheme) Non-Compliant**	**Standard.** **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?** **Evidence.** Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. C**ompliant** The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. **Non-compliant**

		A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. **Compliant** A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care , postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 week's gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. **Non complaint** Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. C**ompliant** Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to Badger Net. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but co Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. **Non complaint** An action plan to address local findings from the audit of the pathway and Avoiding Term Admissions into Neonatal units (ATAIN) reviews has been agreed with the maternity and neonatal safety champions and Board level champion. **Non complaint** Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting. **Non-compliant**
4	**Clinical Workforce Planning Partial Compliant**	**Standard** **Can you demonstrate an effective system of clinical workforce planning to the required standard?** **Evidence.** **Obstetric medical workforce** (by 16th June 2022. By 29th July and monitored monthly from then) The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ **Compliant** Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed

		at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS. **Compliant** **Anaesthetic medical workforce** (any 6-month period between August 2021 and 5th December 2022) A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1). **Compliant** **Neonatal medical workforce** (a review has been undertaken in any 6-month period between august 2021 and 5 December 2022), The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **Non-Compliant** For both level 1 and 2 junior medical rotas based on the BAPM requirements. The additional twilight registrar shift has helped with some mitigations but the weekends are not always covered within the current rota (and rely on locum shifts being picked up). On the risk register. The neonatal network is trying to identify ways in which rota gaps within the medical workforce can be addressed as this issue is not unique to this Trust. Waiting for Lower Unit Neonatal status to be recognised (under 1000 beds days for ICU / HDU) **Neonatal nursing workforce** (nursing workforce review has been undertaken at least once during a year 4-year reporting period august 2021 and 5th December 2022). The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead. **Compliant**
5	**Midwifery Workforce Planning (6/5/2022 – 5/12/2022) Partial Compliant**	**Standard** **Can you demonstrate an effective system of midwifery workforce planning to the required standard?** **Evidence.** a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. **Compliant** b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. **Non-compliant** (business case to be progressed) c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service **Non complaint** d) All women in active labour receive one-to-one midwifery care **Non-compliant** e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period. **Compliant**

6	**Saving Babies Lives Care BundleV2 (Trusts should be evidencing the position as of 2nd February 2023) Partial Compliant**	**Standard** **Can you demonstrate compliance with all five elements of the Saving babies Lives care bundle version 2?** **Evidence.** Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board. **Non-compliant** **Element One** **Compliance with 36-week carbon monoxide monitoring** (planned piece of work to understand the issues) **Element Two** **Serial scans to 36 weeks, not 40 (** scanning capacity increased and expected compliance February 2023 **Element Five** **Administration of steroids** Consistency in the administration of steroids within the 7-day period ,
7	**Maternity Voices Partnership (6/5/2022 -5/12/2022) Non -Compliant**	**Standard** **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?** **Evidence.** Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for an MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems · **Compliant** Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. **Non-compliant** Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. **Non-compliant** Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high

		levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. · **Non-compliant** Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP. **Non-compliant** This is a Commissioned Service, Chair now appointed at York who will support the East Coast in the short term.
8	**Local Training Plan – six core modules of the Core Competency Framework (Any 12 consecutive months within the period 1/8/2021 until 5/12/2022) Non-Compliant**	**Standard** **Can you evidence a local training plan is in place to ensure that all six core modules of the core competency framework will be included in your unit training programme over the next 3 years starting from the launch of Mis Year 4?** **In addition can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in-house' one day multi professional training day, which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new born life support, starting from the launch of MIS year 4** **Evidence.** A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. **Compliant**. 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021? **Non-compliant**. 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021. **Non-compliant**. Can you evidence that 90% of the team required to be involved in immediate resuscitation of the new-born and management of the deteriorating new-born infant have attended in-house neonatal life support training or a New-born Life Support (NLS) course starting from the launch of MIS rear four un August 2021 **Non-compliant**. Due to staffing levels and a period without a PROMPT trainer the maternity service is not compliant but pans are in place to achieve this in the next reporting period
9	**Maternity and Neonatal Safety Champions Partial Compliant**	**Standard** **Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.** **Evidence.** The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level

		intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. **Non-Compliant** Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, the training update should include any modifications made because of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. **Compliant** Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes**. Complaint** Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) **Non complaint**
10	**Reporting to HSIB and NHS Resolution Compliant**	**Standard** **Have you reported 100% of qualifying cases to healthcare safety Investigation branch (HSIB) and to NHS Resolution early notification scheme for 2021 /22?** **Evidence.** Reporting of all qualifying cases to HSIB 1 April 2021 to 5 December 2022/ **Compliant** Reporting of all qualifying EN cases to NHS Resolution's Early Notification Scheme from 1 April 2022 until 5 December 2022.**Compliant** For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 5. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. **Compliant**

5 Next Steps

The Board are asked to consider the content of this paper and note the plan from the Care Group in supporting Maternity Services to understand and support all elements outlined within the MIS Ten Safety Actions. A comprehensive detailed Improvement Plan to include all elements within each individual Safety Action will require implementation from January 2023 with identified leads to enable robust oversight and monitoring through Maternity and Care Group Governance.

Date: 21st December 2022

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 14

Report to:	Board of Directors
Date of Meeting:	25 01 2023
Subject:	Guardian of Safe Working Hours 2022-2023 Q3 report
Director Sponsor:	Dr Karen Stone
Author:	Dr Ruwani Rupesinghe

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:

- A decision on how to spend the outstanding £15,000 national funding provided to "enhance junior doctor rest facilities" on the York site is yet to be made. The process being led by a junior doctor with support from the wider JDF.
- There are Education Supervisors who are not supportive of the exception reporting process. This is currently being addressed through increased education but escalation may become necessary.
- Requests for locums (bank and agency) fell compared to Q2. This is despite staff shortages regularly mentioned in exception reports.

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 report: Guardian of Safe Working Hours 2022-2023 Q3 report

1. Introduction and Background

This is the 2022/2023 Q3 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The quarterly report is for 1st October 2022 to 31st December 2022 and summarises key findings from the Junior Doctor Forum (JDF), Exception Reporting and Agency/Bank shift data.

The primary role of the GoSWH is to ensure compliance with contractual stipulations regarding safe working hours for junior doctors employed by the Trust and provide assurance of this to the board.

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

The Director of Medical Education has access to review reports related to training and supervision.

The GoSWH also holds the position of Chair of the JDF. The Forum has core representation from Medical Staffing, Medical Deployment, Medical Education, Care Group management, Local Negotiating Committee and British Medical Association. It is open to all junior doctors working in the Trust.

2. Current position/issues

2.1 *Guardian funds*

One Guardian fine was levied in Q3. This was attributed to Care Group 2.

The doctor reported being unable to complete the paperwork for a patient who had died during their rostered hours on two consecutive days. To avoid further delay they did so after handing over at the end of their shift. As the doctor was on a long day it led to a 15-hour shift, the maximum allowed being 13 hours.

The report also states, *"As this was the second day of the new rotation, hopefully increased familiarity with the ward means that in time ward jobs are completed at a faster rate."* It provides a degree of reassurance that events such as this are not commonplace or indeed expected to continue.

The total Guardian fine for this breach of safe working hours was £174.16. This was split as follows: £65.28 to the trainee and £108.88 to the Guardian.

The current balance from fines received is £869.09. However, £500.00 of those funds has been ring-fenced for a games console for the York Doctors' Mess.

Guardian funds levied from fines

Detail	+/-	Balance
Opening balance at 1 October 2022		**£858.65**
(-) JDF meeting catering 13-12-2022	*-£98.44*	£760.21
(+) Guardian fine	+£108.88	£869.09
Closing balance at 31 December 2022		**£869.09**

The Guardian cost centre also currently holds the remaining £15,000 government funding for improving Junior Doctor wellbeing. This money is being managed separately as detailed in previous reports. A final decision on what to spend it on is yet to be made – discussions are ongoing amongst the junior doctor body which was hoping to get sleep pods installed. However, it is not feasible to create an appropriate location for them before the end of this financial year. Alternative options are being explored. The process is being led by Dr Hester Baverstock, President of the York Doctors Mess Committee.

2.2 *Exception reporting trends*

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

Most reports continue to come from doctors working in services delivering the bulk of acute and unplanned care; acute medicine, general medicine, care of the elderly and general surgery.

We continue to receive most exception reports from Foundation Year Trainees. This is a pattern seen across the region.

Most reports are submitted as a result of missing breaks and/or working overtime. In Q3 we received four reports pertaining to insufficient supervision or inability to attend scheduled teaching/training.

Based on the information contained within the reports and subsequent supervisor review the key themes in Q3 are:

- Staff sickness, rather than rostering gaps, often causing departments to operate below minimum staffing levels.

- The high volume of acute admissions, medical outliers and extra capacity wards further compounding the workload.

2.2.1 Safety concerns

When submitting an exception report, it is possible to check an "immediate safety concern" box. It is not a replacement for employing Trust escalation protocols. They should be submitted within 24 hours to highlight an "immediate and substantive risk to the safety of patients or the doctor making the report".

Two reports were submitted with an "immediate safety concern" that met the contractual definition in Q3.

Report 1:

"2 hours extra. Not enough staff on ward 32 to see all patients, especially lack of senior doctors"

Report 2:

"I supposed to be Medical SpR for medical wards. But there was vacancy for acute take medical registrar and rota team was unable find someone to fill up. I had to carry 2 Spr bleeps and covering both acute floors and wards. There were many patients awaiting in Eds to be reviewed and clerked as well as unwell patients in the wards needed to be reviewed. Two men jobs by one man led to very busy nights with enormous physical and mental pressure for a junior medical registrar. Thankfully the shift concluded uneventfully. Physical and mental well-being is markedly affected due to lack of break in 12.30 Hr shift. I've escalated to bed managers who already aware and informed acute medical consultants about the situation."

The initial review for report 1 is yet to be completed by the supervisor despite regular reminders and offers of assistance.

Report 2 has been closed following a meeting between the doctor in training and their supervisor. This was done within 3 weeks of submission. It was ascertained that the second night registrar was vacant due to sudden sickness. A locum doctor was found for the remaining night shifts. It is not clear whether the situation was escalated to the consultant on-call or ops team; the supervisor has asked the Medical Deployment Team to review the escalation process. *"No incidents occurred that he was specifically concerned about. But it sounds like [ ] did what [they] could in challenging busy times."* There were no ongoing concerns about the doctor's wellbeing.

2.2.2 Supervisor engagement with exception reporting process

The discrepancy in response illustrated in the examples above is repeated across all exception reports with some supervisors being more engaged than others. To improve this situation the Guardian produced and circulated a myth busting newsletter aimed at supervisors. The content was influenced by comments in the annual survey.

Additionally, the Medical Education Team has agreed to invite the Guardian to local supervisor training sessions to further boost engagement. It should be noted that Health Education England is also doing more to ensure supervisors have a better understanding of the process and how it fits in with their role.

The agreed escalation pathway is to Clinical Director and Associate Chief Operating Officer, then to Chief Executive. To date the approach has been for the Guardian to manage overdue reports if sufficient information was included and no obvious concerns were raised which warranted supervisor involvement. If the extra training and support does not lead to a noticeable change in supervisor response rates it may be necessary to utilise the pathway.

2.3 *Summary of rota gaps and locum usage*

At the time of writing, vacancy information for junior doctor grades was not available due to issues extracting the data from ESR. It is understood that the data will be available for next quarter.

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

4,984 shifts were requested via Patchwork in Q3. Excluding shifts that are clearly identified as being for non-junior doctor grades (marked with asterisk in Appendix 2, Table 6) this reduces to 4,482, approximately 500 fewer than in Q2. Around 20% of shifts went unfilled through Patchwork.

Data on agency locum bookings are in Appendix 3. 1696 shifts were requested for non-consultant grades. 98% of these shifts were filled.

2.4 *Junior Doctor Forum*

Dr Lucy Sapwell has taken up the position of Vice-Chair. She is a Foundation Year 1 doctor based in York Hospital. She has worked closely with colleagues to recruit several Forum Representatives. Attendance in December was markedly improved as a result, although remains low in Scarborough. A contributing factor to this is the presence of a similar forum led by operational managers in Care Group 2. As they can take direct local action on items raised, doctors don't necessarily see any added benefit.

However, not all junior doctors based in Scarborough work in Care Group 2, and we continue to explore methods of improving overall attendance.

One avenue is enhanced presence at junior doctor induction. In addition to delivering a formal presentation as part of the agenda, the Guardian team will now have a stall for new starters to visit. The Medical Education Team trialled stalls in August which proved successful. It is hoped that the less formal face-to-face interaction to highlight the benefits will entice them to attend at least one meeting.

The Guardian has also forged links with the regional Yorkshire and Humber Trainee Forum and attended their Wider Trainee Forum. The meeting is attended by trainees of all grades across the deanery. Although invited to talk about exception reporting the increased visibility has led to their members taking a more active role in our Forum and the "crib sheet" produced by the Guardian to support this is being shared on their website.

3. Summary

- A decision on how to spend the outstanding £15,000 national funding provided to “enhance junior doctor rest facilities” on the York site is yet to be made. The process being led by a junior doctor with support from the wider JDF.

- There are Education Supervisors who are not supportive of the exception reporting process. This is currently being addressed through increased education but escalation may become necessary.

- Requests for locums (bank and agency) fell compared to Q2. This is despite staff shortages regularly mentioned in exception reports.

Date: 13 01 2023

Appendix 1: Exception reporting data for 2022-2023 (Q3)

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions still open**
CG1			
Acute Medicine	4	4	
Cardiology	6	1	5
Emergency Medicine	1	1	
Elderly/rehab medicine	12	12	
Gastroenterology	9	9	
General medicine	1	1	
Renal	6	6	
Respiratory	3	2	1
CG2:			
Elderly/rehab medicine	1	1	
Gastroenterology	3	3	
CG3			
Surgery: colorectal	3	3	
Surgery: upper GI	3	3	
Surgery: vascular	5	5	
Urology	7	7	
CG4	0	0	
CG5	0	0	
Obstetrics & Gynaecology	3	0	3
Paediatrics	2	2	
CG6			
Trauma & Orthopaedics	2	2	
Total	**71**	**62**	**9**

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
F1	49	57%	51	72%
F2	10	12%	9	13%
CT1-2 / ST1-2	17	20%	3	4%
IMT3/ ST3+	10	11%	8	11%
Total	**86**	**100%**	**71**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
Late finish	72	84%	56	79%
Missed breaks	7	8%	4	6%
Late finish and missed breaks	5	6%	7	10%
Difference in working pattern	2	2%	0	0%
Inadequate supervision	0	0%	1	1%
Inadequate supervision & unable to achieve breaks	0	0%	1	1%
Unable to attend scheduled teaching/training	0	0%	2	3%
Total	**86**	**100%**	**71**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	21	11	14	5
FY2	3	3	0	3
CT1-2/ST1-2	1	0	2	0
IMT3/ST3+	6	0	1	1
Total	**31**	**14**	**17**	**9**

63% addressed within 7 days (61% in previous quarter)

Appendix 2: Locum booking (bank) data

Table 5: Locum bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine SGH	165	155	1,697	1,577
Acute Medicine YH	599	333	5,779	2,972
Ambulatory Care SGH	1	0	10	0
Cardiology SGH	2	1	12	4
Cardiology YH	2	1	16	8
Cellular Pathology (SHYPS Network)	4	4	9	9
Community In Patient Units	39	34	293	255
Elderly Frailty Unit RAFA ED YH	2	0	16	0
Elderly Medicine SGH	75	71	735	699
Elderly Medicine YH	156	130	1,424	1,190
Emergency Department SGH	548	436	5,370	4,246
Emergency Department YH	860	684	8,001	6,382
ENT YH	101	101	1,109	1,113
Gastroenterology SGH	1	1	8	8
Gastroenterology YH	1	0	8	0
General Medicine SGH	723	587	6,331	5,191
General Medicine YH	94	66	804	511
General Surgery SGH	71	67	813	769
General Surgery YH Consultants	15	15	209	209
General Surgery YH Juniors	141	113	1,542	1,266
Home First Unit (HFU) SGH	168	161	1,640	1,573
Maxillo Facial YH	52	51	659	647
Obstetrics & Gynaecology SGH	97	95	1,052	1,034
Obstetrics & Gynaecology YH	110	100	1,006	933
Occupational Health YH	10	10	80	80
Oncology YH	28	25	207	187
Ophthalmology SGH	17	15	168	138
Ophthalmology YH	65	61	642	601
Paediatrics SGH	238	232	2,771	2,715
Paediatrics YH	170	155	1,718	1,548
Radiology YH	26	26	75	75
Respiratory YH	11	11	54	54
Theatres, Anaesthetics and Critical Care SGH Consultants	46	45	676	660
Theatres, Anaesthetics and Critical Care SGH Juniors	92	92	936	936
Theatres, Anaesthetics and Critical Care YH Consultants	11	11	71	71
Theatres, Anaesthetics and Critical Care YH Juniors	17	15	183	157
Tier 1A Emergency Medicine SGH	35	14	354	141
Trauma & Orthopaedics SGH	27	24	373	341
Trauma & Orthopaedics YH	163	155	1,780	1,700
Urology YH	1	0	11	0
Total	**4,984**	**4,097**	**48,635**	**39,995**

Table 6: Locum bookings (bank) by shift grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
ACP*	3	3	32	30
Anaesthetic ICU different base cover	14	14	179	179
Anaesthetic Juniors & SAS	104	103	1,054	1,041
Anaesthetics General different base 24 hr on-call gap	10	10	240	240
Anaesthetics General different base Mon-Fri on-call gap	18	18	228	228
Anaesthetics General same base Mon-Fri on-call gap	4	3	56	40
Anaesthetics ST3+/Specialty Doctor/SAS	8	6	82	60
Consultant*	339	333	2,372	2,322
Consultant WE/Bank Holiday/Discharge*	118	109	1,324	1,222
CT/GPStR/ST1-2	2,258	1,870	22,149	18,394
FY1	194	125	1,768	1,166
FY2	362	179	3,551	1,735
On-call consultant*	42	41	587	579
On-call ST1+/SD	36	34	399	376
ST3+	1,068	907	10,745	9,146
ST4+	375	313	3,350	2,762
T&O ST3+/Specialty Doctor/SAS	31	29	521	478
Total	**4,984**	**4,097**	**48,635**	**39,995**

Table 7: Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Agency Locum Cancelled	1	0	12	0
Annual Leave	45	42	485	457
Bank Holiday	32	15	363	160
Bed Pressure	28	12	230	96
Compassionate Leave	13	12	152	139
COVID-19 (Additional demand)	14	11	84	67
COVID-19 (Staff sickness/isolation cover)	38	35	384	351
Extra Clinic	33	12	330	100
Extra Weekend Support	11	2	130	19
Induction	22	22	173	175
Maternity Leave	36	26	358	241
On-call cover	202	196	2,167	2,101
Service Requirement	1,511	1,184	13,876	10,870
Sick Leave	474	284	4,945	2,995
Sickness - Long Term	73	60	688	563
Sickness - Short Term	44	30	491	342
Special Leave	11	8	115	74
Vacancy	2,338	2,123	23,078	21,011
Winter Pressure	58	23	578	235
Total	**4,984**	**4,097**	**48,635**	**39,995**

Appendix 3: Locum booking (agency) data

Table 8: Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Accident & Emergency	306	296	2,418	2,383
Acute	166	150	1,337	1,203
Anaesthetics	115	55	923	441
Dermatology	20	0	161	0
Ear Nose & Throat	185	185	1,482	1,482
Gastroenterology	30	0	242	0
General Medicine	590	505	4,733	4,051
General Surgery	370	370	2,965	2,965
Geriatric Medicine	120	120	963	963
Haematology	16	1	130	9
Histopathology	20	0	161	0
Obstetrics & Gynaecology	202	186	1,636	1,500
Oncology	227	227	1,820	1,820
Ophthalmology	133	133	1,067	1,067
Orthopaedics & Trauma	145	145	1,163	1,163
Paediatrics	350	346	2,814	2,778
Paediatrics & Neonates	5	5	41	41
Renal Medicine	0	0	0	0
Respiratory Medicine	80	65	643	522
Rheumatology	15	0	121	0
Stroke Medicine	230	220	1,844	1,763
Total	**3,325**	**3,009**	**26,664**	**24,150**

Table 9: Locum bookings (agency) by grade				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Consultant	1,629	1,346	13,055	10,812
Specialty Doctor	424	408	3,404	3,273
FY1	0	0	0	0
FY2	0	0	0	0
ST1-ST2	973	960	7,804	7,699
ST3+	299	295	2,401	2,366
Total	**3,325**	**3,009**	**26,664**	**24,150**

Table 10: Locum bookings (agency) by reason				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	0	0	0	0
COVID-19	0	0	0	0
Deanery Gap in Rota	0	0	0	0
Increased Capacity Need	26	26	211	211
Other	8	8	72	72
Sickness	1	0	13	0
Site Pressures	5	5	41	41
Staff Shortages	0	0	0	0
Target Provision	1	0	0	0
Vacant Post	3,279	2,965	26,286	23,785
Winter Pressures	5	5	41	41
Total	**3,325**	**3,009**	**26,664**	**24,150**

Minutes

Quality and Safety Assurance Committee
22 November 2022

Members in Attendance: Stephen Holmberg (SM) (Chair), Jenny McAleese (JM), James Taylor (JM), Caroline Johnson (CJ), Mike Taylor (MT), Lorraine Boyd (LB)

Attendees: Shaun McKenna (SM), Tara Filby (TF), Sue Glendenning (SG)/Sarah Ayre (SA) (item 41-22/23 only), Hannah Gray (HG) (71-22/23 and 72-22/23), Ruth Render (minute taker)

SH thanked JM for chairing the last Quality and Safety Assurance Committee meeting and declared the meeting quorate.

58-22/23 Apologies for Absence

Apologies were received from Heather McNair (HM)

59-22/23 Declaration of Interests

No declaration of interests.

60-22/23 Minutes of the meeting held on 18 October 2022

The minutes of the last meeting held on 18 October 2022 were agreed as a true and accurate record.

61-22/23 Matters arising from the minutes and outstanding actions

SH advised most actions have been completed.

SH and MT discussed assurance from Care Groups. MT will pick up with CJ regarding a proposal for Care Groups to attend on a rolling basis. SH highlighted discussions with the CQC who have indicated that this should be in place. QAC have wanted to action this for some time but also wanted to give Care Groups time to embed their own Quality and Safety agendas to see how they settle with QPAS and Executive Committee. MT to finalise with CJ who can attend and when moving forward.

SH queried the role of the Quality Regulatory & Assurance Committee, as an assurance committee. MT to discuss further with CJ. SH queried how it fits with the governance process. MT confirmed it linked with work being done by NHS England (Lorna Squires) and related to the Clinical Governance structure.

TF explained that the Quality, Regulatory & Assurance Committee is time limited. It has been set up to provide oversight to some CQC actions. A new Mental Capacity Act Improvement Group has been established, the audit information and updates from Care Groups should go through the Mental Capacity Act Improvement Group which will then report to the Executive Integrated Governance Group for safeguarding and in turn to QPAS. CJ agreed that there is some duplication at present.

SH asked JT regarding patient story. TF confirmed that HM asked for the update be moved to the December meeting and explained Alison Pollard (AP) has nominated herself to lead the piece of work around moves of patients out of hours at night. Asked to leave on action log for December. SH questioned regarding the medical part and JT has written a report regarding Bill's story, which is a separate patient story going to Board this month. JT discussed moves during the last Board meeting. JT confirmed recent experience as Director on call whereby he moved every patient that could be moved multiple times due to pressure and stated the number of bed moves to create space in resus or move one patient in the ambulance crew is inordinate. JT confirmed a challenging issue to improve upon. MT confirmed if acceptable at Board level, for Board to close.

TF spoke regarding falls and pressure ulcer reports not being on the agenda because Q2 reports are ready for QPAS in December. HM instructed the reports are to go to QPAS first then Quality and Safety Committee meeting in December.

SH queried if CJ updating regarding the Mental Health Strategy and Quality Strategy. CJ confirmed the reports were sent through last time. Mental Health Strategy paper discussed at last meeting, Quality strategy is out for consultation and will go to Executive Committee in December and then to Quality Committee for comments. CJ is happy to circulate ahead for comments. SH asked to add to agenda in December.

SH flagged the last action log item to JM. JM commented regarding the Emergency Department culture and leadership which varies depending upon the staff on duty. JT agreed with Professor Matthew Cook of Emergency Department Medicine to come to support Emergency Department colleagues.

Action – Add Quality Strategy report update to December meeting (CJ)

62-22/23 Escalated Items

There were no escalations raised.

63-22/23 Annual Patient Equality Diversity and Inclusion Report

TF explained that Helen Ketcher (HK) is attending the Fairness Forum meeting. The committee agreed to move agenda item to December when HK can attend.

TF explained Virginia Golding (VG) EDI (Lead) is looking to launch an EDI workstream to operationalise delivery against objectives. SH asked to invite VG to December meeting.

Action – Forward item to December agenda
Action – Invite Virginia Golding (VG) EDI

64-22/23 Ockenden Update Report

LB asked regarding progress of the scrub teams.SG explained a Band 7 post has been advertised for a Maternity Theatre Team Leader, led from Care Group 3 and that the post is now closed. Staff are linking in from maternity theatre to main theatres. There is also an active advertisement for Theatre Nurses. SG confirmed Midwives are still scrubbing in for theatres, but checks are being made to ensure competencies completed.

LB enquired regarding the escalation processes and protocols noting the highest numbers of closures through July, August and September coinciding with a period of maximum

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instability in the leadership team and asked if any reflection of an improving situation. SG commented that it feels better on the ground and it will be interesting to see figures this month; SA is working on an escalation policy, sent for comments. Liaison with LMS is underway but SG flagged the need for own local-linking, a more robust policy linking into escalation policy for on call.

LB queried the timescale.SG explained the timescale is tight. Jo Mannion (JM)/Caroline Alexander (CA)/SG spoke at Oversight and Assurance and Melanie Liley (ML) asked to work on a paper. Paper to be ready by next week.

LB spoke of the CQC highlighting concern regarding diverts and closures and associated harm. LB asked for an update to include babies born outside of hospital.

SG advised the terminology is being looked at. Some BBAs were born in the car park which would have happened and not necessarily due to diverts and closures. SA has looked at this matter in detail and there was no resulting harm. Moving forward aiming to make sure have more oversight. There is a meeting on Monday with SA and Sarah Gallagher (SG).

LB mentioned following up women who had been diverted with regards to the outcome.SG confirmed women will be followed up with a letter and also to have a conversation.

LB commented that there could be other adverse outcomes as a result of delays. LB also noted the significant increase in moderate harm shown on BAF indicating special cause for concern, mentioning working group and asked when to expect resultant action.

SG spoke of the working group around still births and highlighted 2.2 of the paper; moderate harm and serious incidents are not all intrapartum deaths. 4 incidents were related to medication, 2 incidents related to clinical care and 1 intrapartum death. SG has asked for more information moving forward for the paper. Michaeline Holder-March (MH-M), Improvement Advisor is supporting and SG has asked to look into the intrapartum details, working on the paper which should be returned in two weeks. SG would like to see the link into SI action plans and improvement plans. Sarah Gallagher (SG2) is completing the paper for governance.

LB checked regarding CO2 monitoring and high pre-term birth rate of 8.2% below 37 weeks gestation, cited as a reason why could not comply with 95% CO2 monitoring. LB queried if there an issue with high pre-term birth rate?

SG explained if babies are born before 36 weeks cannot monitor CO2 but will look into pre-term 37 weeks and below as not clear. If the digital midwife cannot get the data then the statistics are not being picking up. CQC highlighted today regarding the CO2 monitoring.

SH asked LB if assured by SG’s responses and LB confirmed yes.

SH drew attention to 4 things in Maternity which are of concern including an issue with training and handover and asked if doing the best with limited resources regarding scanning.

SG confirmed scanning is becoming much more compliant against the guideline. Next year, the fourth scan room is opening. There are more available scan slots but will not be compliant with CNST this year and not just on saving babies lives. Maternity should be scanning within three days but can sometimes be scanning at seven days.

SH asked regarding handovers to teams.

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SG advised BA is very engaged and speaking with Medical Staff. Picking up on Ockenden audits, there are no stats to share today but will look into this for the next paper.

SH mentioned training figures.

SG commented on training stats and confirmed the figures are the same but added there will be improvement next time. A lot of work is being carried out with Medical Staff and for example foetal monitoring. Face to face complaint but not compliant with assessment. More input is needed on the training day. The Foetal Monitoring Lead does not have time at the end of the day to take through assessment. Also, action to try to ensure computers are available in the library but starting to understand the issues with training.

65-22/23 Serious Incident Report (Including Maternity SI reports) and Quarterly Serious Incidents Report

JT discussed the 2 serious incident reports, a short update for this month serious incidents and a quarterly report. The shorter report includes 4 clinical SI's, 3 relate to Ophthalmology and 1 relates to a Cardiology ward patient. This is a recurrent theme regarding Ophthalmology related to RAG rated follow up plans, not adhered to by clinical admin staff resulting in significant delays to patients, no escalation to Clinicians. It was found there were 2 separate admin processes and 2 separate Teams at York and Scarborough Hospitals. Post investigation revealed health inequalities. There is a longer follow up partial booking backlog at Scarborough Hospital than York Hospital which is being looked at by an Improvement Group. JT asked for this to be carried out as quickly as possible and asked committee to monitor.

SH enquired as to whether there is assurance that this will not happen again/less likely to happen again and if there is anything that has happened to reduce the risk?

JT added he cannot yet offer stronger assurance. A conversation has been had before regarding Ophthalmology serious incidents, has been informed work to be done and clearly not there yet. Now aware of health inequalities, finally got to the bottom of the issue. Have had to escalate to Care Group 6. SH asked if there is a benefit to inviting the Care Group to attend the committee. CJ suggested completion of an assurance report to then present to the next committee would be feasible.

MT in agreement and to show evidence of assurance.

LB suggested it should be pulling together what the Care Group are already doing.

JT commented regarding some of problems at the moment, there is only a York admin team in Care Group 6, the admin team that delivers the appointments in Scarborough is a generic, cross Trust admin team. JT suggested a single Ophthalmology admin team is required.

LB questioned what is being done in the meantime and raised the need for assurance that risk is being kept to the lowest possible level.

JT reported the last serious incident 14090 relates to a 67-year-old patient with Covid pneumonia who was commenced on low molecular weight Heparin due to suspicion of PE, which is a common covid complication. The patients CT report was negative for pulmonary embolisms. Heparin was continued for 4 further days. A rare complication developed; spontaneous retroperitoneal haemorrhage that can only relate to the Heparin and the patient sadly died. Learning from this to improve MDT working in communicating, whole ward MDT oversight patient pathway. Consultant had seen CT report and aware the result was

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negative but did not act. Need to bring to MDT, see improvements regarding oversight of tests and managing changed plans.

JT talked through the second report regarding themes and trends and stated no special variation in serious incidents looked at over a two-year period. A high proportion of serious incidents happened at Scarborough Hospital and the majority in Care Groups 1 and 2. Common themes noted a lack of safety netting, communication and documentation, inadequacy of safety checks, capacity and demand issue, Ophthalmology had a special mention. The Q2 review was a problem with the report and to committee. Does not make sense, suggested looking at timings of reports. CJ confirmed a rolling theme over a two-year period, not necessarily themes in that quarter.

SH asked regarding the timeline to finalise reports. CJ stated a 60-day timeline for serious incidents and that on some occasions extensions are agreed due to Clinicians being busy.

JT discussed the never events and informed the committee that Liam Wilson (LW) completed a report on never events before leaving, Alice Hunter (AH) then picked up the report. Two reports have been semi amalgamated to one. There are 6 never events in the initial report. Not enough to see themes or trends, then look at near misses. Single report completed in two halves. Review of 24 instances between January 2021 and August 2022 (6 never events). January to August 2022 there were for near misses. Near misses showed the main risks of retained foreign bodies swabs (22 of 24 instances), near misses, 20 of 24 happened in theatre and 4 happened in non-theatre-based sites where there should be a LocSSIPs process in place. Numbers are not quite correct as reported. Regarding the 6 never events these included; wrong site nerve block, wrong site hand surgery, retained guide wire, wrong site steroid injection, retained vaginal swab and incorrect orthopaedic implant. There is a need to look at quality of the safety checks not in theatres. There are more robust safety processes in place in theatre, less so outside of theatre.

SH asked regarding work going forward. JT advised good learning from the papers and some assurance regarding safety checks. Not seen material change regarding what is a never event. SH highlighted the need to increase rigor in non-theatre environments. CJ added LocSSIPs Group working through to look at areas where should be in, firmed up LocSSIPs audits, how do we make sure to have safety checks in non-theatre environments. Richard Matthews has taken over the group.

SH asked to hear an update.

CJ agreed can bring an assurance report next time.

CJ spoke positively regarding the new framework. At present broadening the review themes/trends from serious incidents to incidents, complaints etc. Will receive a paper in January regarding local priorities. There are National priorities and local priorities that are safety issues. Will have QI work streams and a process of how to investigate recurring themes. There is an Oversight and Assurance Group for QI.

LB asked SM regarding serious incident sign off. SM confirmed multi-faceted. The Groups sign off final serious incident reports that they are content with the report. The action plans are then generated based on the recommendations. On a separate date the Care Groups will bring back actions to propose when actions will be closed, reasons why and evidence base. The Group have ability to challenge. Can then take the learning further, may like to see audit for actions before closing. Hopefully reduce the risk and share learning.

Action: CJ Care Group 6 – Assurance Report
CJ Assurance Report

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66-22/23 CQC Compliance Update Report

SM spoke of the CQC paper key points section. The Trust retains the two section 31 conditions of registration from January 2020 inspection that pertains to mental health. Hoping following inspection, the conditions will be removed as in a better place regarding mental health risk assessments within Emergency Department. There are 4 section 29A warnings from the March Medicine inspection and 1 from January 2020 inspection that are retained. Appendix A included is the action plan pertaining to Medicine from March 2022. Lot of actions are completed, 11 are now overdue for delivery but each action has been risk assessed and will have minimal impact. ICS action plan attached (ML, Chief Operating Officer) responsible for relationship between ICS and Trust and actions being delivered. Have made progress in some areas and not others, minimal impact so far on bed base regarding numbers and length of stay. Was an initial drop with delayed discharges, when back up has significantly increased because of length of stay. Work ongoing. Action plan for York Hospital Emergency Department from most recent inspection included (Appendix D). No actions overdue, 2 amber, both actions implemented but in infancy, need to become embedded in everyday practice. Maternity action plan (Appendix E) 2 actions overdue but in progress. 4 x amber, ongoing but delayed from initial roll out. Little ambitious. Evidence uploaded to Inphase. Will look different next month as will see updated comments. No whistle blowing concerns/enquiries in October possibly due to CQC inspection. Exploring each enquiry individually. Initial letter/feedback from October stated would have draft reports by 7 November, inaccurate and draft report due at the end of December/January. Will also wrap up Well-Led and inspections at the same time this give a chance to focus on existing action plans for immediate concern.

SH asked about other current high-risk areas. SM's opinion of high-risk areas include; Emergency Department pressures and the ability to deliver care. CQC looking past performance metrics, less focus on numbers. Scarborough have some good processes in place, York Hospital are developing and embedding. Also included Maternity, due to national picture and staffing, IPC, environment and workforce biggest risk from a clinical point of view. Well-Led likely governance processes. Governance framework and structure split in two, Quality and Regularity Assurance Group which is fortnightly dedicated to seeking assurance, immediate responsive firefighting and Journey to Excellence Delivery Group once every two months regarding what can be done proactively to improve services. Journey to Excellence Bulletin every fortnight, need to highlight good and bad. Big high-risk areas, know what they are, need to deliver and be realistic regarding what can be delivered in the timescales.

SH asked regarding block on delivering on things known to be wrong.

SM added different factors and that each portfolio has its own governance and style of reporting. Areas have their own reasons for not being able to deliver. There are human factors involved. Patient safety incident response framework will support but will take time to embed.

SH questioned TF/JT and SG regarding further observations as to why have not been effective on delivery where improvements required.

TF commented multi-faceted, portfolios that TF leads on for example falls and pressure ulcers, lot of improvement work over the last two years, not seeing the output in regards to the numbers, some themes repeating for example workforce. Key theme around pressure ulcers and falls is not being able to give care at the prescribed frequency. Difficult for Improvement Groups to address workforce shortfalls, tried to put systems and processes in place with HCA/Nurses for example Nucleus, benefits not seen as yet. Some cultural and

leadership elements. Multiple different causative factors involved; human factors, teams under pressure and burn out contributing factors.

SH asked JT regarding unwarranted variation.

JT echoed TF in that has seen some improvement in staffing, not necessarily seen the benefit. Staffing has gone up but productivity backwards, net gain close to zero. Possibly relates to behaviours and cultures and impact of working in an environment which is difficult to make change in.

SG stated worked in the Trust since last year which had been through a restructure of Care Groups in 2019. Questioned the maternity structure. Maternity possibly do not have as many whole-time equivalents as other Care Groups but highlighted the complexity of maternity and trying to get the management and leadership structure right. SG came into post following Covid. SG stated there is an immense amount of work to do regarding strengthening the governance of maternity and Ward to Board. Not using maternity dashboard to best effect, mistakes made as manual and managed by one individual band 7 working well above contracted hours. Band 7s not substantive, on secondment or rotated with no job description.

LB stated key question is how do you start to make an improvement, know and known for some time and to do at pace. Where does the conversation need to take place to sort priorities and then support everyone else to deliver.

JM added that it was helpful to hear responses but thinks sometimes try to do too many things and end up doing nothing which has been a past problem. Need to decide on priorities.

SH flagged not turning into business as usual in an effective way. Senior leaders spending too much time on tasks they should not be. Not confident will get it done. The support structure of more senior leaders has been neglected.

SH highlighted the issue of accountability.

JM sensing starting to be more coherent and cohesive, work ongoing with Care Groups, trying to pull things together. Discussions had regarding Care Group governance. Before Care Groups more so as had Directorates, share themes moving in right direction, could it be done more quickly? Confident moving in the right direction.

67-22/23 Quality and Patient Safety Escalation Report

JT's initial summary mentions problems with violence and aggression and also limited EHP input into York Care Unit. Care Group escalation noted York Stadium delays which impacts cancer position and outpatient position and could correlate with Care Group 4 escalation regarding diagnostic capacity. Deteriorating position in clinical effectiveness and audit regarding compliance and baseline assessment and clinical documents.

LB highlighted alarm bells related to York Care Unit, set up to minimise harm but evidence succumbing to more harm than less than before for example pressure ulcers, falls, aggression/violence, need to keep an eye on.

SM mentioned the need to challenge York Care Unit put in place to minimise harm to acute inpatients and those waiting TCI Emergency Department than harm of patients awaiting discharge. To balance across whole patient bed base.

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SM commented the escalation in the QPAS paper was for Executive Committee to have debate. Inequality in services across sites. Will be good to get assurance.

JT commented as part of the 100-day discharge challenge, more minded to report harm regarding delayed discharge population. More reporting and focus and to drive change in social care.

Action: To escalate cancer position, Emergency Department, IPC, Maternity, Workforce to Board.

68-22/23 Quality and Safety Assurance Metrics (TPR) and Quality and Safety Mandatory Reporting Scorecard

SH queried anything to raise - no issues raised.

69-22/23 Deteriorating Patient

SM confirmed take paper as read. Highlighted in taking a step back you realise how much has been achieved as an organisation, does not feel like it from serious incidents, put bad in context of good, getting it right for the majority of patients. Paper outlines plans to put in place with Patient Safety Team to break up deteriorating patient pathway for the right focus and level of assurance. SM described a theme whereby a delay in escalation, human factor looking after several patients at once. SH countered the CQC would highlight to improve the process for escalation. Processes need to be looked at. SM added the need to get the level of detail from serious incidents and understand delays. Not there with the level of analysis. Need to get the detailed information to Improvement Groups.

JT agreed the process can be improved, system smart enough go straight to an outreach team and be proactive. JM explained using telephones is so outdated. Should be automatic, some parts NHS high tech and others not.

SM spoked regarding automating system, now have dashboard. Time referred, seen. Is there an issue. Tried to put different phases of pathway to drive improvements. Flags TPR, 87% most months, outlier. Target 90%, could show an issue with level of responsiveness.

JM explained at the Learning from Deaths and End of Life meeting it was discussed the issue of being slow to recognise a patient has deteriorated to the extent dying. Would be good to see recognising beginning of the dying process as Deteriorating Patient Group to support patients and families of life. SM explained the DNA CPR/Escalation group need to link.

70-22/23 Q1 Nutrition and Hydration Report

TF added strengthened governance surrounding nutrition/hydration over recent months. Improvement work is split out to Task and Finish Groups to education and training. Had approval around required learning for all patient facing staff for nutrition and hydration. Work undertaken regarding unsafe swallow. Outstanding actions with referral process, logged as a request. Last hydration audit showed significant improvement at Scarborough site, little on York Hospital site. Representatives from Corporate Improvement Team attending Nutrition and Hydration Steering Group. Trialling hydration stations. Still a gap between Care Group nutrition and hydration and Trust level improvement plan. First time in paper added key risks work around nutrition and hydration. Victoria Mulvana-Tuohy is leading a piece of work looking at establishment reviews for AHP's. Shortage of speech and language team means inequality in training. Tried to mitigate with training on learning hub. Trying to

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relaunch nutrition champion. Risk been to QPAS in previous paper, risk using MetaVision in ICU, different area to chronological notes. Put process in place.

71-22/23 Patient Experience Report Q2 2022/23 Report

TF introduced HG to the committee.

LB asked SM regarding serious incident sign off, all elements of plan complete or sign off that the risk has been resolved. SM confirmed multi-faceted. The Groups sign off final serious incident reports that content with the report. The action plans are then generated based on the recommendations. On a separate date the Care Groups will bring back actions to propose when actions will be closed, reasons why and evidence base. Group have the ability to challenge, then take the learning further, may like to see audit for actions before closing. Hopefully reduce risk and share learning.

72-22/23 Inpatient Survey update

HG spoke regarding the papers. Scores 2021 are comparable with results from 2020, not been previously. Patient experience and response rates have deteriorated Nationally. For the 2021 results Covid-19 should be taken into consideration. National response rate fallen to 39%. Nationally issues highlighted that fundamental care needs not being met including help to get washed, eat meals and getting help from staff when needed. Hospital discharge also a challenge and deteriorated Nationally since 2020. Key points as a Trust, not a National outlier, continued trend of improvement. Discharges are worst performing area for all. Individual scores are higher than Trust average, performance better in some areas than others. Disturbance at night has improved, particularly at Scarborough. Patient rated food about the same, food at Scarborough better than at York Hospital, patients understanding what to do what not to do is about the same at York and Scarborough. Bottom 5 scores were around care and treatment, hospital and ward, leaving hospital and nurses. Bottom 5 scores mirrored themes through other data Friends and Family, PALS and complaints and concerns. No surprises, knew what action taking to meet those.

JM highlighted frustration, keep seeing the same things over and over again. If know things are issues, what have been getting wrong, not doing but pleased see improvement regarding noise at night disturbance. What needs to happen? Queried are assurance plans robust and realistic enough to deliver.

HG spoke regarding key things around nutrition and hydration. Care Group 1 have requested 135 new volunteers to free up staff in order to meet CQC requirements. Recruitment ongoing, have recruited 70 volunteers so far who are being deployed onto wards. Care Group 2 hydration/nutrition implemented for 1 week, started in October. Introduced mocktails, juicing/smoothies. Ensuring hydration needs being met. Staff shortages key to a number of frustrations. Patients noticing not enough staff, not enough nurses.

LB commented on the majority of complaints relating to medical care rather than nursing care. Very nursing led. LB asked how are the themes secondary to Medical Practitioner input shared with Medical Teams?

TF advised first time pulled out Medical Teams and themes. Paper not yet seen by QPAS, will be a challenge for Care Group Directors in terms of highest number of cases this quarter relating to main themes around 4 out of top 6 areas specifically Medical Teams . Paper has been through Patient Experience Group, representatives attend, comment made do not have any members of Medical staff at the Patient Experience Group. Would be keen to see. Try to ensure the themes are shared within local quality committees at Care Group level.

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SH shared some frustration, no doubt what needs to be done, but progress is very slow. The committee are keen to help, plan to have the Care Group Directors attend in rotation and provide assurance regarding their work on the topics would be helpful.

73-22/23 Risk Management Update – Corporate Risk Register

MT introduced the risk management paper, the cut of risks under responsibility of this Committee. Encouraging to see some papers being discussed as routine are on the Corporate Risk Register e.g. deteriorating patient. Work continues with Interim Risk Manager, JB to help and support the Care Groups to report and escalate risks.

SH confirmed happy with paper, agenda aligns with the risks.

74-22/23 Issues to escalate to the Board and/or other Committees

No escalations

75-22/23 Issues to escalate for BAF and CRR consideration

No escalations.

76-22/23 Any other business

SH thanked Jim for everything he has done.

77-22/23 Date and Time of next meeting

The next meeting will be held on 13 December 2022 2.00pm-4.00pm

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Item 3

Minutes

Quality and Safety Assurance Committee
13 December 2022

Members in Attendance: Stephen Holmberg (SH) (Chair), Jenny McAleese (JM), Karen Stone (KS), Heather McNair (HM), Caroline Johnson (CJ), Mike Taylor (MT), Lorraine Boyd (LB)

Attendees: Sue Glendenning (SG) (item 85-22/23 only), Benjamin Adekanmi (BA) (item 85-22/23 only), Michaelene Holder-March (MH-M) (item 85-22/23 only), Sue Peckitt (SP), Ruth Render (minute taker)

SH welcomed attendees and particularly Karen Stone (KS) as a new member of the Committee.

78-22/23 Apologies for Absence

Helen Ketcher (HK) unwell, not in attendance. HM asked for agenda item 83-22/23 to be moved with January meeting.

79-22/23 Declaration of Interests

None

80-22/23 Minutes of the meeting held on 22 November 2022

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

81-22/23 Matters arising from the minutes and outstanding actions

CJ confirmed Assurance Report forwarded following last meeting and action complete. NHSEI will be hosting meetings in January to review clinical governance

Action 61: SH asked regarding the intention to receive escalation reports as a matter of routine. CJ suggested requires discussion, flagged deep dive into Care Groups each month. Asked if an escalation report still required. Escalation reports at present go through QPAS but vary in quality, is a need to improve consistency.

KS added that work can be done to streamline flow of information up and down and the two days in January will be important as will give CJ focussed time to support the work. Starting to form a view on clinical governance and the pathways and where to add value.

Following review KS and CJ to review Terms of Reference for all reports into QPAS to follow through, then be able to give the Quality and Safety Assurance Committee better reports and assurance and ability to question.

SH asked KS for first impressions regarding work to be done and queried better placed to defer to February.

Action 75: SH clarified this action is complete. Confirmed to close action 75.

Actions 93 and 94: SH queried actions 93 and 94 falls and pressure ulcers. HM confirmed going through QPAS tomorrow. Will be forwarded to January meeting.

Action 98: SH confirmed 98 deferred to January.

Action 99: MT confirmed action 99 is on the agenda today.

Action 100: SH commented that action 100 is complete.

82-22/23 Escalated Items

SH had a request from the Digital, Performance & Finance Committee to ask if the Quality and Safety Assurance Committee have some oversight regarding the risks and mitigations of the Medisite introduction. SH had a call with Luke Stockdale (LS). SH does not think he is the appropriate person but asked who might be and if an appropriate ask.

KS confirmed not appropriate for this committee. Need a QIA and EIA.

HM confirmed Care Group 6. Care Group to move forward with proposal and QIA and EIA required regarding changes and impact.

83-22/23 Annual Patient Equality Diversity and Inclusion Report

Action: forwarded to January meeting.

84-22/23 Nurse Staffing Report

HM highlighted page 40 regarding nurse registered vacancies. No commentary as to why double the number of leavers this month. The report is also deficient in lacking exit leaver interview data, temporary staffing and sickness and absence also October's data. Workforce development escalation section (44) documents the red flag system and mitigation but not HM will discuss with EG regarding more focus within the report.

JM flagged that the position looks to be deteriorating rather than improving.

HM agreed and confirmed more leavers and not as many starters as anticipated. Report needs to be restructured to provide more assurance content

JM asked if everything was being done to get new starters on board

HM stated probably not and flagged page 45 re PSOs, PM's team struggle with capacity. There are also clinical issues to consider.

JM queried increasing capacity to reduce costs in the longer term. JM asked regarding volunteers and maximising the number and the way in which the volunteers are used in the Trust.

HM confirmed not captured in the paper. Could possibly invite Lauren Rainer (LR), many more volunteers than can be placed. Wards state too busy to provide support. Mismatch between perception of needing and reality of placing.

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LB commented on the table regarding the registered vacancies not being easy to understand the trends due to set up. A lot of the data relates more to People and Culture.

HM asked if preferred to just have the quality impact documented in the report.

SH found the paper to be featureless. Need to be careful regarding boundaries so not discussing the same items at meetings.

HM confirmed certain data mandatory but can go from Workforce committee.

LB discussed red flags and asked regarding closed items and also regarding assurance for closed items.HM confirmed can only close items if adequate mitigation is in place.

SH asked for a re-vamp of the report to focus on assurance around safety and quality of care in relation to staffing.

SH asked if helpful can escalate to Workforce regarding the concern at the number of leavers.

Action – SH to escalate number of leavers to Workforce Group.

85-22/23 Ockenden Update Report

SG apologised for 2 slight errors. This month's paper taken as read. Asked regarding questions.

SH asked regarding PCQS and asked SG for the top three messages.

SG highlighted the CQC inspection and imposition of regulatory action Care Group is preparing a Maternity Incentive Scheme paper to be distributed via virtual board. Requires HM approval. Will be declaring non-compliance, 4 of the 10 safety actions are compliant, 3 not compliant and 3 partially compliant. Saving babies' lives has been huge piece of work. Hopeful by January/February to be compliant with all scanning. Part of the saving babies' lives surrounds the administration of magnesium sulphate that has not always been compliant. Quality Improvement Lead working with Consultants. SG talked through Ockenden, not really managed to progress mainly due to resource issues. LMS advised would work with them alongside East Kent report. Sarah Ayre (SA), Associate Director of Midwifery is leading on antenatal assessments. There is a need to make the report easier to understand, CQC highlighted as a concern. Nic English (NE) workforce lead is helping.

SH asked SG and BA how people are in the service and asked if a clear desire for improvement and an understanding of the ask to achieve?

BA confirmed he feels following discussions with staff that people want improvements. A barrier can be that they do not know the full ask but there is a balance regarding confidentiality and risk of interpretation when keeping staff up to date. Having regular briefings with staff.

SH queried regarding difficulty in achieving effective handover and different staff groups not being on the same page regarding their contribution.

BA confirmed gradually improved particularly since Ockenden. Put process in place for a handover with Consultant and also to include a ward round. New Consultants have started

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and given feedback regarding processes in other Trusts. Have written a SOP regarding the expectation of medical staff, to clarify minimum expectation. Want to ensure consistency.

KS added a need for consistency of cover and actions. What BA is aiming to do is correct. KS disappointed not already in place when joined the Trust.

SH suggested that the first part of assurance is that the ask is very clear and not optional.

MH-M remarked issues relate to all, not just Midwifery or Obstetricians but to include Paediatrics and Anaesthetists. New management SOP specifically for maternity and risk assessment for PPH has been reviewed. Aiming to show a trajectory of improvement that is ongoing. As well as walk throughs, have reviewed case notes, involving the Obstetricians, Registrars, SHO's and Midwives looking at the referenced CQC cases. CQC have made errors regarding referencing. There are gaps, identification regarding reporting and risk rating, will be a change from January looking at risk registers, how to escalate risk and using Datix to a maximum. 2 closed off, management whereby Anaesthetists been involved in how to transfer from ICU, next to close off is regarding triage process but financial implications. Have closed off regarding fire safety and Darren Miller (DM) has been fantastic, doors have been changed with regards to security and amber. Mitigating serious risk is still amber, scrub nurse has been updated today with Caroline Alexander (CA) and have a team looking into this. Red areas include governance and oversight, post-partum haemorrhage

SH confirmed optimistic and realistic. Found maternity situation to be a rollercoaster. Recurrent themes. Discussed PPH for over three years.

MH-M part of APS for patient safety that write clinical guidelines for PPH. Lots of organisations are trying to find the answer for PPH, problems so called triggers are difficult to pinpoint woman to woman. Moved from the number to the patient information aspect. Oversight of the number of PPH is required, are the patients being seen by a Consultant and moved from midwifery led to Consultant led?

SH added if PPH/APH happens need to be confident with the process which manages it and that it is adhered too.

LB asked regarding the TPR which is showing a rise in moderate incidents. Are they entirely accounted for by reclassification of PPH's or is there something else happening that need alerting to?

MH-M confirmed doing a deep dive at present. Have been policies and risk assessments.

CJ commented that the CQC picked up underreporting. The CQC also felt that the rating of incidents was not correct.

MH-M confirmed some of PPH classified as moderate incidents may need to be classed as an SI. Looking through the cases to determine whether any should.

LB asked regarding assurance around under reporting and if just associated with PPH or other areas to be concerned under reporting missing opportunities.

MH-M confirmed going to look into reporting in other areas and will be in the Improvement Plan. Focus on section 31.

LB asked for further assurance than just what is listed on Section 31.

KS added that PPH's are challenging regarding knowing if it is, has it been measured as accurately as possible and have the processes been followed. This needs to be right to produce the correct data.

CJ stated that PPH data is captured via CPD, department did oversee the PPH's, through CPD data. There were not added to Datix for under 1500mls. It was hidden to Popel working outside of the department. This has now been addressed and all PPH over 500mls are now reported via Datix.

HM added Care Group were out with the National guidance.

CJ confirmed MH-M has carried out a full review of still births, which should be completed today.

LB also queried regarding the TPR red rating 4 months for pre-term births - should this be a worry.

MH-M highlighted the Obstetricians are going to look at that element in January. Patient information leaflets are currently being updated to give guidance and using national benchmark. All policies that have been updated have a section regarding having a conversation with the women regarding care being offered. Learning and sharing also included.

86-22/23 Serious Incident Report (Including Maternity SI reports)

CJ discussed the monthly report showing headlines declared this month and what is closed that have been sent to the ICB. Newly declared include 2 still births and had a never event last month, misplaced NG tube. Full investigation. MH-M doing a still birth review. To do patient safety instant review as well as referral through to HSIB. Need to have actions in place to prevent further still births. Will come back through the Quality and Safety Assurance Committee.

CJ spoke regarding identifying still births and wanting to make sure not waiting for HSIB which could take 6 months, being proactive to do a full review. National focus on still births.

HM commented that anything of immediate of concern HSIB will report straight back, report to follow. No red alert immediately as yet.

KS added that HSIB track back so is a helpful external review.

SH asked KS thoughts regarding the way in which SIs are being looked at and are the themes being triangulated.

KS unable to answer fully as yet. Confirmed a process when an incident raised for it to be looked at and declare if an SI. The investigation starts. Not been in the Trust long enough to see to be sure that when action plan for SI that it is appropriate, SMART and delivered and embedded. No point having an action plan unless it is going to deliver what it needs to. May need a year or two to see it followed through.

LB queried if usual practice to decide if something an SI on the basis of the degree of harm, running the risk of missing out on the near misses and the learning.

CJ confirmed every single incident is reviewed on Datix and incidents of concern pulled out. Can sometimes disagree with the categorisation of harm. Review on the basis of the incident itself. If not reported on Datix would not necessarily know about it. People are

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getting better at reporting on Datix as seeing the consequences. Still not where want to be in regard to reporting.

KS highlighted the busier and more challenging the organisation the less the lower no harms get reported.

HM added that things can be picked up through complaints that have not been logged elsewhere.

CJ could bring some assuring data. When first looked at the data was seeing lots of claims and inquests that had not had an SI or any form of patient safety incident report. Now seeing very few. 100% deaths being reviewed by ME.

JM agreed with KS regarding closing the loop of learning. An area where there is work still to do. KS will look into this further.

87-22/23 CQC Compliance Update Report

CJ asked if any questions related to the report. Regarding governance delivery, there are fortnightly meetings, not just looking at action plan delivery but assurance of delivery. Having themed reports. All Care Groups have to bring assurance reports.

HM part of a monthly Quality Improvement Group chaired by Margaret Kitching (MK) with representation from ICB and Social Care Services. Trust required to provide assurance to the group. Not just focussed on Maternity but also Medicine and ED.

SH hoping to avoid an inadequate rating from the CQC.

CJ commented when the CQC returned to ED they were sufficiently assured improvements had been made. In Medicine picked up significant improvements made from March inspection. Maternity is principal concern.

88-22/23 Q2 Infection, Prevention and Control Update Report

SP taken report as read. Key highlights from November IPC report. C. diff rates are exceeding the trajectory at end of November and unlikely to meet annual objective, 14 cases in November against trajectory of 10 and already 7 cases in December.

SH advised had DM attended Board and pointed out that even if trajectory was achieved this would still represent approximately twice the incidents of comparable Trusts.

SP confirmed National outlier and under scrutiny from NHS England. MRSA perspective Methicillin-resistant Staphylococcus Aureus is zero tolerance. No cases in November, 1 case in December. Respiratory virus perspective Trust now under significant pressure regarding number of cases of influenza. Both sites have enacted influenza plan. Have number of diarrhoea and vomiting patients particularly at Scarborough. Pressured from IPC perspective.

HM added page 138 Medical Elective Suite move to the stadium, has been delayed until March. Risk regarding environment. Also mentioned flu and flu action plan enacted with designated flu areas. Biggest risk is patients in the corridor of ED. National Cleaning Standards still not been delivered through LLP.

SH asked SP regarding thoughts on MSSA and rates.

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SP confirmed not a National target, it is internal. Higher than would want it to be, not measured against it. Work being undertaken around cannula management and aseptic non touch techniques.

SP added in conversation with a company to come in to provide training re IV canula devices in the New Year. Need to upskill staff in clinical areas. Some of the documentation around management of sites is not as good as it should be but the electronic system should help.

SH asked regarding C. diff and challenges of the built environment

SP commented multi factorial. Environment does not help and one element. Doing some work around cleanliness of mattresses. Work around antimicrobial prescribing. Re cluster on Cherry ward identified antimicrobial prescribing was outside of guidance and is being investigated

SH asked KS around how Clinicians see the importance of IPC.

KS confirmed clinicians need to be involved in post infection reviews to understand the importance. Flagged the importance of hand washing, looking after cannulas and devices properly and the right time to sample C. diff to try and improve rates. Antimicrobial stewardship is key.

89-22/23 Quality and Safety Assurance Metrics (TPR)

SH highlighted lack of target on metrics.

MT discussed with Nicky and Team around streamlining report.

LB flagged pressure ulcers still rising which is disappointing.

HM highlighted data not showing which wards where pressure ulcers were a particular problem and whether this correlated with the wards with high levels of staffing vacancies. Report needs level of detail.

SH asked regarding aspirational targets. HM confirmed had no input into report. A lot of work to be done before can take any assurance.

SH commented regarding last page figures almost meaningless. Worried about what the report does not show.MT will feedback to Team to make alterations.

SH thought Executive Leads for areas of old IBR were going to move through data points and take expert decision regarding which to retain, change and remove. Not happened and is a real worry.

KS confirmed need to have the right data, what is required at this Committee and what is taken into QPAS.

SH asked CJ regarding highlighting major issue that the flow of assurance from ward to Board is not there and worry regarding missing data.

KS commented if the right data below high points is given to the Committee below QPAS will confirm that there are no issues behind the data or there are.

KS flagged regarding clinical governance review and the need for the right data going to the right Committee in the right order with the right degree of challenge.

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Action: MT to feedback to Team regarding alterations to report.

90-22/23 Q2 Mortality Report

CJ confirmed DR wrote the report. Themes coming through from learning from deaths, consistent with previous reports indicate more to do regarding action plans and integrating these with patient safety incident data, complaints and learning from deaths and claims. HM quoted large proportion of referrals going to Scarborough regarding the medical examiner reviews.

CJ commented regarding medical examiner officer practice across two sites have a difference in the way one medical examiner works in comparison to the other medical examiner. HM reported higher proportion of referrals from Scarborough.

KS advised if get same learning from SJCR's why doing them, should do 20% or 30% at random as know what the learning is and embed the learning rather than more reviews.

SH queried too much work done on processing not on learning.

KS proposed more thematic reviews. Need best use of clinical time not repeated reviews.

CJ commented regarding patient safety incident review often more detailed than SJCR. Not seeing major issues through data. DR advised bronchitis review should be undertaken.

91-22/23 Q2 Mental Health Report

CJ still stated that the Mental Health Act activity appears particularly low and the Mental Health Steering Group data also have suspicions it is inaccurate. When a section is applied the paperwork should be sent to Bed Managers and then forwarded to Tees Esk & Wear Valley for scrutiny. There is a suspicion that the paperwork may be remaining on wards so never being set for scrutiny, hence skewing data Several actions taken, look back audit of data, changes to Datix. Suspect patient placed on section and stayed on medical notes not being forwarded. New policy complete. Training lined up for Junior Doctors and will be recorded. Progress incremental as there is no dedicated MH lead. CJ leading the work in addition to usual portfolio.

SH asked HM regarding early data regarding mental health assessment being influenced by Nucleus. CJ confirmed mental health assessment being agreed currently for building into Nucleus.

HM added risk assessments for ED live trial last week and whole of CPD brought down. Will be a further trial this week (Friday) if does not work will be abandoned until after Christmas. Will have data once it goes live. Took Business Case to Executive Committee for a Mental Health Lead, principal supported but no money to support.

CJ confirmed working on 1:1 support for patients with mental health difficulties and aggression and violence. Discussion at QPAS looking at developing specific resource.

92-22/23 Risk Management Report

MT spoke regarding the Corporate Risk Register. A lot more to follow now have Interim Risk Manager in post who is working with Care Groups and provided a lot of training for the governance facilitators. All the risks in the Care Groups have been reviewed ahead of Risk Committee next week. Will then start to look at the reports, more dashboard focussed.

DRAFT

HM and KS to meet with JB, Interim Risk Manager.

93-22/23 Issues to escalate to the Board and/or other Committees

HM confirmed Maternity Incentive Scheme has to go through ICB Board in January.

94-22/23 Issues to escalate for BAF and CRR consideration

No items escalated.

95-22/23 Any other business

KS still working through papers and flow of information.

96-22/23 Date and Time of next meeting

The next meeting will be held on 17 January 2023 2.00pm-4.00pm

DRAFT

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 16

Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	Acute Flow: current pressures and learning
Director Sponsor:	Melanie Liley, Interim COO
Author:	Gemma Ellison

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
	☐ Sustainability

Summary of Report and Key Points to highlight:
The acute pathways in our hospitals have been under ongoing exceptional pressure prior to/following Christmas and at the start of the new year.

As a response to the situation on 3rd January 2023 enhanced OPEL measures were implemented following a decision by Gold Command.

The full lessons learned exercise will inform any sustained the improvements gained from these actions and learning to inform the care groups and trust UEC Transformation Programme.

Recommendation:
It is recommended that the detailed learning exercise is completed alongside the scheduled winter plan review and this is used to inform ongoing improvement work on transforming Urgent and Emergency Care.

Resource is required to progress a number of the measures and this will be need to be addressed as part of the review.

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

Acute Flow; current pressures and learning

1. Introduction and Background

The acute pathways in our hospitals have been under continued exceptional pressure following Christmas and at the start of the new year.

Attendances to the Emergency Departments across the organisation in December continued at the same level, however, the number of patients that do not meet the criteria to reside has increased significantly. This recent period specifically saw an increase proportionally in admitted patients from the Emergency Departments and acuity of those patients attending. Flu attendances also saw a rapid increase requiring the Trust flu plan to be enacted and a ward at York being full within a week. Alongside this the organisation also saw high numbers of covid patients attending and requiring admission. In addition to this there was the first Ambulance strike in the week running up to this period.

2. Planning

A challenging winter was anticipated for 2022/23 and plans were put in place in advance of the period. Winter funding this year was allocated at Place and supported a number of schemes (for example, CRT capacity) but meant that we did not implement schemes in the same way as previous years. Also, this year, in comparison to previous years a plan could not be made to cancel elective surgery due to our Tier 1 position and significant backlog. The IPC issues experienced as a result of the number of Covid and Flu patients has also had a significant impact

In York the winter system plans included additional ED consultants and junior staff, ward based juniors and some AHP support for acute areas. Alongside CIPHER were funded to provide staffing for ED cohorting. The main investment was in the York Care Unit, 19 beds of residential care with GP support through Nimbuscare. The Emergency Assessment Unit (EAU) was also implemented over 24 hours and 7 days a week. This was not specifically a winter scheme, however, it formed part of the overall resilience plan. In addition, for Community Services in York the expanded Urgent Community Response (UCR) service was implemented as well as additional Community Response Team resource and the first 5 beds opened on the Virtual frailty ward.

In Scarborough a key scheme of the system winter plan was the CIPHER additional resource to assist with Discharges and Ambulance Cohorting. The team have also put in place new weekend Consultant rota that provides (a) GIM on call (post take in ED), (b) Acute Physician (to cover LILAC (flu & short stay) and SDEC); (c) Cardiologist for CCU and ED in reach. The conversion of LILAC as the FLU Ward was also planned to allow the Flu patients to be cared for by a single team and the AMU ward team who are used to a short stay approach and shifted the AMU post take function to the front door. Financial delays have led to the SDEC expansion in Scarborough not progressing until March.

3. Response

Despite the existing plans, The Trust experienced a challenging operational position across the two Bank Holidays and as a response to the situation on 3rd January 2023 enhanced OPEL measures were implemented following a decision by Gold Command.

Numerous actions were put in place, and a detailed learning exercise is being undertaken to review all of these.

On initial analysis it has been identified that the following measures had a significant impact on improving the situation.

- Additional capacity: 7 beds on Haldane, in Scarborough and 12 beds on Ward 25 in York. It is important to acknowledge here the plan to open ward 25 was due to the potential to have capacity of 25 beds in total. However due to the limited availability of workforce capacity had to be limited to 12 beds.
- Cancellation of SPA and training activity, to create additional clinical capacity to focus on senior decision making for acute admissions and discharge.
- Removal of requirement for medically fit patients with no right to reside to be routinely reviewed, this created capacity to provide specialty input into ED.
- Provision of additional AHPs shifts at the weekend. The AHP support into different areas was identified as a key support from ward MDT's to speeding up discharges.
- Improved porter provision and Transfer team resource made a huge difference to flow and would be beneficial to continue.
- Cancellation of routine elective surgery.
- IPC mitigations in relation to isolation of patients.
- Additional on-site operational management capacity out of hours to support clinical teams and enhance decision making.

Benefits:
As a result of providing additional capacity a number of benefits were achieved:
- The flu ward and outliers received more timely senior reviews.
- Discharges (especially for pathway zero patients)
- Increased specialty in reach to the Emergency Department.

Challenges:
- Impact of the cancellation of elective activity
- The workforce capacity to implement all of the measures was limited and although some could be achieved by cancelling other activity, ward staff could not be identified to implement the planned number of beds.

4. Sustaining improvements

There are a number of measures that had a positive impact and should be considered to become business as usual and not reserved for extreme situations. The care group teams are working on the following measures as there are some issues to address to be able to fully implement them consistently:

a) The flu mitigations and IPC quality impact assessment work on isolations and mixing strains / contacts could become part of the usual flu escalation process, this needs to be assessed for risk and could be approved as an organisation approach.

b) In York action was taken to not use the TAF referral form for CRT referrals and this made a great difference from feedback across therapy teams with no reported adverse impact. A review is now being led by the Deputy Chief AHP with partners to further improve the process.

c) The York team will continue their work on strengthening the discharge work and embedding a weekly pathway zero long length of stay review process (in addition to the current pathway 1-3 process).

d) In Scarborough the specialty in reach to ED plans are being progressed, however, revised job plans will be required to make this sustainable.

e) The impact on the elective recovery programme will also be considered as part of the review going forward as continued cancellation of planned surgery cannot be sustained.

f) The organisation's Urgent and Emergency Care Transformation Programme is being strengthened and refocused in order to deliver against acute flow priorities including the Urgent Care Review, Children's and Young People's integrated care, SDEC, internal discharge framework including 7 day standards and post hospital care.

g) Further work is required with strong clinical leadership, to progress learning from this period for the workstreams leading internal discharge standards and 7 day standards.
Specifically:
    - Discharge of patients with a NEWS score of 2 and below,
    - Function of board rounds
    - Setting of discharge standards
    - Review of long stay patients
    - Preparing for the weekend
    - Removal of the requirement for medically fit patients with no right to reside to be routinely reviewed.

These measures all have a beneficial impact on flow and further emphasise the need for internal professional standards on how we manage patients across the acute pathway to ensure they are applied consistently across the organisation and routinely.

h) Closer partnership working took place especially with local authority colleagues and Place teams and all parties are committed to continue to with this. The UEC Programme is also progressing work in relation to integrated intermediate care and discharge models with our partners to formalise these improving processes.

A number of measures which require additional resource will be reviewed in detail as part of the lessons learned exercise to fully understand the benefits and the investment required to sustain the impact.

5. Summary

The recent weeks have seen significant operational pressure on our organisation. This is due to a number of factors including, the rapid increase in Flu cases and the number of patients who do not meet the criteria to reside.

Enhanced OPEL 4 measures were implemented with immediate impact to reduce the pressure across the organisation.

A number of the measures are now being reviewed to sustain the benefits, however, some measures especially those in relation to additional capacity are not sustainable.

6. Next Steps

A detailed lessons learned exercise is being undertaken which will be complete in February. This exercise will be used to inform the consideration of developing an enhanced OPEL level 4 position with associated actions that can be initiated by Gold Command in times of extreme operational pressure. It will also inform the potential for some of the measures used to become business as usual. All learning will be reviewed to ensure benefits are achieved across all sites.

The winter plan will also be formally reviewed with the usual process and learning will inform the following years plan.

Date: 12 01 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 17

Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	Chief Operating Officer's Report
Director Sponsor:	Melanie Liley, Chief Operating Officer
Author:	Lynette Smith, Deputy Director of Planning and Performance Gemma Ellison, Programme Lead Urgent and Emergency Care

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 highlights

The Trust has continued to experience ongoing urgent care pressures with 38% of ambulance handovers taking more than 60 minutes, 23% of Type 1 patients spending more than 12 hours in ED and 1234 12 hour trolley waits in December. The Trust has a growing waiting list for planned care at 50,379 open clocks with 623 patients waiting over 78 weeks. The Trust had 370 patients waiting over 63 days on a Cancer Pathway in December.

Recommendation:

1. **That the Board note the report and associated actions**
2. **That the Board note the IST report and support objectives for the Trust.**

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 for 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 Trust has experienced significant pressures over the winter bank holiday period, with enhanced OPEL measures implemented in the first week of January. The Trust has seen an increase of COVID-19 cases in the bed base, as at 10th January there were 132 confirmed cases, 108 within acute hospitals. The number of influenza patients has also increased from 24 at the time of the last report with 58 patients now in the bed base. The enhanced OPEL measures including a step down of routine operating to reduce pressure on the bed base (ordinary electives) and day case (redeployment of nursing teams to open additional capacity). The operational teams are reviewing the effectiveness of the actions within the winter plan in light of the extreme pressures in preparation for the January Board. The winter plan is attached at Appendix A for reference.

Alongside these winter pressures, the Trust is working through the Emergency Preparedness, Resilience and Response (EPPR) framework for the potential industrial action. There will be an anticipated impact on electives for the Trust on the days of the proposed action.

3.1 Board Priorities: Acute Flow

The refreshed Urgent and Emergency Care Programme key aim is:

To deliver high quality, safe, urgent and emergency care, for our communities, with our partners, delivered in the right place, at the right time, appropriate to our patient's needs.

There are three primary drivers:

- Develop pre-hospital attendance avoidance
- Improve internal systems and processes
- Increase post hospital access to required care

These have informed the 7 key workstreams and an over-arching theme of health inequalities. The existing Care Group Transformation Programmes continue and also include relevant care group specific urgent and emergency care improvements.

3.1.1 Urgent Care: Review of the current service with the aim of co-producing a new integrated care model to be in place before October 2023, including single point of access for health care professionals and improved signposting to service users. Initial workshops have taken place and plans are being made for further discussion in January.

3.1.2 Children and Young people Integrated Care and Assessment: To work as a partnership to improve and integrate assessment and care for C &YP in York and

North Yorkshire. The partnership group is now well established and four streams of work are being progressed: Understanding behaviors and population, workforce, models of care, access and delivery. The initial focus is on understanding children and their family's behaviour around accessing healthcare and progress is being made with the population health team as well as with detailed work by our analyst team. In addition, a social prescriber has been appointed who will specifically work with families where a child has attended on multiple occasions to understand this. Alongside this models of care such as the CAT hub are being further developed and testing delivery options to inform the future model.

3.1.3 Virtual Ward: Strategic scoping to identify the infrastructure required and clinical priority for the expected 300 virtual beds to be in place by December 2023. An initial workshop is being scheduled for February to explore the opportunity available to this organisation and local clinical ambition.

3.1.4 SDEC: Maximise use of all SDEC areas in line with four pillars: SDEC direct, protect estate, Rapid diagnostics, capacity &demand. The December UEC Programme Board focussed on the four pillars as well as digital requirements for SDEC, following a baseline assessment of all areas and agreed a number of actions to take forward in 2023 to ensure that SDEC units are maximised to their full potential.

The Trust streamed 16.77 % of ED attendances direct to Same Day Emergency Care (SDEC) services in December, against a Trust target of 20% by March 23.

As planned Dr Matthew Cooke visited the York ED in December and has provided a comprehensive report which is now being reviewed to ensure the key themes are integrated within the programme. To summarise he identified the following key actions:

- Professional standards with other specialties and wards in terms of referrals and associated behaviours as well as improving communication with the site management office.
- Clear plans for maintaining patient flow out of the front door services (UCC, ED, SDEC) – to be done by considering earlier transfers to the discharge lounge or reducing the number of ward moves for patients.
- Capacity and demand analysis to ensure adequate and responsive staffing in all acute areas. As well as full hospital escalation to implemented when appropriate and boarding.
- Agreed clinical pathways including externally to improve non conveyance and GP referrals to ED.
- Clarity over the five year vision for front door urgent and emergency care and the milestones on the way.

3.1.5 Discharge: Develop and implement a pan-trust discharge framework. This document is being drafted and developed with the medical director and will be the focus of the January Programme Board. The framework will set standards for consistency across the organisation and build upon existing work in this area. It will provide a refreshed focus especially for patients on Pathway 0 (no additional support required on discharge). Across the Trust, 57.62% of all patients were discharged before 5pm in December, however, this remains below the Trust target of 70%, the earlier the patients are discharged, the quicker the bed can be used for a patient awaiting admission.

3.1.6 7 day standards: Work is progressing to ensure that plans are in place to achieve the four priority standards in relation to post take, diagnostics and review of patients. At the January programme board these actions will be confirmed, following detailed discussion in December.

3.1.7 Access to post hospital care: To scope provision of a domiciliary care service and associated options to improve access to post hospital care for our patients. A discussion paper has been completed and debated with the Executive Committee and Corporate Directors. The preferred options are to expand capacity in our existing care units as well as increasing capacity of community response teams to allow prompt discharge of patients needing care after hospital. These options were put forward for the additional social care funding as the Trust's priority. Funding has been confirmed for Bridlington Care Unit and some funding towards York CRT, however the funding is still under review for the other areas.

The Trust is continuing to work with partners in developing a wider system plan to include admission avoidance actions as well as supporting discharge actions, with a view to reduce the number of patients in the general and acute bed base who do not have a 'criteria to reside'. The system remains above trajectory, with a weekly meeting in place to review progress and expedite actions.

3.2 Board Priorities: Elective Backlogs

The Trust has received the final version of the Intensive Support Team report and support objectives agreed with the regional team. The report confirmed the areas the Trust had identified as concerns and notes the high risk to the delivery of the 78 week and cancer trajectories.

Through the Tier 1 regime, the Trust has been provided with management and analytical capacity through EY Consultancy funded by NHSE, with a dedicated member of staff to progress mutual aid and agreed support for analytics on diagnostic demand and capacity. This has commenced from 9th January. The Trust will also receive on site support from the Intensive Support Team from the end of January, with a view to 6 months of support. This will focus on strengthening governance and recovery planning for core specialities, refreshing the patient tracking processes, demand and capacity analysis and data reporting.

The Elective Recovery Board has commenced, with a review of recovery actions. The Executive Oversight of high risk specialities to progress actions at pace have commenced in January. The Trust Board will have a focussed session on elective recovery in February.

3.2.1 RTT 78-week position:

The Trust declared two 104 week waiters at the end of December, one patient was delayed due to testing positive for COVID-19 in November, and a further patient was cancelled on the day due to no High Dependency Unit availability post-surgery.

The Trust was ahead of the revised 78-week trajectory for December at 623 (target 670) and despite the winter pressures the Trust has remained below trajectory for the first week in January. However, the surgical specialities, particularly Upper GI,

Urology and Orthopaedics are off trajectory following the reduction in day case and ordinary elective operating implemented during the enhanced OPEL arrangements.

The Trust has signed up to the national Digital Mutual Aid System which launched in December to match demand to capacity across both NHS and Independent providers. The Trust is targeting mutual aid for the specialities most affected by the winter pressures.

Additional actions taken in December include writing to long wait patients on the waiting list as part of a wider validation process of the waiting list; refreshing the PTL arrangements for routine care to launch in mid-January; mobilising the revised Elective Recovery Board and securing the RTT training for operational and administrative staff. This will launch in January and is being taken to Executive Board to mandate the training for core staff groups.

The Trust continues to see an increasing waiting list and increased above 50,000 in December for the first time, with 50,379 open RTT pathways declared at the end of the month. This remains a significant risk to ongoing elective recovery. The number of 52-week breaches remains significantly off plan at 4447, although this does represent an improvement from November 2022. Addressing the time to first appointment delays is key priority for the refreshed elective recovery programme. The Trust has published indicative waiting times to first appointment for the first time since the pandemic with technical and Business Intelligence support. The Trust has a high volume of clinics running with over 6 months delay to time to first appointment. The Trust has agreed to implement partial booking to more effectively manage the long waits in outpatients, however this project is currently paused due to technical and administrative capacity. The IST has recommended this is an area for immediate review.

Theatre productivity was at 81% for December, with the GIRFT target of 85%. This was affected by the Christmas period and January's position is likely deteriorate due to the step down of electives to support the non-elective position.

The Cancer November figures were not finalised at the time of writing the report, however unvalidated figures continue to show challenges in the Faster Diagnosis standard (56.5%) and 62 day position (52.9%). The Trust remains off trajectory for the number of patients over 63 days at 370 patients at the end of December, against a trajectory of 256.

4. Operational Activity Plan

The Trust has delivered lower levels of activity in December than planned for ordinary electives. Activity levels have been affected by the reduced Service Level Agreement and bed pressures. The trust has not delivered the planned levels of 1st outpatient activity, however remains in line with 19-20 activity levels.

December Activity

December 2022	Planned	Actual	% Plan	% 19-20 outturn
Advice & Guidance	3531	2626	74%	120%
Outpatient 1st	16243	12145	75%	101%
Outpatient FU	27781	31054	112%	102%
Day Case	6178	6185	100%	107%
Ordinary Elective	621	497	80%	93%

Non-Elective	6808	5496	81%	88%

The national 2023/24 Planning Guidance and Priorities was published at the end December. Detailed technical guidance is anticipated to be published shortly. The plan sets out three headline ambitions for 2023/24:

- Improve ambulance response and A&E waiting times
- Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- Make it easier for people to access primary care services, particularly General Practice.

The operational planning guidance sets out the NHS objectives, which include a revised target of 76% for the Emergency Care Standard, elimination of waits over 65 weeks and 75% Faster Diagnosis Standard. The guidance can be found at: NHS England » 2023/24 priorities and operational planning guidance, a summary is attached at Appendix B.

The Trust has completed the confirm and challenge of the Care Group's operational plans, working collaboratively with workforce and finance colleagues. The first draft of the plan is expected in mid-January and will be brought to Board in February.

Date: 10th January 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item ??

Report to:	Board of Directors
Date of Meeting:	Wednesday 28th September 2022
Subject:	Winter Plan 2022-2023
Director Sponsor:	Melanie Liley - COO
Author:	Richard Chadwick – Emergency Planning Manager

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:

The NHS E Winter Plan is a series of specific actions that have been agreed with the ICB and there are 8 areas of action for Acute Trusts to consider. This year, in the absence of internal funding, a Winter Workshop has convened to review Care Group plans for winter pressures and mitigations, collating them into an overarching Trust Winter Plan. The Winter Plan for 2022-2023 is framed to provide assurance to the board against the 8 principles set out by NHS E. It should be noted that some of this work is already business as usual and not additional schemes just for winter.

The plan seeks to exploit opportunities for increasing additional capacity in our hospitals and wherever possible prevent avoidable admissions. Where admission is required the plan seeks to protect EDs by improving flow, reinforcing alternative treatment pathways and facilitating timely ambulance handovers through robust ED escalation plans.

The prevalence of Flu over this winter period is expected to be high and a separate Flu Plan has been written to clearly set out how patients with a suspected respiratory virus will be tested and then streamed to an appropriate treatment pathway and if required an

appropriate in patient location. This should be managed in conjunction with the ongoing management of COVID-19.

All the actions described in the Winter Plan need to be underpinned by a well-motivated, resilient and available workforce. The Trust response to COVID-19 has increased staff fatigue and workforce challenges have reduced the availability of staff to provide the fundamentals of care. Initiatives to improve retention and maximise recruitment will be key to patient care over the winter, as will the system response to support timely discharge for those patients who do not meet the criteria to reside. Timely and effective communication with our staff must be a priority as we move through Winter.

The Winter Plan has been developed with the expectation of high levels of operational pressure over the winter period. The Trust response to COVID-19 has resulted in a strong and well understood command and control system should escalation be required. The newly established Winter Tactical Group will control and coordinate the Winter Plan until operational pressures may require escalation to a full Trust response when SILVER Command will be formally activated.

This plan was endorsed by the Trust Executive Committee on 21st September 2022.

Recommendation:

The Board of Directors are invited to note the recommendations summarised at paragraph 13.

Winter Plan 2022-2023

1. Introduction and Background

The Winter Plan in previous years has comprised of several schemes and initiatives that are implemented to mitigate operational pressures from December to March. The continuing requirement to coordinate the Trust response to the COVID-19 Pandemic in addition to the enduring heightened operational pressures experienced throughout 2022 has necessitated a more holistic approach to winter resilience; this year is no different.

Clear direction from NHS E has been received for the preparation of winter plans in the form of a letter setting out focus areas that providers are to focus on during the winter period. The Winter Plan 2022-2023 has reviewed Care Group plans for this winter and aligned them to the NHS E focus areas. In addition, the plan will describe the command and control arrangements to implement the winter response, make recommendations and identify continuing work required to be fully prepared for the winter.

2. NHS E Direction

The eight areas of focus that NHS E have prescribed are summarised below:

- **Ambulance Handovers.** NHS E confirm the essential requirement to ensure there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital. They are working with Ambulance Trusts to improve ambulance availability and look to Acute Trusts to agree and implement good practice principles

for the rapid release of queuing ambulances and develop solutions to minimise ambulance handover delays including expanding post-ED capacity.

- **Prevent Avoidable Admissions.** A full range of urgent care services should be available to ensure patients can access the right care in the right place. Same Day Emergency Care, frailty and "hot" outpatient services should be available for patients requiring urgent specialist treatment but not necessarily via an ED.
- **Demand and Capacity.** The NHS are working with local areas to open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds nationally, through a mix of new physical beds, scaling up virtual wards, and improvements on discharge and flow. Areas relating to community care, primary care, mental health, cancer and elective care have also been identified for providers to concentrate on.
- **COVID-19 & Respiratory Challenges.** The Government Scientific Pandemic Influenza Group on Modelling scenarios for COVID-19, combined with scenarios for Flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during the winter. Integrated COVID-19 booster and flu vaccination programmes to minimise hospital admissions from both viruses will be delivered. Trusts will be required to implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of "void" beds.
- **Discharge.** NHS E acknowledge that challenges are often seen at the "front door" however the root cause is often in the ability to discharge patients from, and flow through, hospitals. Providers must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. NHS E will continue to work with social care to encourage a shift towards home models of rehab with less severe injuries or conditions and maximise support provided by Voluntary and Community Sector strategic partners.
- **Workforce.** NHS E acknowledge how hard the staff have worked through the COVID-19 response. The health and wellbeing of the workforce is crucial and interventions targeting recruiting and retention will be important in managing additional demand this winter.
- **Data and Performance.** Making the full use of data at a local, regional and national level will help inform operational decision making and improve the delivery of services.
- **Communications.** NHS E are implementing a winter communications strategy to support the public to minimise pressures on urgent and emergency services.

The full NHS E planning guidance can be accessed here: NHS England » Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

The Winter Plan for 2022-2023 is framed to provide assurance to the board against the 8 principles described above. It should be noted that some of this work is already business as usual and not additional schemes just for winter.

3. Risk and Mitigation Summary

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

Ser	Risk Title	Risk Description	Winter Resilience Plan Mitigation Measure
(a)	(b)	(c)	(d)
1	Ambulance Handovers	Long ambulance delays at ED reduce the ability of YAS to respond to the most urgent calls and transport patients to hospital.	• ED Escalation Plan – YTH • ED Escalation Plan – SGH
2	Prevent Avoidable Admissions	Lack of services designed to provide patients requiring urgent specialist treatment but not necessarily via an ED will increase presentations in the urgent and emergency patient pathway.	• SDEC • Acute Frailty Service • "Hot" Outpatient Services • Consultant Connect / ALERTIV • Out of Hospital Home Based Pathways • Virtual Wards
3	Demand and Capacity	Lack of capacity in access to social care, primary care, community health services and mental health services for urgent patients is insufficient and results in patients presenting to emergency and acute services in hospital.	• Opportunities for Additional Capacity • Children's Ambulatory Treatment • OPEL Framework
4	COVID-19 & Respiratory Challenges	High numbers of beds are required for respiratory patients during winter resulting in complex bed management challenges and a reduction in patient flow through the acute/emergency patient pathway.	• Flu Plan • COVID-19 & Flu Escalation Plans
5	Discharge	Significant number of patients spend longer in hospital than they need to occupying beds that otherwise would be used to maximise patient flow.	• Discharge Command Centres • Use of Private Providers
6	Workforce	Staff fatigue, lack of staff retention and an inability to recruit will reduce availability of staff and the ability to provide the fundamentals of care.	• Health & Wellbeing • Pastoral Support • Incentives
7	Data and Performance	The inability to identify trends in performance in a timely manner will prevent the agile and timely adaptation of plans to respond to any changes in service delivery.	• Elective Recovery Plan • Reports, Returns and SITREPs
8	Communications	The public are unaware of the pressure that the healthcare system is under and present to EDs with minor illness/injury that otherwise could be treated in an alternative pathway.	• Communications Plan

4. Command and Control

The Trust continues to experience significant levels of operational pressure. The continued impact of managing COVID-19, plus the recovery of services and relative return to usual activity levels has led to a challenging summer; especially in the context of constrained capacity due to COVID-19 related infection prevention and control (IPC) and workforce issues.

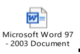
The decision to evolve the Living with COVID-19 Working Group (LWC WG) into a Winter Tactical Group (WTG) from September 2022 - March 2023 is due to the fact that we recognise that as we move into the winter months, we need to plan to manage capacity to respond to demand that may be fuelled by further waves of COVID-19 and/or severe outbreaks of respiratory and other illness.

As demand increases over winter so too will risk. The Trust will need to be agile in assessing risk and taking appropriate action, minimising pressure where possible and spreading workload across and between systems where appropriate.

The Winter Tactical Group will:

- Hold the ongoing actions referred to in the Winter Plan and ensure that they are implemented or concluded.

- Monitor weekly COVID-19/flu/workforce data to spot early trends and take remedial actions.
- Meet weekly to assess any changes to risks (out with the agreed Trust Winter Plan).
- Provide collaborative subject matter advice and decision making on tactical issues.
- Escalate to Executive Lead for Emergency Planning when there is a consensus view that a return to full command and control is warranted.

The draft terms of reference of the Winter Tactical Group can be found here: 

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5. Ambulance Handovers

5.1 ED Escalation Plan – YTH

The options for escalation within the ED footprint at YTH is limited due to the ongoing building work. The department now has an ambulance cohorting SOP in place and a dedicated space has been identified. YAS are planning to provide paramedic staff to cohort patients so that patients can be handed over and crews can be released in a timelier manner. In order to further enhance the escalation plan, it has been identified that consideration should be given to review the Boarding Protocol within the Full Hospital Capacity protocol to determine if the “Bristol Model” of boarding would have utility this winter.

Work is ongoing to increase capacity within the UTC primary care system.

5.2 ED Escalation Plan – SGH

The ED Escalation Plan for SGH is well established. An Ambulance Handover SOP is in place and Fracture Clinic and the Outpatient area (overnight & weekends only) are recognised cohorting areas. YAS have agreed to implement a secondment for a cohorting team to operate in SGH ED 7 days a week overnight; recruitment is underway to the scheme. First assessment has been re-established for ambulances and ED (Type 1) walk in attendances and ongoing streaming improvement (in collaboration with VOCARE) continues albeit at a very slow pace. Mitigation plans to backfill VOCARE services when they are unable to provide is in place but puts significantly more demands on the ED team to cover, particularly when VOCARE rescind at short notice. This backfill of workforce also adds in Type 1 activity which should be recorded as Type 3.

In order to further enhance the escalation plan, it has been identified that consideration should be given to review the Boarding Protocol within the Full Hospital Capacity protocol to determine if the “Bristol Model” of boarding would have utility this winter.

Recommendation 1: A Clinical Summit to discuss the implications of changing the Trust Full Hospital Capacity Protocol is convened for each site to allow Executive Teams to discuss the risks and benefits with CGDs/Lead Clinicians etc.

6. Prevent Avoidable Admissions

6.1 Same Day Emergency Care

The EAU at York is now open 24/7 and work is ongoing to increase overnight capacity from 10 to 15 patients. Direct YAS pathways are now operational and work continues to agree the protocol and SOP for re-direction of all GP telephone calls to speciality clinicians. The

SOP and protocol will include EAU accepting all relevant GP referred admissions. The outstanding risk to the EAU at York remains the provision of appropriate nursing and medical staffing overnight to maintain safe levels of care and prevent closure of the unit.
Recommendation 2: The provision of nursing and medical staff to the York EAU remains an outstanding risk to be monitored by the Winter Tactical Group.

The EAU in Scarborough operates 24/7. A business case was approved by the Executive Committee on 21st September 2022 to extend the EAU into the Respiratory Office. This work requires the Discharge Liaison Team to vacate the Discharge Command Centre allowing the Respiratory Team to occupy. Work services are required to convert the pre COVID-19 Discharge Lounge into a suitable office for the Discharge Liaison Team, to convert the vacated Discharge Command Centre into a suitable office and to convert the current respiratory office into a clinical area for Medical Frailty SDEC. The target date for completion has recently been delayed until February 2023. The current unit comprises of 15 chair spaces and 7 trolley spaces in the daytime and 10 bed spaces overnight; the extension will provide an additional 8 – 10 chairs 24/7. The YAS direct admission pathway to EAU is in place and a successful clinical pilot has been completed at Filey GP practice. Once the extended EAU works have been completed then the processes trailed in the pilot will be rolled out to the top 5 referring GP practices in the area. There remains a requirement for a Junior Dr to reinforce the EAU overnight to provide further resilience.

Recommendation 3: If additional winter funding becomes available over the winter period then the provision of a Junior Dr will be considered a priority.

The compliance with mixed sex accommodation in EAU does result in an inability to utilise all beds in busy periods for the hospital. The balance of risk of timely treatment versus patient dignity may need to be reviewed during periods of extreme operational pressure.

Recommendation 4: A review risk assessment of the relaxation of mixed sex accommodation guidance is conducted for EAUs in times of extreme pressure.

The use of the SAU capability at York has been a success in diverting patients away from ED. The unit's opening hours have been limited at peak times due to workforce pressure and resulted in its' closure. In addition, the use of direct admission pathways similar to the medical model may provide further opportunities to divert surgical patients away from ED. This work is being progressed as part of the Urgent and Emergency Care programme (Building Better Care).

6.2 Acute Frailty Service

RAFA capacity is currently available 24/7 in York with intensive input 12 hours per day. In Scarborough the dedicated RAFA capability is not yet in place (location and workforce) with Frailty services provided in EAU and ED. In ED the DALES unit provides 6 trolley / chair spaces (Monday – Friday at 12 hours per day) for Frailty services.

6.3 "Hot" Outpatient Services

Scarborough Hospital has a dedicated facility on HAZEL Ward which has been operational for several months. HAZEL Ward delivers 8 chair spaces (Monday – Friday at 10 hours per day) for Hot Outpatient Clinics.

York Hospital has no dedicated separate facility for “Hot” Outpatients services currently. Work is planned to address this. The plan in SDEC is to split the planned and unplanned work and this will be in place for this winter.

6.4 Consultant Connect / ALERTIV

The Clinician to Clinician project has been ongoing for the last 11 months through the national Talk Before You Walk programme. Scarborough will be trialling the system for SDEC and Frailty on behalf of the region. The idea is that NHS 111 direct patients who meet set criterion are admitted to EAU instead of ED. The application to communicate between NHS 111 and EAU is called ALERTIV and updated software to run the link is still awaited.

Recommendation 5: The Clinician to Clinician project, if the trial is successful, is implemented as soon as possible and does not await the ALERTIV software update.

6.5 Out of Hospital Home Based Pathways

Funding has been secured from the ICB Community allocation (£300K) to reinforce the York Community Rehabilitation Team over the winter period.

6.6 Virtual Wards

Work is in progress to deliver 12 virtual frailty beds in York by the end of March 2023. Work is also in progress between Scarborough and Humber FT to create 20 virtual beds with an aspiration for them to be operational by December 2022. Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. It will allow us to discharge patients more quickly and facilitate timelier patient flow. In a virtual ward, support can include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters. Support may also involve face-to-face care from multi-disciplinary teams based in the community.

7. Demand and Capacity

7.1 Opportunities for Additional Capacity

The ICB has approved funding of £1.7M for additional winter schemes at York and Scarborough Trust as follows:

- The continuation of the Bridlington Care Unit (BCU) with 15 beds as part of the social/acute model for patients who have no right to reside in hospital. Supported by primary care the beds are funded from August 2022 through until the end of March 2023. There is a surge capacity on the unit for an additional 3 beds within current staffing levels.
- The opening of the York Care Unit (YCU) operating similar to the BCU with 15 beds funded from October 2022 until the end of March 2023. Additional funding for 4 extra beds has been agreed as part of the Rapid Quality Review action plan to bring the total to 19 beds (see paragraph below for more details of the review).
- The York Hospital ESA has been funded to move to a 24/7 capability starting in 2022 and going through until the end of March 2023. This is the equivalent of 3 beds and will support additional capacity for both medical and acute surgical pathways.

The Winter Tactical Group will monitor the expenditure against the plan and adjust accordingly.

A Rapid Quality Review for the York site was initiated by the ICS and CQC in August 2022, following the unannounced inspection of medical wards in York hospital earlier in the year. A system plan has been developed to reduce York Hospital bed base by 30 beds. This reduction is needed to try and 'right size' the number of beds we have open on the acute site with the available nursing workforce, to ensure delivery of the fundamentals of care. The system has committed to mitigate the reduction of 30 beds on the York site by reducing the number of patients who do not meet the criteria to reside by 30 (from a peak of c.120 at York Hospital), by the end of September 2022. The second phase of the plan is a further reduction of 30 patients who do not meet the criteria to reside by the end of October 2022, this second phase of the system plan is to support flow throughout the York site and the decompression of ED.

7.2 Children's Ambulatory Treatment (CAT) Hub in York

Throughout the year, but particularly in winter, the single most important area of demand/ need for local systems to manage in relation to children and young people is admission avoidance and reducing the pressures on ED of low acuity attendances which would be better managed in out of hospital settings (primary care and community hubs). There are virtually no issues with delays in discharging with children (in contrast to adult delays in discharge).

The Trust continues to provide as robust ED, CAU and acute inpatient care as is possible with the available acute paediatric workforce and there is 24/7 access to expert advice and guidance via the Consultant of the week to support acute flow. During winter the twilight registrar capacity becomes invaluable to the ED and acute paediatric team in supporting medium to high acuity attendances after the school day, and these shifts will be filled wherever bank and agency cover is available.

In order to mitigate avoidable attendances and admissions this winter, the Trust and Nimbuscare as partners have confirmed the ability to re-establish the Children's Ambulatory Treatment (CAT) Hub to support a forecast Respiratory Syncytial Virus (RSV) and flu surge in autumn / winter 2022 which would mirror that experienced in the southern hemisphere as children return to school.

The CAT Hub will support the ED and paediatric acute teams in managing additional pressure on their workforce and services during the winter period from the 19th September to the 31st March 2023. The Hub can be developed to manage other conditions than RSV and flu in order to be able to alleviate the pressure on York ED from low acuity ED attendances which would be better managed in primary care.

The CAT Hub can be mobile for 5 days per week (Monday to Friday) using a mixture of substantive hours from core teams (2 days) and additional bank shifts (3 days). The funding for the 3 days of bank shifts for the Trust have been supported through Trust winter funding but the ICB have not supported funding being prioritised for the Nimbuscare costs of delivering the additional 3 days as the criteria for prioritisation at ICB is currently on supporting discharge delays in adults. Without ICB funding the CAT Hub can only mobilise 2 days per week. This shortfall is being escalated to the ICB through the Trust Executive Team with a request to reconsider funding support to enable 5-day CAT Hub provision.

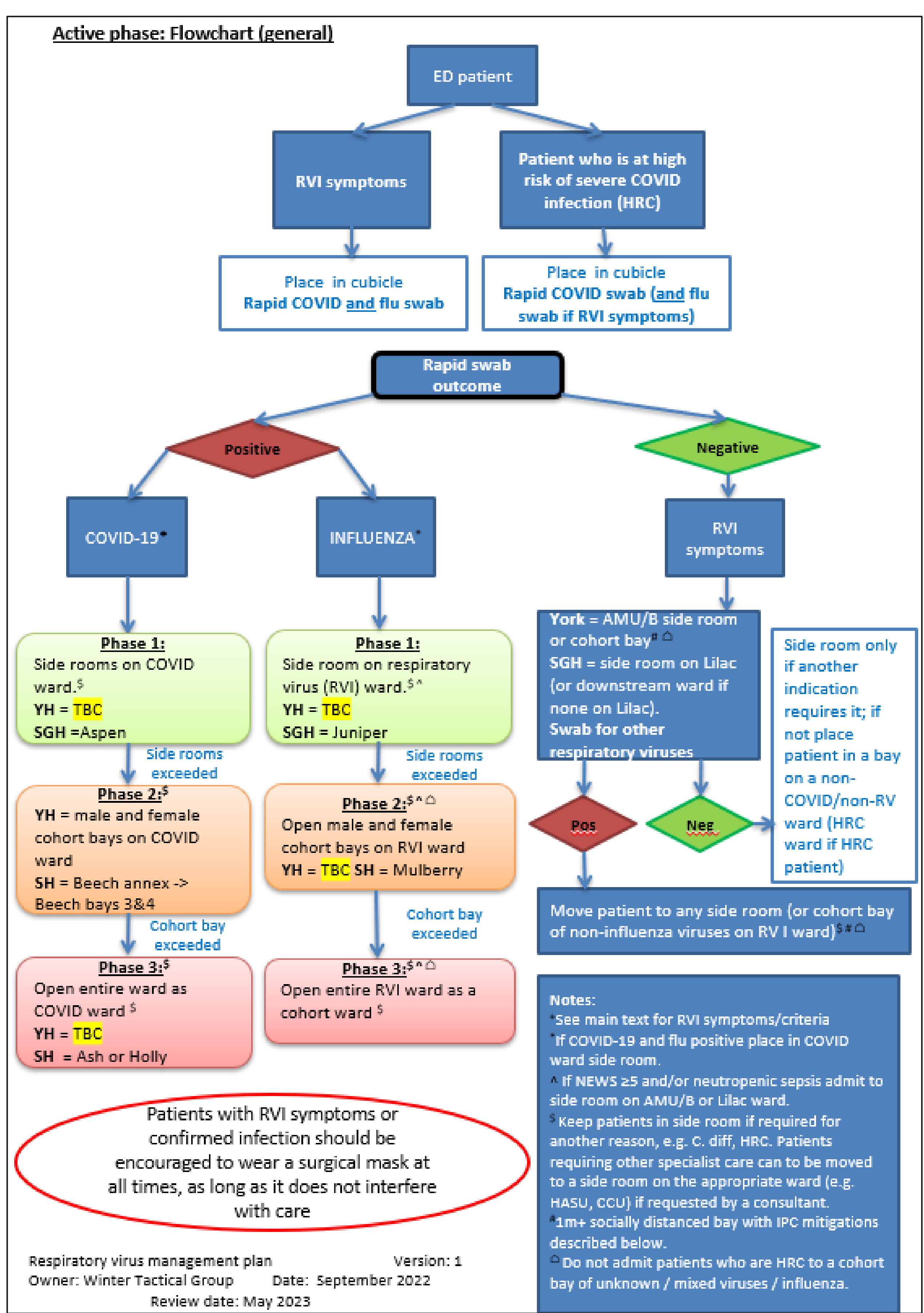
7.3 OPEL Framework

The OPEL Framework continues to be the process to manage the escalation in operational activity. The framework requires review to better articulate what the ask is of external healthcare partners and how to reinforce the out of hours response. Extra OPEL 4 actions are currently being trialled on OAK ward and if successful will be rolled out across the Scarborough site and shared with Care Group 1.

8. COVID-19 & Respiratory Challenges

8.1 Flu Plan

The Trust Flu Plan has been coordinated by the Infection Prevention Team in close collaboration with stakeholder care groups. The plan articulates the testing regime, in line with the Living with COVID-19 principles (symptomatic testing apart from those patients that meet the HRC criterion), the patient pathway and patient placement both for Flu and COVID-19 patients. In addition, the plan makes provision for support to clinical teams i.e. facilities, diagnostics and increase to testing timings in laboratories. The plan is written in 3 escalatory phases and will be coordinated by the Winter Tactical Group. Below is a diagrammatic depiction of the plan:



The plan also includes how GP admissions to York will be tested and placed in the bed base. The plan can be found here:

8.2 COVID-19 & Flu Escalation Plans

The Trust escalation plan remains extant for this winter, initial escalation will occur as per the Flu Plan (see para 8.1) and it is expected as the Trust moves towards Phase 3 of the Flu Plan then SILVER Command will be stood up to coordinate the further escalation beyond the Flu Plan.

9. Discharge

9.1 Discharge Command Centres

There is no requirement for additional Discharge Command Centre staffing as all posts identified in previous winter plans have now been brought into core as whole time equivalent posts. Trials are ongoing to determine the benefits of a late Discharge Liaison Officer (DLO) on each site and to rota two DLOs on a Saturday.

9.2 Use of Private Providers

Private providers to assist with discharge of patients and ambulance offloading is funded by the ICB. The agreed levels of support are:

- **YTH**
  - 2 x Discharge Crews 1000-2200 with TTO transportation.
  - 1 x HCA for Ambulance cohort / corridor care 24/7, 7/7 for the period January 2023 – February 2023.
- **SGH**
  - 1 x Discharge Crews 1000-2200 with TTO transportation.
  - 1 x HCA[1] for Ambulance cohort / corridor care 24/7, 7/7 for the period January 2023 – February 2023.

10. Workforce

Workforce supply has been challenging throughout the year and these challenges are expected to continue throughout the winter months. The labour market is highly competitive from an employer's perspective and candidate pools are significantly depleted. Ongoing volume recruitment campaigns continue, as well as International Recruitment plans, with registered and non-registered staff due to start in the coming three months, including 84 Pre-Registered Nurses, 21 Registered Nurses and in excess of 150 Health Care Support workers. Even with these new starters there will still be a number of vacancies across the organisation. As such, a real focus must be placed on retention of our existing and new staff to see us through the winter months:

- **Health & Wellbeing.** Sickness absence regularly rises across the winter months. As such we can expect to see increased sickness absence levels. To mitigate this the Trust will deliver a Flu and COVID-19 vaccination booster programme. The Moderna Spikevax bivariant booster will be delivered from 12th September 2022, with Flu vaccinations starting from 3rd October 2022.

[1] CIPHER, the private provider, have indicated that recruiting an HCA to operate out of SGH may not be possible.

- **Pastoral Support.** Pastoral support for both new starters and existing staff will be critical to aid retention. An increase in the number of Clinical Educators is being explored by the Chief Nurse Team with stakeholders. There will be other interventions to aid teams support their staff throughout the coming months assisted by workforce leads.
- **Incentives.** A review of incentives offered to Bank and substantive staff last winter has taken place. From this review a plan will be developed detailing what (and when) incentives will be used for Bank and substantive staff this winter. This will allow for a greater lead in time for pick-up of shifts and transparency to the workforce around any additional payments.

There is also a potential for industrial action and as a consequence an impact on the organisation's workforce supply across the winter period. At this stage the outcome of the ongoing ballots of Trade Union members is not known, however national, regional and local contingency planning has commenced.

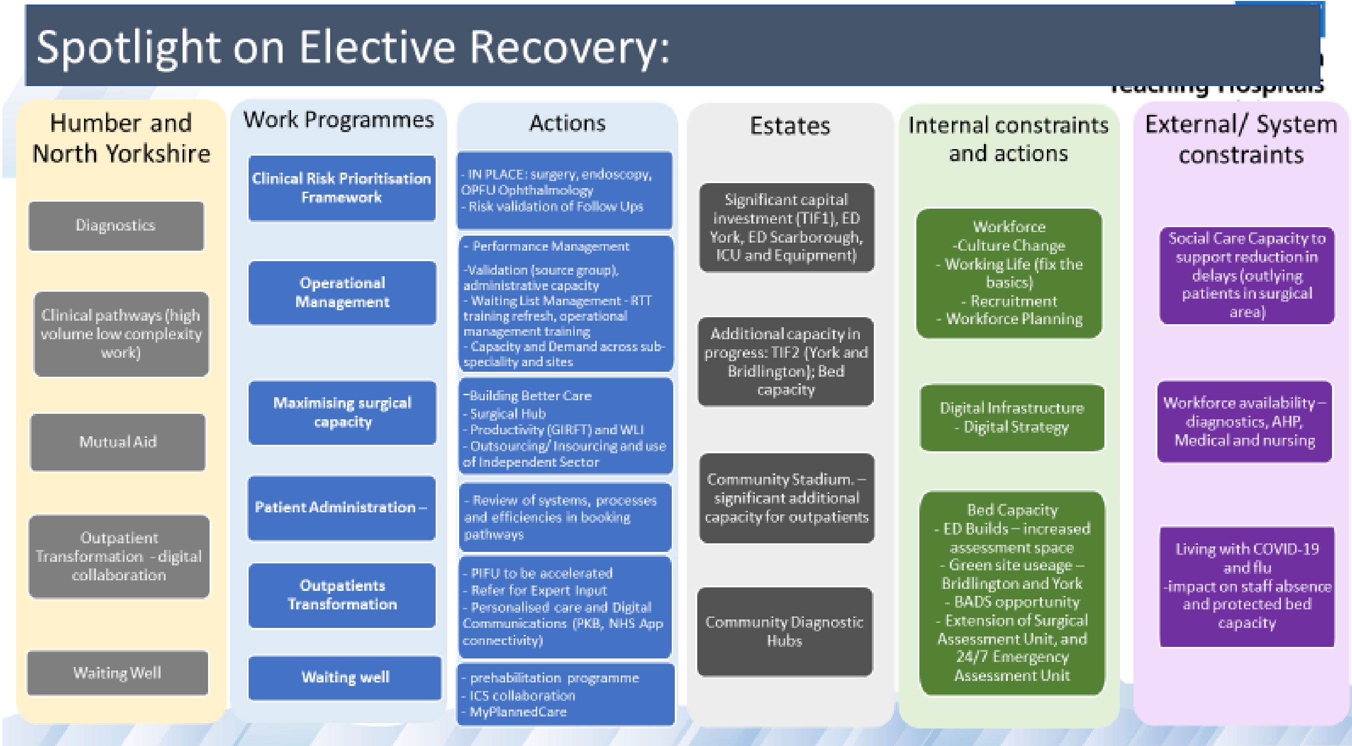
11. Data and Performance

11.1 Elective Recovery Plan

The Trust has an elective recovery plan, comprising the following:

- Improved productivity of internal capacity, this includes focussing on achieving BADS targets for elective and acute day cases, to reduce the pressure on surgical bed capacity and software to improve the utilisation of outpatient's rooms. In addition, the Trust has committed to additional capacity through insourcing over weekends to the end of March to ensure continuation of surgical capacity and is working with partner trusts on 'mutual aid' arrangements for the longest waiting specialities.
- Separating acute and elective to enable ongoing elective work despite the winter pressures. This includes the Elective Hub at Ramsay Clifton Park York (commenced in June) and use of Bridlington Hospital for routine electives. The Trust is expanding the range of the services provided through the Community Stadium in York to provide off-site capacity for the local population.
- Operational management, including weekly reviews of outpatients, long wait patients, cancer patients and diagnostic pathways to ensure visibility of pathways and rapid escalation and resolution of any barriers to delivery.

A diagram summarising the elective recovery programme is below:



11.2 Reports, Returns and SITREPs

The Information Team will continue to provide automated reports and returns in addition to SITREPs as per the NHS E mandated requirements. The SIGNAL dashboard will continue to be used to analyse data and identify trends to inform decision making. This review of data, both clinical and workforce absences, are standing agenda items on the Winter Tactical Group.

12. Communications

The communications team is pivotal in supporting the dissemination of information to staff, patients and the public. The approach to sharing the key messages regarding this year's Winter Plan will build on the approach from previous years and lessons learned.

Information will be cascaded across the Trust via the existing communications channels including the weekly all-staff bulletin and monthly Staff Brief. Where appropriate the trust's social media channels will also be used to share key messages for staff. This will include updates and changes to the plan, what's working well/successes, particular areas of focus/challenge and examples of where we have listened and acted upon staff feedback. This information will be coordinated through the Winter Tactical Group, who will work closely with the Communications Team to ensure information is disseminated appropriately and in a timely manner.

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

Internal communications will be supported through sharing information key operational meetings particularly to specific groups of staff who require more detailed operational information, ensuring relevant staff are briefed on the plans specific to their own area of work.

Externally, the Trust is working with partner organisations in the ICB to develop and deliver a system-wide communications plan. This reflects the outcomes from the ICB-facilitated system-wide Urgent and Emergency Care Summit. The trust will also continue to support any national communications and campaigns.

13. Summary of Recommendations & Future Work Required

An action plan of future work required is below:

Serial	Action	Action Lead	Target Date
1	Convene a Clinical Summit per site to review Trust Full Hospital Capacity. Incorporate any changes into the Trust OPEL Framework and communicate with staff.	Winter Tactical Group	Oct 22
2	YAS Cohorting Team seconded to SGH ED. Sally Alexander is lead and to report progress to the Winter Tactical Group.	Sally Alexander	Oct 22
3	Increase in capacity withing YTH UTC primary care stream.	Jamie Todd	Oct 22
4	Increase York EAU capacity from 10-15.	Jamie Todd	Oct 22
5	Extend EAU provision to all GP attendances in York.	Jamie Todd	Oct 22
6	Extend EAU at Scarborough into Respiratory Office.	David Thomas	Q4
7	If the Filey pilot is successful, establish GP admission pathway to EAU in Scarborough.	David Thomas	Dec 22
8	Conduct a review of the relaxation of mixed sex accommodation guidance in EAUs.	Emma George	Oct 22
9	Complete Clinician to Clinician trial and report to Winter Tactical Group.	Sally Alexander	TBC
10	Establish 12 virtual frailty beds at York.	Jamie Todd	Mar 23
11	Establish 20 virtual beds in consultation with Humber.	David Thomas	Dec 22
12	Review of OPEL Framework to be conducted.	Sara Kelly	Nov 22
13	Confirm benefit of late DLO once trial completed and report to Winter Tactical Group if the establishment of 2 x DLOs on a Saturday on each site is achievable.	Sara Kelly	Oct 22
14	Coordinate the allocation of the residual £190K funding from the ICB to appropriate winter schemes.	Winter Tactical Group	Oct 22
15	Create a separate dedicated "Hot Outpatient" facility for York EAU.	Jamie Todd	Nov 22
16	VOCARE recharging system required for short notice cancellation of services due to staffing shortages.	David Thomas	Oct 22
17	The staffing shortfall to establish the CAT Hub is being escalated to the ICB through the Trust Executive Team with a request to reconsider funding support to enable 5-day CAT Hub provision.	Caroline Alexander	Oct 22
18	Develop a plan detailing what (and when) incentives will be used for Bank and substantive staff this winter.	Lydia Larcum	Oct 22

A summary of recommendations is as follows:

Serial	Topic	Recommendation	Proposed Owner
1	Full Hospital Capacity Protocol	A Clinical Summit to discuss the implications of changing the Trust Full Hospital Capacity Protocol is convened for each site to allow Executive Teams to discuss the risks and benefits with CGDs/Lead Clinicians etc.	Lucy Turner / Melanie Liley or Jim Taylor
2	York EAU	The provision of nursing and medical staff to the York EAU remains an outstanding risk to be monitored by the Winter Tactical Group.	Winter Tactical Group
3	Scarborough EAU	If additional external funding becomes available over the winter period then the provision of a Junior Dr will be considered a priority.	Winter Tactical Group
4	EAU Mixed Sex Accommodation	A review risk assessment of the relaxation of mixed sex accommodation guidance is conducted for EAUs in times of extreme pressure.	Emma George
5	Clinician to Clinician Project	The Clinician to Clinician project, if the trial is successful, is implemented as soon as possible and does not await the ALERTIV software update.	Winter Tactical Group

Date: 16th September 2022

2023/24 Planning guidance and priorities

To help provide certainty for local health and care teams, NHS England has published its annual Priorities and Operational Planning Guidance. ICBs are asked to work with system partners to develop plans to meet the objectives set out in this guidance before the end of March 2023.

Areas of focus for 2023/24

The 2023/24 planning guidance sets out three core priorities informed by three underlying principles:

Recovering our core services and improving productivity	Make progress in delivering the key NHS Long Term Plan ambitions	Continue transforming the NHS for the future
Smaller number of national objectives which matter most to the public and patients		
More empowered and accountable local systems		
NHSE guidance focused on the "why" and "what", not the "how"		

Headline ambitions for recovering our core services and improving productivity

Improve ambulance response and A&E waiting times.

Reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard.

Make it easier for people to access primary care services, particularly general practice.

Recovering productivity and improving whole system flow are critical to achieving these objectives, and we must collectively address the challenge of staff retention and attendance. Throughout all the above will be a focus on **narrowing health inequalities in access, outcomes and experiences**, and **maintaining quality and safety in our services, particularly in maternity services.**

Delivering the key Long Term Plan ambitions and transforming the NHS

We need to create stronger foundations for the future, with the core goals of the NHS Long Term Plan our 'north star'. These include our commitments to:

- Improve **mental health services** and **services for people with a learning disability and autistic people**.
- Continue to support delivery of the **primary and secondary prevention priorities** and the **effective management of long-term conditions.**
- Ensure that the workforce is put on a sustainable footing for the long term, including publication of a NHS Long Term Workforce Plan.
- Level up **digital infrastructure** and drive **greater connectivity**, including development of the NHS App to help patients to identify their needs and get the right care in the right setting.

Local empowerment and accountability

ICSs are best placed to understand population needs and are expected to agree specific local objectives that complement the national NHS objectives. As set out in Operating Framework, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

Funding and planning assumptions

The Autumn Statement 2022 announced an extra £3.3 billion in both 2023/24 and 2024/25 for the NHS to respond to the significant pressures we are facing. We are issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity. Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

Further reading

Full planning guidance documents and supporting guidance can be read here: [NHS England » NHS operational planning and contracting guidance].

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Digital, Performance & Finance Assurance Committee
22 November 2022

47-22/23 / Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (AB), Melanie Liley (ML), Denise McConnell (DM), Mike Taylor (MT), Lynette Smith (LS), James Hawkins (JH), Luke Stockdale (LS2), Bernard Chalk (BC – observing), Rhiannon Heraty (RH) (minute taker)

Apologies for Absence: Jim Dillon (JD)

LM introduced BC, Trust Governor for East Coast of Yorkshire and LS, Chief Technology Officer to the meeting.

48-22/23 / Declarations of Interests

There were no declarations of interests.

49-22/23 / Minutes of the meeting held on 18 October

LS asked for two changes on P9 – the ICS target is 121 patients not 150, and the wording in the third paragraph was changed from ‘clinical pathways’ to ‘patient pathways’. Aside from these changes, the minutes of the last meeting held on 18 October were approved as a correct record.

50-22/23 / Matters arising from the minutes

Action 28 – the desktop scenario has not progressed. Following a detailed discussion by the committee on this action it was agreed LS2 would return to the Committee in January with a plan on the areas the desktop exercise would concentrate on for the YTHFM.

Action 54 – JH said this is now being prioritised within the wider portfolio but will take an estimated 9-12 months. The lack of a fully-fledged Medisight system is now having an impact on patients. LM asked for a reassessment of the risk to patients and would flag to the Quality and safety committee for their involvement/awareness.

Action 55 – confirmed closed as details provided in the TPR.

Action 59 – to be discussed at the December meeting.

Action 86 – confirmed closed.

Action 88 – confirmed closed as detail included in COO report. ML added that the agreement is that through PLACE, the ICB are funding 5 months at SGH and 3 months at YH for ambulance handover work with CIPHER.

Action 89 – LS suggested that this remain open pending a discussion on cancer and noted it may be beneficial to invite Kim Hinton (Associate Chief Operating Officer, Care Group 4) and Jenny Piper (clinical lead for cancer) to a future meeting. LM said a more detailed deep dive would be helpful as soon as possible in one of the next committee meetings.

Action 90 – confirmed as closed.

Action 91 – LM raised at Board and action confirmed as closed.

51-22/23 / Escalated Items

There were no escalated items to discuss.

52-22/23 / Trust Priorities Report – Digital, Finance and Performance, to include:

Digital and Information Update

JH gave a KPI update and said there had been some focus on Nucleus over the past month. The Committee noted that there were some setbacks such as the failed link to the Community Stadium due to a faulty circuit, along with two core system failures – one around certificate renewal and one around changes made to the main controls that manage load distribution. Calls to service desk are at a good level and P2 calls are running as expected. Further helpdesk recruitment has been undertaken to improve service. We need to focus on closing more calls at the end of the month. We have reached the end of our stock for end user devices over 4 years old so these will need to be refreshed unless we receive EPR funding. The number of information governance incidents has increased this month, which is being investigated. We receive c.150 FOI requests a month but are currently only responding to 48% in line with the statutory 20 days, however we are responding to 100% of SARs within the timescale.

There was a discussion about the number of end user devices (we are at 24% against a 100% target) and LM asked if more can be done through avenues such as external companies or charity funding. LS2 confirmed that we have a funding forum to capture any funding opportunities but that we have not been successful this year. Internally there was a digital amnesty but only 6 devices were repurposed and recirculated. AB said this could be incorporated into the efficiency work and asked if we could be more targeted in terms of identifying users of multiple devices. LS2 said yes but that support would be needed. LS agreed to come back to the committee with an update on further investigation of end user devices e.g. recovery, reuse and funding

JH confirmed that we have been allocated EPR funding from NHSE and that we have bid for a no-regrets capital request to upgrade Wi-Fi connectivity across YH and SGH sites. It has been confirmed that there is not an opportunity to move funding between years, which means we may be able to use our EPR money for end user devices. Whilst not ideal, the reality is that there is not funding to introduce new devices trust-wide so LS2 is looking into procurement routes. This may mean that EPR funding for infrastructure is diminished. AB said that charity funding may be able to help if presented with a strong proposal. LM said this would not only help staff but increase patient accessibility to records as well as promoting sustainability.

Cyber Security Status

JH shared a presentation on cyber security that included Trust physical and environmental security, information security management system, vulnerability management, logging and monitoring, training and awareness, secure checklist configuration, security team/target operating model and people. In terms of cyber maturity we scored relatively low on the baseline and JH said we need to employ cyber strategy principles of focusing on the basics, having simple processes that can be easily followed, achievable results, exploit NHS toolset and support, training to reiterate universal responsibility and using the tools we already have. The aims of our cyber strategy are to reduce impact or likelihood of Trust threats, ensure the Trust is better informed to identify risks, exploit and utilise current toolset to support risk management, provide the Trust with a basic secure foundation and support governance through a robust security management system. The Committee discussed the priority activities based on the level of risk and how best to tackle these.

Action: The Committee requested that the Board has a session to understand the current cyber risk status and to support the speedy remedy of priority actions needed to address the risk

Action: LS2 agreed to come back to the committee with an update on further investigation of end user devices e.g. recovery, reuse and funding

Operational Performance (Trust Operational Performance to national standards, Recovery Plans and Chief Operating Officer Report)

Shaun Stacey (interim Improvement Director - SS) commenced in post on 14 November. He holds oversight of our transformation programme around acute and elective recovery and has been asked to review programmes to check and challenge. Gemma Ellison (urgent care lead) is focusing on discharge, SDEC and urgent care as the top three priorities. ML referred to P52 and confirmed that we are still off trajectory for the number of patients that do not have right to reside within our bed base. A daily escalation call has been set up between Trust executives, the local authority, and York Place directors to unblock complex patients; there has been some traction but not enough to see a consistent reduction and therefore we have not yet received enough confidence to reduce our bed base, as required by the CQC.

19% of ED attendances are being streamed directly to SDEC against a 20% target. We will continue to try and exceed this position through the additional work being done with YAS around diversionary tactics. This is due to start in the next few weeks.

Dates have been secured for the previous clinical Chair of the Royal College of Emergency Medicine to visit in December to check and challenge our proposed clinical model for ED as we move into the new build. They will also review culture and behaviours. Progress has been made with the system in agreement around prioritisation of our urgent care review and it is being supported by York Place and North Yorkshire Place.

We have moved into Tier 1 for elective recovery. The Elective Intensive Support Team (IST) are visiting the Trust on 06 and 07 December and will undertake deep dives into our plans. ML referred to P53 for actions implemented to improve our 78-week position including the establishment of star chambers, which will bring clinical and executive teams together to undertake deep dives in high-risk specialties.

We are in the process of writing to primary care re the FIT diagnostic tool for colorectal fast track, which will help us ot manage patients more effectively and safely. It is now a

national requirement to provide FIT testing so we are working with primary care and the ICS, and Lucy Turner (Deputy Chief Operating Officer) will also support this when she moves into her new cancer alliance role.

ML noted the risks and mitigations shown within the TPR for transparency and recognised that performance is not where we need it to be. There is good progress against actions, but this has not yet translated to an improvement in performance. DM asked how confident ML was that these actions are the right ones. ML said that once SS has reviewed the plans, we will have a better indication of any changes that need to be made. ML added that she was confident that SDEC, urgent care review and discharge work are the right areas to focus on, and the areas of less traction are around consistency of application and engagement.

LS noted the significant delays in urgent and emergency care and said we remain off trajectory against the end of March position. Interim targets have been set to encourage improvement, but we are still a significant outlier in 12-hour delays. From an elective perspective we are not fully compliant with self-certification for tier 1 and 2 status, so a forward plan is being worked on for Board. We do not have all the data yet, so this is being prioritised to ensure the Board has oversight.

Our waiting list continues to accelerate and has almost doubled. If this reaches 50,000 patients, which is likely imminent, it will be a significant issue for the Trust. There is no funding allocated for this and all administrative and operational teams are currently running a double workload. The focus needs to be on opportunities for clock stops, diligence within patient pathways and ensuring validation. LS said we are suffering from system changes around primary care infrastructure, noting a 20% increase in East Coast GP referrals. We are working with Place colleagues around a refreshed focus on demand management pathways for both routine and cancer as this is not a sustainable position.

The cancer target for patients waiting over 63 days is 300 and we are currently at 314, marking a significant improvement from the end of October. This is mainly due to administrative focus on benign letter distribution and closing these patients off the list. To achieve the end goal target (121) a deep dive is needed around maximising the benefits of the new Somerset system and how we can support tracking and pathway management. There is support from clinical teams to see cancer reprioritised and Kim Hinton (Associate Chief Operating Officer, Care Group 4) said she would welcome a deep dive. A significant part of the delay is diagnostics, but we do not yet have the turnaround times. LS said it would be helpful to discuss in more detail once we have this.

We have not met any points of delivery within the operational plan other than follow-ups. LS noted the blood stock shortage as a contributory issue that mainly affected the Trauma and Orthopaedics team. We need to run activity in the autumn months ahead of winter to level out demand. This year we have not done the same level of activity, which is a risk for our overall recovery position.

DM asked how many trusts were in Tier 1. LS confirmed it was the bottom 20 based on the distance we are from being able to achieve the national ask and the confidence level in us achieving 0 for 78-week waiters and 121 for the number of patients over cancer 63 days. ML said she was positive that the IST visit would be beneficial and noted the more tangible support than was available during Tier 2 status.

There was a discussion about whether the Trust can produce enough income from activity when we are so far from the operational plan. AB gave assurance that our income is fixed, noting the only significant variable income is the elective recovery fund (ERF). AB added

that the guidance from NHSE is to still plan on the assumption that we will receive the funding regardless of whether we deliver activity or not.

LM welcomed the new format of measures in the TPR and said this allowed the Committee to see trajectories more clearly. LM referred to the ICS plan on P61 and noted that there was no mention of deadlines and asked how our ICS colleagues could support us in holding others to account. ML gave assurance that she had made the following comments to the ICS:

- Potential of reshaping the agenda to allow a look at data and impact first to influence tone of meeting
- Agree specific trajectories by pathways to see which pathways are performing differently and to agree process measures alongside the trajectory
- Further development of action plan from a pathway perspective so that any improvement schemes that we wish to add in that may not need additional funding can be added
- Help to direct the action plan to a more performance-focused conversation

ML said she would also request that the ICS action plan has deadline dates. Specifically referencing the plan ML added that the first seven measures have allocated funding and the others are waiting to be activated should additional funding become available. LM said it would be good to know which of these measures would have the biggest impact and whether they need funding now.

LM noted her concern around cancer and the importance of a longer-term strategy as well as ambulance handover times and the substantial growth of our waiting list (LS said we are designed to manage a waiting list of c. 26,000 and we are on a trajectory to hit 50k) and asked if escalation to Board would help.

Action: The Committee would welcome a Board discussion on the Elective Backlog improvement plan and specifically how the Trust can mitigate the risk of elective backlogs rising by almost 50% (suggested to have a deep dive review session in January following the Elective Intensive Support team visit in December)

Finance Update (Income and Expenditure Position; Efficiency Programme Update; and Cash and Capital)

AB gave an update on our Income and Expenditure position and confirmed we are £4.6m adrift of the plan. £2m of this relates to the unfunded pay award and mobile CT scanner. AB said he was partially optimistic and optimistic about these respectively and continues to push for external support for both. The remaining £2.6m is an internal issue, due in part to spending more on Covid than initially expected, our CIP position, pay pressures and doing less activity than anticipated, which is manifesting into an underspend on non-pay.

Protocol for changes to in-year revenue financial forecast

The Committee noted the stringency of the protocol and talked through P82-3 of the paper. AB said this was thoroughly discussed at Executive Committee and it was agreed that an internal recovery plan is needed to reduce our underlying spend rate by c.£2.5m. The most significant gain will be reducing agency spend, which is currently c.£400k a month via Thornberry, and actions are being undertaken to progress this.

With regards to the 2nd stage recovery action, AB was explicit in that there is no suggestion that we take any of these actions at this stage. AB said he was hopeful that the

stage 1 actions will take enough out of our monthly spend to place us in the usual position for year-end finance measures. In terms of the initiatives outlined on P85, AB said we may need to consider charitable support as they are not within our forecast position.

DM queried how many other Trusts are in the same position and what the implications would be should we fail to return to a balanced budget. AB said he felt it was realistic that we can reduce our overspending trend but that if we don't, the national team will implement this protocol to apply the pressure in order to return finance to the agenda with corporate, executive and Board teams.

53-22/23 / Executive Performance Assurance Meeting (EPAM) minutes

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

54-22/23 / Information Governance Executive Group (IGEG) minutes

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

55-22/23 / 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.

56-22/23 / Any other business

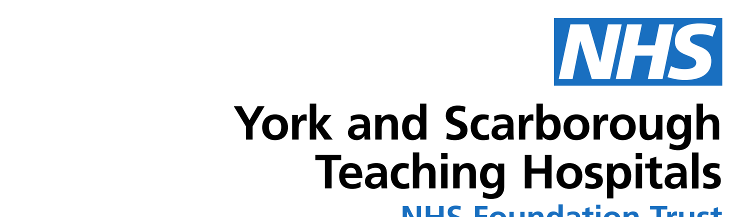
AB confirmed that he had met with John Bynoe (Interim Risk Manager – JB) and updated his corporate risk to reflect the protocol.

MT gave assurance that additional item 9i (risk management paper) around the corporate risks that fall under the Committee's responsibility has been updated to reflect today's conversations and JB will update the Executives ahead of Board.

DM said the meeting needed to be extended to allow for more comprehensive discussion.

57-22/23 / Time and Date of next meeting

The next meeting will be held on 13 December from 9am-11:30am.



Minutes

Digital, Performance & Finance Assurance Committee
22 November 2022

47-22/23 / Attendance: Lynne Mellor (LM) (Chair), Andrew Bertram (AB), Melanie Liley (ML), Denise McConnell (DM), Mike Taylor (MT), Lynette Smith (LS), James Hawkins (JH), Luke Stockdale (LS2), Bernard Chalk (BC – observing), Rhiannon Heraty (RH) (minute taker)

Apologies for Absence: Jim Dillon (JD)

LM introduced BC, Trust Governor for East Coast of Yorkshire and LS, Chief Technology Officer to the meeting.

48-22/23 / Declarations of Interests

There were no declarations of interests.

49-22/23 / Minutes of the meeting held on 18 October

LS asked for two changes on P9 – the ICS target is 121 patients not 150, and the wording in the third paragraph was changed from 'clinical pathways' to 'patient pathways'. Aside from these changes, the minutes of the last meeting held on 18 October were approved as a correct record.

50-22/23 / Matters arising from the minutes

Action 28 – the desktop scenario has not progressed. Following a detailed discussion by the committee on this action it was agreed LS2 would return to the Committee in January with a plan on the areas the desktop exercise would concentrate on for the YTHFM.

Action 54 – JH said this is now being prioritised within the wider portfolio but will take an estimated 9-12 months. The lack of a fully-fledged Medisight system is now potentially having an impact on patients. LM asked for a reassessment of the risk to patients and would flag to the Quality and safety committee for their involvement/awareness.

Action 55 – confirmed closed as details provided in the TPR.

Action 59 – to be discussed at the December meeting.

Action 86 – confirmed closed.

Action 88 – confirmed closed as detail included in COO report. ML added that the agreement is that through PLACE, the ICB are funding 5 months at SGH and 3 months at YH for ambulance handover work with CIPHER.

Action 89 – LS suggested that this remain open pending a discussion on cancer and noted it may be beneficial to invite Kim Hinton (Associate Chief Operating Officer, Care Group 4) and Jenny Piper (clinical lead for cancer) to a future meeting. LM said a more detailed deep dive would be helpful as soon as possible in one of the next committee meetings.

Action 90 – confirmed as closed.

Action 91 – LM raised at Board and action confirmed as closed.

51-22/23 / Escalated Items

There were no escalated items to discuss.

52-22/23 / Trust Priorities Report – Digital, Finance and Performance, to include:

Digital and Information Update

JH gave a KPI update and said there had been some focus on Nucleus over the past month. The Committee noted that there were some setbacks such as the failed link to the Community Stadium due to a faulty circuit, along with two core system failures – one around certificate renewal and one around changes made to the main controls that manage load distribution. Calls to service desk are at a good level and P2 calls are running as expected. Further helpdesk recruitment has been undertaken to improve service. We need to focus on closing more calls at the end of the month. We have reached the end of our stock to replace end user devices over 4 years old so these will need to be refreshed if we are able to access the EPR funding. The number of information governance incidents has increased this month, which is being investigated. We receive c.150 FOI requests a month but are currently only responding to 48% in line with the statutory 20 days, however we are responding to 100% of SARs within the timescale.

There was a discussion about the number of end user devices (we are at 24% against a 100% target) and LM asked if more can be done through avenues such as external companies or charity funding. LS2 confirmed that we have a funding forum to capture any funding opportunities but that we have not been successful this year. Internally there was a digital amnesty but only 6 devices were repurposed and recirculated. AB said this could be incorporated into the efficiency work and asked if we could be more targeted in terms of identifying users of multiple devices. LS2 said yes but that support would be needed. LS agreed to come back to the committee with an update on further investigation of end user devices e.g. recovery, reuse and funding

JH confirmed that we have been allocated EPR funding from NHSE and that we have bid for a no-regrets capital request to upgrade Wi-Fi connectivity across YH and SGH sites. It has been confirmed that there is not an opportunity to move funding between years, which means we may be able to use our EPR money for end user devices. Whilst not ideal, the reality is that there is not funding to introduce new devices trust-wide so LS2 is looking into procurement routes. This may mean that EPR funding for infrastructure is diminished. AB said that charity funding may be able to help if presented with a strong proposal. LM said this would not only help staff but increase patient accessibility to records as well as promoting sustainability.

Cyber Security Status

JH shared a presentation on cyber security that included Trust physical and environmental security, information security management system, vulnerability management, logging and monitoring, training and awareness, secure checklist configuration, security team/target operating model and people. In terms of cyber maturity we scored relatively low on the baseline and JH said we need to employ cyber strategy principles of focusing on the basics, having simple processes that can be easily followed, achievable results, exploit NHS toolset and support, training to reiterate universal responsibility and using the tools we already have. The aims of our cyber strategy are to reduce impact or likelihood of Trust threats, ensure the Trust is better informed to identify risks, exploit and utilise current toolset to support risk management, provide the Trust with a basic secure foundation and support governance through a robust security management system. The Committee discussed the priority activities based on the level of risk and how best to tackle these.

Action: The Committee requested that the Board has a session to understand the current cyber risk status and to support the speedy remedy of priority actions needed to address the risk

Action: LS2 agreed to come back to the committee with an update on further investigation of end user devices e.g. recovery, reuse and funding

Operational Performance (Trust Operational Performance to national standards, Recovery Plans and Chief Operating Officer Report)

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55-22/23 / Consideration of items to be escalated to the Board and/or other Committees

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56-22/23 / Any other business

AB confirmed that he had met with John Bynoe (Interim Risk Manager – JB) and updated his corporate risk to reflect the protocol.

MT gave assurance that additional item 9i (risk management paper) around the corporate risks that fall under the Committee's responsibility has been updated to reflect today's conversations and JB will update the Executives ahead of Board.

DM said the meeting needed to be extended to allow for more comprehensive discussion.

BC had the following observations:

Operational Performance

BC said that the act of introducing new processes to manage activity felt repetitive and noted that targeted outpatient follow-up reduction does not seem to transpire as well as challenges around PIFU. BC added that the East Coast was not happy about the process and that it was not realistic in terms of reducing outpatient follow-ups. ML reiterated that SS would use his wealth of experience to advise on appropriateness of processes. LS added that we are in a similar position to most other Trusts but that there is a clinical nervousness around discharging patients when primary care mechanisms are not as robust as they once were. Whilst it is hard to give full assurance, there is the appetite for improvement.

BC asked if referral rates from the East Coast were unrealistic for the demographics. LS said there is some disparity on the waiting list between socio-economic groups, which is being investigated. The Committee noted that the East Coast primary care is in a slightly more fragile position.

BC asked how waiting list validations and fit for surgery processes were being communicated and worked through to manage acute and elective activity. LS gave assurance that we are one of the top-performing Trusts for technical validation. Additional resources were applied to the Patient Pathway Trackers team for administrative validation, which included funding an external company to run a full waiting list validation, who came back with just a 1% error rate. There is an ongoing debate about how best to use resources.

Finance Update

BC said there was an issue around electives, noting that it seems like elective funding will be retained for this year. BC said that by taking agency work away (noting Thornberry's provision of specialist nursing) it could reduce elective capacity. AB accepted this as a fair challenge in part and said that Thornberry has now branched out into more general areas rather than solely specialist.

57-22/23 / Time and Date of next meeting

The next meeting will be held on 13 December from 9am-11:30am.

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Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Lynne Mellor	Date: 17 January 2023

2022-3 – Trust Priorities covered by DPF Board Assurance Committee: Acute Flow & Elective Backlog

	Summary	Receiving Body: Board/ Committee	Recommendation/ Assurance to the receiving body: Information, Action, Decision
Digital			
i)	- The Committee welcomed a number of guests to the meeting including the Governor Abbie Denyer, Cancer: Kim Hinton and Jenny Piper, DIS: Luke Stockdale, Nucleus: Janet Farr/Nik Coventry. - The Committee discussed the DIS dashboard and asked for an update on the device refresh in March. It welcomed the addition of key Cyber monitoring KPI, and the recruitment of both the cyber and platform leads. - The Committee noted the excellent progress with Project Nucleus including the benefits especially to patient safety by releasing time to care for nurses. Since August 2022 there have been 61k nursing assessments using 320 mobiles and 100 tablets. All of these assessments would have been performed using printed records which then have to be physically stored – e.g., £150k p.a. of savings on printing. The committee is keen to understand the forecasted benefits v costs of this programme as its scales up to encompass other specialities and roles. The committee suggested the production of a case study/further stories about Nucleus success – internal/external. - The Committee also noted the EPR central funding and risk to the plan. It was agreed there is a need for the Committee to review the EPR business case following market testing prior to submission to the Board.	BOARD	INFORMATION
Performance			
i)	- The Committee noted that the Trust has experienced extraordinary operational pressures over the December/early January period impacting Acute Flow and Elective Recovery. The Committee discussed the Urgent and Emergency Care (UEC) interventions, given increased pressures e.g., a rise of 5% to 23% of Type 1 patients spending more than 12 hours in ED and increase of 12-hour trolley waits by 360 from last months report to 1234. The Committee noted the recommendations from Dr Matthew Cooke for York ED which included improvements in plans for patient flow, professional standards and a clear 5-year strategy. - The Committee also welcomed the report from the former Clinical Chair of the Royal College of Emergency Care Medicine. - The Committee noted the further plans to alleviate the issues around discharge and welcomed the news that HNY has been allocated £5.9M additional allocation to support discharge. The Committee seeks further assurance on what will be allocated to the Trust and how it can make an impact swiftly.	BOARD	INFORMATION
ii)	- The Committee discussed the key operational measures and risks to patients, again it was noted that more		

	needs to be done to increase the volume of first appointments for outpatients to reduce the backlog. - The Committee noted the comprehensive report from the Elective Care IST RTT and Cancer long wait following the Trust being designated Tier 1 intervention from NHSE. There were a number of areas of concern for the Committee, including governance and process, and asked that a deep dive be presented to the Board. The Committee requested that further assurance is needed on Elective backlogs and that the Committee reiterate the need for a Board session i.e., the real concern over the total waiting list trajectory, which is forecast to rise to over 50k patients. This is a significant risk to patients, and of much concern, given the Trust's current operational systems and plans are designed for a waiting list of circa 26k patients. - **Action:** The Committee would welcome a Board deep dive addressing both short term and longer-term issues/needs particularly on how the Trust can mitigate the risk of elective backlogs rising by almost 50% (suggested to have a deep dive review session following the Elective Intensive Support team visit in December -. *The Committee requests that this session now includes Cancer deep dive.*	BOARD	ACTION
iii)	- The Committee welcomed the presentation on Cancer following its request to have a deep dive. The Committee noted and discussed the issues around the 3 performance metrics, i)faster diagnosis standards within 28 days 75% referred - colorectal and skin particularly challenging. Ii)62-day waiters - currently significant deterioration, colorectal, skin and urology. iii)Size of PTL - currently deteriorating with over 2,400 patients on the list. Ask of the Committee is that more assurance is given that the priorities are clear, with clear dates and one clear set of interventions. The committee asked if a patient experience survey could be conducted for those patients on the waiting lists, both those who need cancer care and those who don't. - **Action:** The Audit committee to consider auditing the process for dealing with cancer patients particularly in the delay between their outpatient appointment and the histology report and the sending of benign letters. - **Action:** The Board to ensure that the Trust reiterates the mandate from the Executive Committee that patients need to be informed of the outcome of their Cancer review outcome within 48 hours	BOARD AUDIT COMMITTEE BOARD	INFORMATION ACTION ACTION
Finance			
i)	The Committee noted the Trust's Income and Expenditure (I&E) position with an adjusted deficit of £6.4M against a planned deficit of £0.4M i.e., £6m adversely adrift of plan. The Committee asked for further detail on the plans and risk assessment given: 1) The Trust is £18M behind on capital spend i.e., will we expect to deliver before year end. 2) The cash flow for the Trust is £30M compared to the plan of £33.5M – given deficit, capital spend and pay increases, it would be good to further understand the current balance and if we still expect to break even at year end.	BOARD	INFORMATION
YTHFT			
i)	The Committee had no planned reporting update this month	BOARD	INFORMATION
Governance			

BAF/Corporate	- The Committee noted no immediate changes to the BAF or Corporate register					BOARD	INFORMATION
Trust strategic goals assured to Committee	**1. To deliver safe and high-quality patient care as part of an integrated system**	☐	**2. To support an engaged, healthy and resilient workforce**	☐	**3. To ensure financial sustainability**		X ☐
	PR1 - Quality Standards	☐	**PR2 - Safety Standards**	☐	**PR3 - Performance Targets**		X ☐
	PR4 - Workforce	☐	**PR5 - Inadequate Funding**	X ☐	**PR6 - IT Service Standards**		X☐
	PR7 - Integrated Care System	X ☐	**Comments: PR7 is interrelated across our agenda, and will be noted as discussions arise.**				

	Key Agenda Items	RAG	Key Assurance Points	Action
PR6 – IT Service standards	Digital		New measure around cyber will be brought to the committee. LLP cyber desktop discussed.	The ask remains from the Committee that the presentation of the report goes to Board early in 2023 to support the speedy implementation of the priorities. Committee welcomed a date has now been scheduled by DIS to conduct the review i.e. LLP cyber desktop exercise needed to ensure we mitigate any risks should an attack happen.
PR3 – Performance Targets	Performance Targets		Significant operational pressures noted.	Focused plans on acute flow and elective backlog to address significant operational pressures – ask for continued identification of focus areas to alleviate biggest pressures.
PR5 – Inadequate Funding	Deficit issue		Deficit issue particularly with premium pay	Monitoring needed with continued focus on areas with gaps such as CIP

NHS
York and Scarborough
Teaching Hospitals
NHS Foundation Trust

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 20

Report to:	Board of Directors
Date of Meeting:	25 January 2023
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 Q3 Board Assurance 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 Q3 2022/23; and,
- The CRR has been updated for January reporting.

Recommendation:

The Board of Directors are asked to approve the Q3 Board Assurance 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	16/01/23	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 January.

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). The 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 January has been updated at appendix 2.

4. Next Steps

Further work on embedding risk management at the Trust is underway with the Associate Director of Corporate Governance and the Interim Risk Manager.

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
Likelihood	4	4	3	Risk Appetite: Exceeding
Impact	5	4	2	Date to achieve target score: Year-End Review
Overall risk rating	20	16	6	

Committee Oversight: Quality & Safety Assurance Committee	
Risk Owner:	Chief Nurse
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 of Directors - Quality and Safety Assurance Committee	- TPR reported to April- June (IBR) and July-October Board of Directors and April-June (IBR) and July-December Quality & Safety Assurance Committee - Minutes and actions of papers April- June (IBR), July-December Board of Directors , Executive Committee and Quality & Safety Assurance Committee inc Nurse Staffing, Ockenden, CQC, IPC	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-October Board of Directors and April-June (IBR) and July-December Quality & Safety Assurance Committee - Minutes and actions of papers April- June (IBR), July-December Board of Directors , Executive Committee and Quality & Safety Assurance Committee - KPIs in Care Group dashboards - Q2 Minutes of Oversight & Assurance meetings	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Q2 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-November Board of Directors and July, September and November People & Culture Assurance Committee - Executive Committee Agency Usage Report	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	-Limited visibility to investments required but not progressed.
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%)	-Training deferred/delayed due to operational pressures.
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- Risk stratified elective waiting lists.	- Diagnostic waiting lists to be risk stratified in July; outpatient list to follow.
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	- April & May Executive Committee and Board of Directors approved plan - Capital planning process underway for 2023/24	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**

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: Q4**	**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 on a case by case basis - Datix incident reports - Monthly SI/Never Event reports presented to Quality & Safety Committee, QPaS, Care Group Boards and Oversight & Assurance meetings April-December 2022 - Learning from deaths and 6 monthly Cancer Harm report to QPaS - Patient experience report Q1 & Q2 reported to Quality & Safety Assurance 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**
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.	Karen Stone	**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: Feb 2023**	**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-November Board of Directors and July-December 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 Q2 & Q3 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 Q2 & Q3 Oversight & Assurance meetings - Minutes and actions of papers April- June (IBR) and TPR July-December (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 - Bronze/Silver/Gold Command for exeptional pressures documented actions throughout January 2023	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 System 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

<table>
<tr><td rowspan="2">Risk description</td><td rowspan="2" colspan="4">PR4 - Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand</td><td>Causes
What has to happen for the risk to occur?</td><td colspan="2">- 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</td></tr>
<tr><td>Consequences
If the risk occurs, what is its impact?</td><td colspan="2">- Deterioration of staff wellbeing
- High attrition rates
- Increased financial costs from interim arrangements
- Potential patient harm
- Reputational damage
- Regulatory attention</td></tr>
<tr><td>Risk Rating</td><td>Gross</td><td>Net</td><td>Target</td><td>Risk Appetite Assessment</td><td colspan="3" rowspan="2">Committee Oversight: People and Culture Assurance Committee</td></tr>
<tr><td>Likelihood</td><td>5</td><td>4</td><td>4</td><td>Risk Appetite: Exceeding</td></tr>
<tr><td>Impact</td><td>5</td><td>4</td><td>3</td><td rowspan="2">Date to review target score: March 2023</td><td colspan="2">Risk Owner:</td><td>Director of Workforce and OD</td></tr>
<tr><td>Overall risk rating</td><td>25</td><td>20</td><td>12</td><td colspan="2">Links to CRR:</td><td>WFOD1</td></tr>
</table>

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/WDES 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 - Board of Directors papers	- Learning Hub - PREP	None identified
Design and Deliver Internal Leadership Programmes	None identified	-Trust intranet - Shadow Board development with NHS Elect	- List of programmes on Learning Hub	None identified
Leadership succession plans	None identified	- Board, REMCOM, Executive Committee - Shadow Board development with NHS Elect	- Board papers (agenda, minutes, action log) - REMCOM papers (Oct agenda, minutes, action log)	None identified
Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Board (reporting 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 AHP and medical recruitment programme	- QIA for new nurse roles - CHPPD - ICS international recruitment programme (Kerala)	None identified
Incentivise recruitment & reintroduced recruitment open days. Launched careers website.	None identified	-Reduced vacancy rates in TBR	- TPR and workforce reporting at July, September, November and January 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	Approximately 50% of AHP rotas remain manual	- Internal Audit	- Internal Audit reports on E-Rostering - CHPPD	None identified
Oversight of Establishments and establishment reviews (nursing and AHP)	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.	- People & Culture Assurance Committee updates July, September, November and January	None identified
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%) - July and November People and Culture Committee reporting, action plan and minutes	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 (to be completed by Mar 23); to be complete Mar 23); New intranet	Polly McMeekin	**Mar-23**
Recruitment	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
Likelihood	5	4	2	Risk Appetite: Exceeding
Impact	5	4	3	Date to achieve target score: Achieved
Overall risk rating	25	16	6	

Committee Oversight: Digital, Finance and Performance Assurance Committee	
Risk Owner:	Director of Finance
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 - December (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 November Board of Directors -System enforced delegation and approval management. - Written confirmation by prime budget holders or responsibilities	Operational pressures and CQC safe staffing level concerns may cause Care Groups to spend outside of budget resource envelopes.
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. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-Executive Committee and Board of Directors approved plan 2022/23 - Capital Programme 2023/24 process underway	None identified
Routine monitoring and reporting against capital programme	None identified	-Financial Services	- Minutes and actions of papers April- June (IBR) and TPR July-December (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-December (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 in the process of being released for 2023/24	Trusts to prepare 2023/24 I&E plan. Next deadline is 23 February 2023 for the first draft plan submission. End of March for final plan submission.	A Bertram	**Mar-23**
Confirm efficiency requirement and match to identified plans with a view to identifying any residual requirement.	Ongoing as part of the 23/24 planning process. Details of the new national efficiency requirement will be worked through along with any residual carry over from 22/23.	A Bertram	**Mar-23**
Model Elective Recovery Fund costs and income earning potential to maximise funded elective recovery activity.	To be evaluated as part of the 23/24 planning round. Details on how the elective payment scheme will operate are still awaited from the national team.	A Bertram	**Mar-23**
Revenue investment programme to be agreed for 23/24	Care Group initial prioritisation has been completed. This needs to be assessed alongside funding allocation details when they are released. This will be managed as part of the I&E plan preparation.	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 July, September and November minutes, papers, agenda, action log - IG Executive Group August and November 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 July and November - 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	**Mar-23**
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	**Mar-23**

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 - Drafting of CAP terms of reference and joint working agreement	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**
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 Q4 2022/23	Exec Team	**Mar-23**
Finance and activity delivery for 2022/23 as part of H&NY system delivery	Progress to be reviewed Q4 2022/23	Exec Team	**Mar-23**

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: Digital, Performance and Finance Assurance 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 York and North Yorkshire Net Zero Fund launched in January for expression of interest by 6th February- options being discussed.	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. Work on-going and currently on time and on budget.	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 a business case which explores 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. Pilot now underway and prices being sought. The prices requested are to supply and install temperature monitoring systems in 2 phases as follows: • Phase 1 York Hospital covering all inpatient Wards • Phase 2 Other sites with inpatient beds	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. Part time support to collate carbon footprint monitoring data commenced December 2022.	Head of Sustainability	**Reviewed Mar-23**

Corporate Risk Register January 2023

BAF Ref	ID	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	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	16/01/2023	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 4. 23/11/2022-There is a detailed piece of design work needed to enable the trust to achieve HTM compliant ventilation on all the ward across the organisation. The Estates department is going round to evaluate this. 09/01/2023 Awaiting the opening of the new Emergency Department at York Hospital on 04/05/2023 which will alleviate the overcrowding at the Emergency Department and asscoiated IPC transmission risk.	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR6	409	Cyber Security	01/11/2018	There is a risk of a Cyber Attacks through a computer virus or malware, malicious user behaviour, unauthorised access, phishing and unsecure data flows. This could result in significant patient harm, reputational damage, unavailability of systems, financial recovery costs, and inability to meet regulatory deadlines (NHSE, HMRC) and additional 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.	Chief Digital and Information Officer	16/01/2023	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	3 - Possible	Significant
PR1 PR2 PR3 PR6	1696	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	16/01/2023	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	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	16/01/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Executive escalation when not on plan 2. Starchambers chaired by Trust Chief Executive with high risk specialities established and commencing January 2023. 3. Trust in National Tier 1 facilitated assistance from National elective IST and Ernst Young	3 - Moderate Harm	3 - Possible	Medium

BAF Ref	ID	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 PR2 PR3 PR4	1695	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	16/01/2023	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	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	16/01/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Develop enhanced reporting to DF&P Committee along with development of the TPR. 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. 4. Trust has created and is currently delivering an Internal Financial Recovery Plan - March 2023. 5. Additional income recovery with NHSE and ICB to help manage specific pressures.	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3	377	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	16/01/2023	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	Insufficient staff	16/12/2022	There is a risk of delays in offering optimum care and treatment 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, Active bank and workforce resilience initiatives 2. Review of the working environment to make it more positive and safe working environment. 3. Retention initiatives Such as: Fix The Basics, Culture Change, Workforce Planning, E&D actions 4. Pastural work-life package in place 5. Recruitment drive with support from Health Education England &ICS with Ongoing campaign to recruit overseas qualified staff 6.Staffing reports are discussed at the following Committees PACC, QPaS, Executive Committee Quality & Safety Assurance Committee 7.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	16/01/2023	4 - Severe Harm	4 - Somewhat Likely	Significant	1. Job Plan re-setting of expectations 2. Safer Care Investment Proposals to Board	4 - Severe Harm	3 - Possible	High

BAF Ref	ID	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 PR2 PR3 PR6	1388	Major IT Failure	18/12/2020	There is a risk of the failure of the core technology estate (e.g. CPD, clinical or admistrative systems or network infrastructure) due to single points of weakness, loss of power/premises, out of data 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. 2. Increasing resilience of core network and server infrastructure.	Chief Digital and Information Officer	16/01/2023	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. 4. Enhanced service management and operations including control, governance, major incident and problem management. 5. Deliver the Essential Services Programme (ESP). 6. Increase pro-active management and maintenance of systems and solutions i.e. upgrades, patching 7. Increase pro-active service management and operations through new event management solutions (Monitor, alert and self fix)	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3	1509	T&O RISK: Failure to offer an effective arthroplasty service	14/10/2021 CRR 19/12/2022	The risk is a failure to offer an effective arthroplasty service Due to the lack of an elective ward and no alternative spaces This could result in Patient harm and distress Poor patient experience Disability Reputational damage Regulatory attention Increased backlog of patients waiting treatment Breach of targets including GIRFT.	Ramsey contract will deliver a proportion of low risk arthroplasty service High ASA utilisation of side rooms in acute bed base via SOP T&O OSM is micro managing day to day lists	Operating Officer, Chief	16/01/2023	3 - Moderate Harm	5 - Very Likely	Significant	discussion by MQ at Exec Board 03/08/2022 19/12/22: Reviewed and added to Trust Corporate Risk Register	3 - Moderate Harm	1- Very Low	Very Low
PR1 PR2 PR3 PR4	1728	Outpatients Services	30/11/2022 CRR 19/12/2022	There is a risk of missed/delayed appointments Due to CPD not being an administrative tool there is a large amount of manual work and a high level of back log due to sickness and vacancy This could result in harm to patients	Agency staffing in place (2). Capacity for a further 4 agency staff, but limited interest from the 200+ agencies approached. All Care Groups advised of capacity issues and asked to support with slot filling and giving suitable notice to the team to fill clinics. All Care Groups asked to let admin staff know of opportunity to undertake additional overtime/bank within the team to support with backlogs.	Operating Officer, Chief	16/01/2023	5 - Catastrophic Harm	3 - Possible	Significant	Continue to try to recruit to agency posts. Continue to try to recruit substantive staff. For review if required on corporate risk register 19/12/22: Reviewed and added to Trust Corporate Risk Register	5 - Catastrophic Harm	2 - Unlikely	High

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 21

Report to:	Board of Directors
Date of Meeting:	25 January 2023
Subject:	Corporate Governance Framework Review
Director Sponsor:	Alan Downey, 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 ☒ Sustainability

Summary of Report and Key Points to highlight:
The purpose of the report is to highlight to the Board of Directors that the Trust's Reservation of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions have been reviewed with the amendments listed.

Specifically to note and discuss:
The Trust reviews the corporate governance documents on an annual basis for recommendation for approval by the Group Audit Committee to the Board of Directors for the forthcoming financial year. Documents are provided in the blue box.

Recommendation:
The Board of Directors is asked to approve the amended Trust Reservation of Powers and Scheme of Delegation and Standing Financial Instructions.

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

Meeting	Date	Outcome/Recommendation
Audit Committee	14 December 2022	Recommend for approval

Corporate Governance Framework Review

1. Reservation of Powers and Scheme of Delegation

The Trust's reservation of powers and scheme of delegation has been revised as follows (additions are in bold and italic text):

Area	Section and Amendment
Page 6 - Scheme of matters reserved for the Board 5.4 Appointments/ Dismissal	Through the Remuneration Committee the appointment and appraisal of Executive Directors / VSM and the disciplinary procedures of the Trust. Now to include ***VSM*** to take into account the hosting of the Collaboration of Acute Providers (CAP) and YTHFM.
Page 9 - Capital Investment and Business Cases	Any urgent approval can be agreed by the chair or deputy chair of the relevant group (Any urgency must be justified). *Deputy Chair added* Authority delegated from Capital Programme Management Group (CPMG) - ***delegated authority from Capital Programme Executive Group (CPEG)*** added Details/Reference - *Business Case Guidance Manual* added
Page 9 - All Business Cases revenue investment	***(planned increases in expenditure or income from existing approved levels)*** added ***Deputy Chair*** *added* Prime budget holder removed ***Care Group Board or Director in Directorates*** added Details/Reference - ***Business Case Guidance Manual*** added
Page 9 - Expenditure variations on capital schemes	***Deputy Chair*** *added* Capital Programme Executive Group (CPEG) *Acronym added*
Page 10 - Planning & Budgetary Control	Delegated matter ***Directorates*** added At individual cost centre level (pay and non-pay) Prime Budgets Holders can delegate budgetary authority to delegated budget holders. ***Budget Unit removed and cost centre added***

	Delegated matter added ***Virement (planned change in use) of resources between Care Groups or specialty/department budgets (per annum):*** ***A register of all virements should be kept.*** Authority delegated to - ***Care Group or Directorate Finance Manager***. Scope of delegation - ***Up to £50k*** Details/Reference - ***SFI Trust Finance Manual Section 8.2.2*** Authority delegated to - Finance Director – ***Over £50k*** Non pay requisitions – Decisions to rent or lease in preference to outright purchase ***Deputy Finance Manager*** - added Authority to change clinical template activity Chief Operating Officer and Finance Director – removed ***Head of Contracting and the Operational Planning & Performance Manager*** - added
Page 11/12 - Non-pay revenue expenditure within budgets	Note: over 50k the Business Case procedure shall apply - removed Establishment of ***emergency*** escalation facilities and associate costs – short notice removed, emergency added Purchasing Cards: Authority to issue purchasing cards and setting of limits – ***Deputy Finance Director*** added
Page 12 – Clinical and contract income credit notes	Removal of: Delegated Matter - FRAC Analyst/Senior Analyst – Up to £250 Delegated Matter - Income Accountant - £250 to £10k Addition of: Delegated Matter - ***Head of Contracting can delegate defined authority to named members of the 'Financial Reporting and Contracting' team up to £250*** - Head of Contracting - ***Up to £1m***
Page 13 - Credit notes / refunds to correct posting errors and	Financial Accountant /Payroll Manager amended from £1k-£10k to ***£1k-£5k*** Details/Reference - Payroll manager for payroll invoices amended from up to £10k **to *up to £5k***

duplicate payments	Head of Corporate Finance ***£25k to £500k*** (amended from £10k to £500k) ***Deputy Finance Director £500k to £1m*** included
Page 13 - Write offs – excluding workforce remuneration over payments	***excluding workforce remuneration over payments*** – added Deputy Head of Corporate Finance £250 to ***£1k*** (amendment from £1000) Head of Corporate Finance £1k to ***£5k*** (reduced from £1k to £10,000) ***Deputy Finance Director*** **£5k to £10k** added
Page 14 - Write offs – workforce remuneration over payments	***Please note it is not Trust policy to write off any workforce remuneration overpayments – Any agreed write off will only be approved as an absolute exception*** added ***Head of Corporate Finance Up to £500*** added ***Deputy Finance Director £500 to £1k*** added ***Finance Director over £1k*** added
Page 14 - Quotations, Tendering and Contracts	Obtaining a minimum of 3 written competitive tenders for goods/services over ***£50k (£25k for YTHFM)*** amended from over £25k Opening tenders – manual All Executive Director***s*** (plural added)
Page 18/19/20/21/22 – Personnel and Pay	***Granting of additional increments to staff outside of the starting salaries process*** added – Above policy level – removed Director of Workforce & OD ***All Very Senior Manager (VSM) posts*** added – Chief Executive and Director Posts including Corporate and Executive Directors – removed Remuneration Committee Chair of the Trust as Chair of the Remuneration Committee Authorising overtime ***(within approved resource)*** added Delegated Budget Holder Authority to pay clinical excellence awards to Consultants

	Board of Directors endorse***ment*** Removal of - decision of Committee chaired by the Chief Executive or Director of Workforce & OD Uplift to starting salary ***in line with policy*** (AfC staff only) Line manager - removal of in conjunction with HR Business Partner ***Outside of Policy*** added **Director of Workforce and OD** - scope of delegation added Removed: Compassionate Leave Line Manager – up to 5 days Prime budget holder in consultation with HR – up to 10 days Special leave guidance Special Leave Line Manager ***(A4C staff)*** added ***As detailed in Special Leave Guidance*** added Medical staff leave of absence paid and unpaid – removed
	Study Leave Clinical Director - Study leave– medical Outside the UK – removed ***Line Manager*** added - Study leave - ***non-medical*** added Outside the UK other – removed Removed: Clinical Director - Medical Staff study leave (UK) Clinical Director - All other study leave (UK) Authority to suspend (AfC) staff Head of Employee Relations & Engagement, ***Director of Workforce & OD Deputy Director of Workforce*** added Authority to exclude medical staff Chief Executive or Medical Director, ***Deputy Medical Director, Director of*** Workforce and OD – removal of Deputy Chief Executive Authority to restrict practice Medical Director, Chief Nurse, Director of Workforce & OD, ***Head of Employee Relations & Engagement, Deputy Director of Workforce***

	Detailed/Reference - MHPS guidance, ***Disciplinary Policy*** added
Page 23 - Authorisation of new drugs	Associate Chief Operating Officers Chief Pharmacist – formatting Approval of nurses and others to administer and prescribe medication beyond the normal scope of practice ***Chief Nurse*** or Medical Director or Chief Pharmacist – Director of Nursing removal
Page 25 - Engagement of Trust's Solicitors	All Directors, Associate Director of Corporate Governance, Deputy Director of Healthcare Governance , Head of Procurement, ***Deputy Director of Workforce*** ***Head of Employee Relations and Engagement*** added
References to NHS Improvement	Changes made throughout to NHS England
References to Foundation Trust Secretary	Changes made throughout to Associate Director of Corporate Governance

2. Standing Orders

Standing Orders are reviewed as part of the Constitution which was approved by the September Board of Directors meeting following recommending for approval by the Council of Governors. The following Board of Directors minimal changes were approved:

Area	Section and amendment
Introduction – Statutory Framework	York and Scarborough Teaching Hospitals NHSFT name correction
5.1 Committees – Appointment of Committees	Amended to state Committee amendments from July 2022

3. Standing Financial Instructions (SFIs)

The Trust's SFIs have been revised as follows (additions are in bold and italic text):

Area	Section and amendment
Author	***Deputy Finance Director*** added Head of Corporate Finance and Resource Management - removed
Terminology	Reference to ***Health and Care Act 2022*** added
Page 31 - Building and Engineering Transactions	The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the ***guidelines and requirements of the DHSC frameworks (e.g. Procure 22 & 23 or successor arrangements) or other equivalent public sector***

	frameworks that may be utilised to procure building work and related services. All works and related contracts (e.g. architects services) should utilise and comply with recognised forms of contract. The technical audit of these contracts shall be the responsibility of the relevant Director. Guidance contained within CONCODE and ESTATECODE, and procure 22 guidance - removed
Page 50 - Risk Management	The ***Audit Committee*** shall review insurance arrangements for the Trust. Board of Directors - removed
References to NHS Improvement	Changes made throughout to NHS England
Minor wording corrections	

4. Recommendation

The Board of Directors is asked to approve the amended Trust Reservation of Powers and Scheme of Delegation and Standing Financial Instructions.

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Audit Committee: Items Escalated to the Board

The Audit Committee met on 14 December 2022.

The meeting was quorate and it was the first meeting attended by our new Engagement Lead from Mazars, Alastair Newall. Alastair replaces Mark Dalton, who retires at the end of 2022
.
The Committee wishes to draw the following matters to the attention of the Board.

Action Required

Risks facing the Trust and the Board Assurance Framework (BAF)
We remain concerned that Board and Sub-Committee agendas do not focus sufficient time and attention on identifying risks and managing these to the lowest possible level. In our view, more proactive use of the BAF could assist with this. We suggest that representatives of the Board look at how progress with this can be made.

Process of Escalation
We recognise that Sub-Committees are routinely escalating items to the Board but that this does not always result in action by the Board. We ask that the Board reviews the system of escalation with a view to ensuring that action is agreed as a result of an issue being escalated.

Reservation of Powers, Scheme of Delegation and Standing Financial Instructions
We reviewed amendments to the above documents and recommend to the Board that these be approved.

Recommendations

Outstanding Actions
As a means of strengthening the process around these, we suggest that these be a standing item on Executive Committee.

For Information

Audit Committee Training
We agreed that it would be useful to arrange an externally facilitated training event to remind us of the role of the Audit Committee and that of Internal Audit. This is being planned for 20 January.

Jenny McAleese
Chair of the Audit Committee
December 2022