York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 26th April 2023
Time: 9:00am – 12.00pm

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: Wednesday 26th April 2023

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:45 – 2:45	Board of Directors - Private	Board of Directors
3:00 – 4.00	Annual Financial Plan Update	Board of Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

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

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9.00
2.	**Apologies for Absence** To receive any apologies for absence	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda, including a full Board of Directors declarations of interest register.	Chair	Report	07	
4.	**Minutes of the meeting held on 29 March 2023** To be agreed as an accurate record.	Chair	Report	10	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	19	
6.	**Staff Story** To receive the international nurse staff story.	Chief Nurse	Verbal	-	9.05

Item	Subject	Lead	Report/ Verbal	Page No	Time
7. 7.1 7.2	**Chief Executive's Report** To receive the: • Chief Executive's Update • The April 2023-24 Trust Priorities Report	Chief Executive	 Report Report	 21 43	9.25
8.	**Risk Management Update – Q4 Board Assurance Framework and Corporate Risk Register** To receive the latest Board Assurance Framework and Corporate Risk Register.	Associate Director of Corporate Governance	Report	76	9.45
Trust Priority: Our People					
9.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 7.2).	Director of Workforce & OD	Item 7.2	-	9.55
Trust Priority: Quality and Safety					
10.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 7.2).	Medical Director/ Chief Nurse	Item 7.2	-	10.05
11.	**CQC Update** To receive an update on the CQC actions.	Chief Nurse	Report	102	10.15
12. 12.1 12.2	**Ockenden Report Update** To receive the report including: • Perinatal Clinical Quality Surveillance report • Maternity Workforce Review Report	Care Group Director of Midwifery	 Report Report	 114 143	10.30

Item	Subject	Lead	Report/ Verbal	Page No	Time
13.	**Q4 Guardian of Safe Hours Report** To receive the report.	Medical Director	Report	155	10.45
14. 14.1 14.2	**Quality and Safety Assurance Committee** To receive the: • March meeting minutes • April meeting exception report	Chair of Committee	 Report Verbal	 To follow -	10.55
Trust Priority: Elective Recovery & Acute Flow					
15.	**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 7.2).	Interim Chief Operating Officer	Report	165	11.00
16. 16.1 16.2	**Digital, Performance and Finance Assurance Committee** To receive the: • March meeting minutes • April meeting exception report	Chair of Committee	 Report Report	 175 182	11.15
Governance					
17.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 7.2).	Finance Director	Item 7.2	-	11.20
18.	**Sustainability Update Report** To receive the report.	Head of Sustainability	Report	186	11.35

Item	Subject	Lead	Report/ Verbal	Page No	Time
19. 19.1 19.2 19.3	**Items for Information** • Executive Committee Minutes (Blue Box) • Star Award nominations (Blue Box) • TPR Mandatory Reporting	All			-
20.	**Any other business including questions from the public**	Chair	Verbal	-	11.50
21.	**Summary of Actions Agreed**	Chair	Verbal	-	
22.	**Time and Date of next meeting** The next meeting held in public will be on 24 May 2023 9:00am.				
23.	**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.				
24.	**Close**				12.00

Item 03

Register of potential conflicts of interest for the Board of Directors 2023/24

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Name	Position	Relevant and material interests						Other
		Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks	Any connection with other organisations
Alan Downey	Trust Chair	Nil	Nil	Nil	Nil	Nil	Nil	Independent Chair – Surrey Mental Health Partnership Board. Spouse works for Price Waterhouse Cooper who work with local authorities.
Simon Morritt	Chief Executive	Nil	Nil	Nil	Trustee – MediCinema (a charity that supports cinemas in hospitals)	Provider member (designate) of Humber and North Yorkshire Integrated Care Board	Nil	Nil
Andrew Bertram	Director of Finance & Deputy Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Heather McNair	Chief Nurse	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Karen Stone	Medical Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Polly McMeekin	Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Melanie Liley	Interim Chief Operating Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Lucy Brown	Director of Communications	Nil	Nil	Nil	Nil	Nil	Nil	Nil
James Hawkins	Chief Digital Information Officer	Nil	Nil	Nil	Nil	Member - Healthcare Information and Management Systems Society	Nil	Nil
Jenny McAleese	Non-Executive Director	Nil	Nil	Nil	Independent Member of Audit Committee – York St John University	Member of Court – University of York	Nil	Nil
Steve Holmberg	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Lynne Mellor	Non-Executive Director	Nil	Nil	Nil	Nil	UNICEF Baby Feeding Institute Guardian for YTHFT	Nil	Nil
Lorraine Boyd	Non-Executive Director	Nil	Nil	Nil	Nil	Trustee – Friends of St Monica	Nil	Nil
Jim Dillon	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Interim Director - Business and Skills for the South Yorks Mayoral Combined Authority

Matt Morgan	Non-Executive Director	Nil	Nil	Nil	Board Member (Director) of York Medical Society	Deputy Dean of Hull York Medical School, Honorary Consultant at Hull University Teaching Hospitals NHS Trust	Nil	Nil
Denise McConnell	Non-Executive Director	McConnell Hollins Limited Yorkshire Collaborative Academy Trust	Nil	Nil	Nil	Nil	Nil	Nil
Ashley Clay	Associate Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Minutes
Board of Directors Meeting (Public)
29 March 2023

Minutes of the Public Board of Directors meeting held on Wednesday 29 March 2023 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:15am and concluded at 12:30pm.

Members present:

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

Stakeholder Non-Executive Director
- Matt Morgan

Associate Non-executive Director
- Ashley Clay

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

Corporate Directors
None

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.

160 22/23 Apologies for absence

Apologies received from:

- Melanie Liley, Interim Chief Operating Officer, Kim Hinton deputising
- Lucy Brown, Corporate Director of Communications

161 22/23 Declaration of Interests

There were no declarations of interest to note.

162 22/23 Minutes of the meeting held on 22 February 2023

The Board approved the minutes of the meeting held on 22 February 2023 as an accurate record of the meeting.

163 22/23 Matters arising from the minutes

The Board noted the outstanding actions which were on track or in progress. Of note:

Action 145 – Director of Workforce and Organisational Developed has drafted a report to be presented to the Executive Committee initially which describes a proposal for a reasonable adjustment policy as one of the outcomes of the patient story. The Executive Committee 3rd May meeting and to subsequently be updated to May Board.

Action 147 – The Board were assured this was in progress for a future Board meeting.

Action 148 – A fixed term position was advertised and interviews were due to take place 5th April.

164 22/23 Patient Story

Jacqueline Felber attended the Board meeting, accompanied by Sarah Ayre, Deputy Head of Midwifery, and presented her experience when she gave birth to her first baby in early 2021 at York Hospital.

Jacqueline detailed a negative experience of pregnancy support and maternity services from about 24 weeks pregnant through to when she and her baby were discharged. There were themes in Jacqueline's experience of being let down by the staff, bullied, dismissed and the systemic issues and pressures influencing staff's behaviour and their language towards her. It was acknowledged that it had taken courage to recall her experience in detail and wasn't easy to write. Jacqueline's account also provided balance, acknowledging and praising the staff who she felt were 'good' and identified the characteristics that made those staff good.

Jacqueline explained that her negative experience was because of systemic issues in the NHS and the Trust and was quick to point out that her complaint was not about specific individuals, but more the poor interactions she, her partner and baby had with staff.
Key points in the experience highlighted:

1. From the outset, an insistence to label Jacqueline as 'risky' because of her age, and inherited conditions.
2. Language around weight, belittling, rude, sarcastic.
3. Informing her of still birth statistics related to age uninvited.

4. Scaremongering, wearing her down, reducing her confidence that she could cope with the birth that lay ahead.
5. “This person I wanted to complain about was the one I had to rely on” – illustrates how disempowered Jacqueline felt.
6. “The NHS is so worried about the worst, and how the worst would impact the NHS, that it doesn’t let you be your best. I and my baby were fine until the NHS broke us.”

After some reflection over a considerable period, and the debrief session following the birth, and motivated by a want for something positive to come from their negative experience, Jacqueline and her partner offered to do some volunteering and to fundraise for blankets (alternative to a heat lamp for jaundice). These offers were met with rude, dismissive comments, and turned down, “The Trust doesn’t use the blankets. What if the Trust can’t afford to buy more of these blankets.” It was after this response that Jacqueline was moved to raise a complaint.

A review/debrief, with Jacqueline, was carried out a few months following the birth (2021), and then a further telephone discussion with a matron a few months later. Jacqueline contacted PALS in June 2022 and raised a formal complaint in December. Sarah Ayre was the investigating officer and in contact with Jacqueline about her experience. Sarah had a discussion with Jacqueline, and they are discussing how Sarah could support Jacqueline to voice her concerns and talk of her experience, which needed to be heard, as it contributed to both quality and service improvements that needed to be made in Maternity services at York.

Sarah had also invited Jacqueline to join the Maternity Voices Partnership (MVP) in Scarborough, which she was happy to do. Sarah’s also suggested that they work together on looking at and revising and improving induction for women and birthing people.

The Board had a detailed discussion around common themes emerging from the story and the staff culture and behaviour and its consequential impact on patients. It was suggested that the patient experience stories could be captured through video or audio and shared with staff through various platforms but acknowledging that all relevant information governance was to be considered. It was also acknowledged that the Board would reinstate its session on culture in the organisation as another outcome of the discussion.

The Board thanked Jacqueline for sharing her story and apologised for the experience she described. They gave assurance that she had been listened to and that the Trust would act on this.

165 22/23 Chief Executive’s Update

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

- NHS staff survey
- Industrial action
- NHS pay offer
- Moving to a single electronic maternity healthcare record
- Elective Recovery
- Annual operational and financial planning for 2023-24
- York Joint Health and Wellbeing Board strategy

The Board touched on the Trust Priorities Report (TPR) and agreed that a further Board development session was required.

Action - Associate Director or Corporate Governance to arrange a further TPR session for the Board.

166 22/23 Risk Management update – Corporate Risk Register

The Board received and noted the Trust's current Corporate Risk Register following review at the March Risk Committee.

The Board discussed non-executive director representation on the Risk Committee which currently comprised of Executive Directors, Associate Chief Operating Officers and the Associate Director of Corporate Governance. It was agreed that this would be discussed and picked up offline.

It was notably good to see movement and trend charts that can illustrate any movement in risks over a period of time (12 months). It was agreed that this would be actioned and included in reporting going forwards.

Concern was raised in relation to the silo of risks in relation to the Assurance Committee's structure, for example there were some risks that were attached to the Chief Operating Officer but would not be presented to the Quality and Safety Assurance Committee due to this and some aspects would require oversight from more than one Committee. It was agreed that there was a need to consider how the committee are structured to address this.

Action – Associate Director of Corporate Governance to address the risk reporting to the Assurance Committees.

167 22/23 Trust Priorities Report: Our People

The Director of Workforce and Organisational Development presented monthly update on workforce recovery detailing its four components agreed through the operational plan:

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

The Board noted the update.

168 22/23 Staff Survey Results

Jenny Flinton, Head of Employee Relations & Engagement attending the Board meeting and presented on the staff survey results for 2022 (presentation enclosed), describing some of the key points of the outcome:

- The national peer averages in this report compare us against the 124 Acute / Acute & Community Trusts in England.
- These results exclude YTHFM as their results are not reported nationally.
- The results are categorised by the seven elements of the NHS People Promise, and the two themes of 'Staff Engagement' and 'Morale'.
- The Trust response rate to the survey increased from 40% in 2021 to 43% in 2022 and is now just below our peer average of 44%.
- The People Promise elements 'We are always learning', 'We work flexibly' and 'We are a team' improved in 2022.

- The elements ‘We are recognised and rewarded’, ‘We each have a voice that counts’, and ‘We are safe and healthy’ remain unchanged.
- The element ‘We are compassionate and inclusive’, plus the themes of ‘Staff Engagement’ and ‘Morale’ all deteriorated.
- Compared to our peer group average only ‘We work flexibly’ is above; ‘We are recognised and rewarded’, We are always learning’ and ‘We are a team’ match the average; the rest are below average.
- ‘Staff Engagement’ is the only theme or element that varied by more than 0.2 when compared to our peers (we are 0.3 below average). Within that theme ‘Advocacy’ is 0.7 below the peer group average.

Board Presentation - Staff Survey Results 2

The Board had a detailed discussion around the result of the survey, questioning the action planning process and how this was being communicated, acknowledging that staff would respond if they can see something is being done as a result of the survey outcome.

The Board shared disappointment in the results and acknowledged greater need to consider what the Trust’s strategy was and the values and behaviours framework and consequently how those are embedded into the organisation.

Following a discussion around next steps, the Board agreed that another series of transactional interventions was not going to support any improvement. The Board agreed to an offline discussion around an appropriate time to hold a Board discussion (ideally as soon as possible) on what was going to support the Trust with something different to what has been tried previously which was more than a series of transactional interventions but recognising that there may be cost implications to consider as an outcome.

169 22/23 Gender Pay Gap Report

Virginia Golding, Head of Equality, Divesity and Inclusion (EDI) and WRES Expert and Amara Ashraf, Workforce Systems Manager attended the meeting to present the report. The Board noted that the Trust’s Gender Pay Gap had reduced since 2022 but there were areas of focus that were causing the main disparities. These were at:

- AFC bands 1, 8a, 8b, 8c and VSM
- Bonus pay for consultants
- Core trainees and Trust doctors and dentists

The Board noted the Agenda for Change Staff Headcount figure noted in the report for 2022 (73802) required updating before publication of the report on the Trust website.

The Board requested that data be seen earlier as it was a concern that data reported was a year out. It was suggested that 2023 snapshot data be shared with the Board ideally May /June. It was agreed that date reporting timetables would be discussed to agree appropriate delivery to the Board ensuring earlier sighting of the data was available in future.

170 22/23 Nurse Staffing Report

The Board received the nurse staffing report and noted how the Trust had responded to provide the safest and effective nurse staffing levels during December 2022 and January 2023. The Board were assured that the nursing establishments had been reviewed utilising best practice guidance and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce were in place.

There were no challenges or comments on the report.

171 22/23 People and Culture Assurance Committee

The Board received and noted the January minutes and March escalation report of its People and Culture Assurance Committee.

There were no challenges or comments of note.

172 22/23 Trust Priorities Report: Quality and Safety

The Board received the monthly update relating to quality and safety.

There were no challenges or comments of note.

173 22/23 CQC Update

Heather McNair presented the report and provided the Board with an update position in relation to the actions being taken in the Trust to address the CQC regulatory conditions. Heather advised that the CQC had lifted the Section 29A warning notices that were in place for York Medicine and Scarborough Emergency department. The section 31 conditions of registration remained in place for Maternity and the Emergency Departments (mental health risk assessments). The Board acknowledged that the CQC had requested an assurance report in relation to the Mental Health Risk assessments, to enable them to consider removal of the condition. The Trust continued to submit assurance reports to the CQC each month in response to the Section 31 warning notice for Maternity.

The Board acknowledged that the lifting of Section 29A provided some positive assurance and marked some improvement.

174 22/23 Ockenden Report Update

The Board received the report and noted:

- Working towards a single maternity improvement plan which addresses the three main national maternity services priorities alongside the CQC KLOEs. The single improvement plan will also prioritise the actions on going by the service to address the areas identified by the CQC inspections in October and November 2022 communicated via the section 31 letter received in November 2022, as requiring immediate improvement action. The single improvement plan has received additional support from the NHS England regional maternity team and is overseen by the Maternity Transformation Programme Board.
- A Strategic Improvement Director as of February 2023 is also now in post and supporting with the creation of a single focused well led and well-resourced improvement plan.
- The workforce and leadership review of the future requirements of the midwifery structure needed to support the aim of the service by embedding the objectives of the single improvement plan continued.

The Board noted that following the CQC visits the Trust had responded to identified improvement requirements to its maternity and emergency services at additional cost. To date this amounted to £370k which was contributing to the overall adverse financial position.

A lot of external support had been embraced by the teams and have gained a lot from that. It was questioned how widely the information on progress had been shared with staff and although there is a monthly update sent to maternity staff from Non-executive Director Lorraine Boyd, the Board suggested the Director of Communications considers a wider communication method to share the monthly update on the services.

175 22/23 Quality and Safety Assurance Committee

The Board received and noted the February minutes and March escalation report of its Quality and Safety Assurance Committee.

The Board discussed remaining an outlier for Hospital Acquired Infections and questioned whether there needs to be an acceptance of the level of HPV that there is or could there be more done to improve. The Board acknowledged a session on IPC had been planned for the Board and agreed to invite Damian Mawer, Specialty Registrar in Infectious Diseases and Medical Microbiology (who had previously presented on IPC) back to present a broader ranging discussion on Infection Prevention but requiring input from other areas to determine how to manage this risk.

176 22/23 Trust Priorities Report: Elective Recovery and Acute Flow

Kim Hinton, Deputy Chief Operating Officer presented the report, highlighting:

- An improved end of March position for 78 weeks compared to the trajectory of 397
- Remained off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 219 against a target of 128 for February, this was an improved position and represents a reduction of 116 patients compared to the end of January 2023
- Submitted the first iteration of the activity and performance plan.
- The level of activity identified to date equated to circa 104% of 19-20 activity levels which contributed to the overall target of achieving 109% of 19-20 activity that had been requested of the ICB.

177 22/23 Digital, Performance and Finance Assurance Committee

The Board received and noted the February minutes and March escalation report of its Digital, Performance and Finance Assurance Committee, highlighting the concern around RTT.

The Board noted the discussion around Electronic Patient Records and key to the success of deployment and adoption was to move to a paperless strategy which the Board were asked to support. The Board were asked to review and discuss the current 'paper light strategy' and lead the way on e.g. the process, system, culture change needed for adoption of a paper light strategy across the Trust. It was suggested and agreed that this becomes part of the strategic mix when considering both the priorities and long-term strategy for the Trust. The Board agreed to hold a session on 5-year strategy planning.

Action - Associate Director of Corporate Governance to arrange a Board Priorities and 5-year Strategy Planning session.

178 22/23 Finance Update

Andrew Bertram presented the report and update the Board on the income and expenditure position. He advised that there was an actual adjusted deficit of £2.3m against a planned deficit of £0.1m for February. The Board noted that the Trust was £2.2m adversely adrift of plan which represented an improvement of the position reported in prior months. The largest adverse variance related to pay at £15.1m. Premium rate pressures linked to vacancies and high sickness levels are continuing to contribute to the adverse position. Andrew highlighted that funding had been confirmed for the unfunded pay award and this was now factored into the reported position. Whereas previously the position was impacted by the cost of the unfunded mobile CT scanner (£1.4m in a full year) that the Board agreed to continue to support because of the safety impact associated with our diagnostic waiting times. The Board noted that the Trust was to receive funding from the Humber and North Yorkshire Integrated Care Board (ICB) to cover this, and this was now factored into the reported position. As previously noted, following the CQC visits the Trust had responded to identified improvement requirements to its maternity and emergency services at additional cost. To date this amounted to £370k 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 £4.1m (£2.7m relating to out of tariff drugs with compensating additional income from NHSE), an overspend on other costs of £4.6m (including particularly a pressure on utilities of £1.8m due to the further price increases seen last autumn) and a CIP shortfall of £0.5m with some compensation from an underspend on clinical supplies and services of £6.5m. Also of note was that the Trust spent £8.5m for the year to date on covid costs compared to a plan of £6.9m and consequently were £1.6m adversely adrift of the covid plan.

179 22/23 Audit Committee

The Board received and noted the Group Audit Committee escalation report from its March meeting.

Jenny McAleese, Chair of the Group Audit Committee, summarised the Committee's discussion around the process of escalation and risks facing the Trust linking with the Board Assurance Framework (BAF). Sub-committees of the Board were routinely escalating items to the Board but doesn't always result in action by the Board. Jenny requested that the Board reviews the system of escalation with a view to ensuring that something happens as a result of an issue being escalated.

In terms of risks, Jenny highlighted the there was concern that the Board and sub-committee agendas were not focussing sufficient time and attention on identifying risks and managing these. More proactive use of the BAF would likely assist this and it was suggested that consideration be given to review the BAF at Board on a monthly basis. It was agreed that Jenny, Mike Taylor and Alan Downey discuss this further offline.

180 22/23 Governance Framework

The Board received and noted the revised Standing Financial Instructions and approved the amendments proposed.

The Board received and noted the YTHFM Reservation of Powers and Scheme of Delegation and Standing and approved the updated reports.

181 22/23 Governance Policies

The Board received the Risk Manager Strategy and Policy, approving subject to the risk appetite session in March.

The Board received and noted the Modern Slavery Declaration and approved for publication on the Trust's website.

The Board received and approved the YTHFM Health & Safety Policy.

182 22/23 Any Other Business

There was no other business discussed.

183 22/23 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 26 April 2023.

Item 05

Action Log – Board of Directors (Public)

Action Ref.	22/23 Old Action Reference (if relevant)	Date of Meeting	Minute Number Reference	Title	Action (from Minute)	Executive Lead/Owner	Update / comments	Due Date	Status
BoD Pub 01	**101**	02 November 2022	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	25.01.23 - scheduled for August (will be September due to no Board in August)	Sep-23	Green
BoD Pub 02	**145**	22 February 2023	142 22/23	Staff Story - Matthew (Matt) Miller-Swain	Director of Workforce and Organisational Development to report back to a future Board meeting on education and training for managers in relation to practical support available and their responsibility to support team members with disabilities.	Director of Workforce and Organisational Development	29.03.23 - Director of Workforce and Organisational Developed has drafted a report to be presented to the Executive Committee initially which describes a proposal for a reasonable adjustment policy as one of the outcomes of the patient story. The Executive Committee 3rd May meeting and to subsequently be updated to May Board.	May-23	Green
BoD Pub 03	**146**	22 February 2023	143 22/23	Chief Executive's Update	Ellen Armistead to attend and present at an upcoming meeting of the Board of Directors.	Chief Executive & Associate Director of Corporate Governance		Apr-23	Green
BoD Pub 06	-	29 March 2023	165 22/23	Chief Executive's Update	Associate Director or Corporate Governance to arrange a further TPR session for the Board.	Associate Director of Corporate Governance		TBC	Green

BoD Pub 07	-	29 March 2023	166 22/23	Risk Management update – Corporate Risk Register	Associate Director of Corporate Governance to address the risk reporting to the Assurance Committees.	Associate Director of Corporate Governance		TBC	Green
BoD Pub 08	-	29 March 2023	177 22/23	Digital, Performance and Finance Assurance Committee	Associate Director of Corporate Governance to arrange a Board Priorities and 5-year Strategy Planning session.	Associate Director of Corporate Governance		TBC	Green

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Chief Executive's Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Simon Morritt, Chief Executive

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

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

Trust Priorities	Board Assurance Framework
☒ Our People ☒ Quality 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 an update to the Board of Directors from the Chief Executive in relation to the Trust priorities. Key areas include: Industrial action and pay consultation, travel and transport, elective recovery, annual operational and financial planning 2023/24, The NHS Delivery and Continuous Improvement Review, and The Hewitt Review.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

Board of Directors only

Meeting	Date	Outcome/Recommendation
Board of Directors	26 April 2023	

Chief Executive's Report

1. Our People

1.1 Industrial action

BMA Junior Doctors' industrial action
The second round of industrial action for junior doctors took place this month, with 96 hours of continuous action.

Junior doctors make up 49% of our medical workforce, therefore it is inevitable that this action has an impact on the activity we can deliver, particularly as it was timed immediately after a four-day bank holiday weekend and during the Easter holiday period.

Thank you once again to our consultants, SAS doctors and everyone else who worked differently to provide support and cover to help ensure our junior doctors feel safe to exercise their right to strike.

Agenda for Change pay offer consultation update
All unions in the NHS Staff Council are voting on the government's offer. While NHS workers who belong to UNISON voted decisively to accept the pay offer from the government, the RCN voted to reject the offer, and as such they remain in dispute.

The RCN has called for negotiations with the government to resume immediately over pay, however in the meantime, they have announced further strike action to take place round-the-clock from 8pm on 30 April to 8pm on 2 May. There will be no national derogations in this round of strike action, and as it coincides with the next Bank Holiday, it is highly likely to cause disruption.

A collective meeting of the NHS unions and the government is planned for 2 May.

1.2 Travel and transport

At the end of last month we announced change to travel and transport arrangements for staff and visitors, including revised criteria for staff car parking permits.

As with any major change, we have received lots of feedback, and listening to this is an important part of the process.

In response to this we have further developed the permit criteria to address the main concerns raised, particularly by staff on the East Coast who live some distance from a site and do not have public transport options.

In addition, to help manage issues related to the permit criteria we have agreed to introduce an exceptions panel to consider extraordinary permit applications from people who fall outside of the standard criteria, but who may have a case of need for either a temporary or permanent permit.

In relation to patient and visitor parking, the introduction of automated number plate recognition (ANPR) in Bridlington, York and Scarborough has been successfully completed.

Whilst it is early days the feedback received so far from users has been positive. The congestion on the York site and surrounding roads has also markedly reduced, which is an important benefit for local residents as well as those accessing the site.

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1.3 Cultural awareness week

The trust's Cultural Awareness week runs from 24 – 29 April. This is the second such event for the trust with events primarily aimed at York-based staff following the hugely successful first week in Scarborough last year, although of course anyone is welcome to get involved.

It is a truly fantastic way to celebrate our cultural diversity. The week also aims to promote social inclusion, awareness, and a feeling of belonging.

There is a full programme of activities across the week, closing with a Family Day on Saturday 29 April in Bootham Park, which everyone is invited to attend. Please do take the opportunity to take part of you are on site, it promises to be a great week!

2. Elective Recovery

There is opportunity to discuss operational performance at a later stage in the agenda, however as part of my report I will share the headlines of our year-end position in relation to elective recovery.

At year end we have no patients waiting 104 weeks. Our original trajectory for patients waiting 78 weeks or more was 397 patients, and we ended the year well ahead of this with 193 patients. We have declared that we will have no patients waiting 78 weeks or more by the end of June, and this trajectory has been approved through the tier 1 meeting. We have also agreed to deliver a target of 0 patients waiting longer than 65 weeks by the end of March 2024.

For 62 day cancer standard we finished the year with 162 patients exceeding the 62 days, ahead of our forecast trajectory of 219 patients. Whilst this is still behind the target of 121 patients, this is best performance we have seen since we began tracking this metric in February 2021. As a consequence of our improved performance we have been moved into tier 2 for cancer. We remain in tier 1 for elective recovery.

3. Governance

3.1. Annual operational and financial planning for 2023-24

Work is ongoing to develop both the trust's plan and the ICB's plan, in partnership with the other organisations in our ICS. The latest draft of the plan was submitted as per the NHS England timetable, however we continue to be in discussions with the ICB to reach a final plan for 2023-24.

As briefed last month, significant demands remain on wider NHS funding, indicating that next year is likely to be particularly challenging.

3.2. NHS Delivery and Continuous Improvement Review

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In April 2022 NHS Chief Executive Amanda Pritchard commissioned the review to consider how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium and long term.

The headline recommendations are to:

1. Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work
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The review has identified six key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

The government is now considering the recommendations.

Date: 26 April 2023

Chief Executive's Report

1. Our People

1.1 Industrial action

BMA Junior Doctors' industrial action
The second round of industrial action for junior doctors took place this month, with 96 hours of continuous action.

Junior doctors make up 49% of our medical workforce, therefore it is inevitable that this action has an impact on the activity we can deliver, particularly as it was timed immediately after a four-day bank holiday weekend and during the Easter holiday period.

Thank you once again to our consultants, SAS doctors and everyone else who worked differently to provide support and cover to help ensure our junior doctors feel safe to exercise their right to strike.

Agenda for Change pay offer consultation update
All unions in the NHS Staff Council are voting on the government's offer. While NHS workers who belong to UNISON voted decisively to accept the pay offer from the government, the RCN voted to reject the offer, and as such they remain in dispute.

The RCN has called for negotiations with the government to resume immediately over pay, however in the meantime, they have announced further strike action to take place round-the-clock from 8pm on 30 April to 8pm on 2 May. There will be no national derogations in this round of strike action, and as it coincides with the next Bank Holiday, it is highly likely to cause disruption.

A collective meeting of the NHS unions and the government is planned for 2 May.

1.2 Travel and transport

At the end of last month we announced change to travel and transport arrangements for staff and visitors, including revised criteria for staff car parking permits.

As with any major change, we have received lots of feedback, and listening to this is an important part of the process.

In response to this we have further developed the permit criteria to address the main concerns raised, particularly by staff on the East Coast who live some distance from a site and do not have public transport options.

In addition, to help manage issues related to the permit criteria we have agreed to introduce an exceptions panel to consider extraordinary permit applications from people who fall outside of the standard criteria, but who may have a case of need for either a temporary or permanent permit.

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Date: 26 April 2023

NHS England

NHS delivery and continuous improvement review: recommendations

How can improvement-led delivery enhance the quality of outcomes for our patients, communities and our health and care workforce?

19 April 2023

Publishing ref: PRN2137

Contents

Foreword

Our health and care systems have navigated the impact of an unprecedented global pandemic, which has taken its toll on our workforce, our communities and the services we deliver. Current challenges across the NHS in its immediate aftermath have posed the question of how we use learning to effectively and systematically deliver real-time improvements at scale and at pace on our shared priorities, while developing the capacity and capability of the service to improve over time.

As a result, I was asked to lead the delivery and continuous improvement review in April 2022, to consider how the NHS can develop a culture for continuous improvement while focusing on its most pressing priorities.

NHS England understands that its role is to support and champion providers and systems in delivering for people (both those who deliver and use our services) and cannot do this in isolation. To this end, while NHS England has co-ordinated this review, its content has been co-designed by engagement with more than 1,000 patients, health and care leaders including clinicians and frontline staff, managers, improvement leads, senior executives across local government, the VCSE sector, NHS providers, ICSs, regional and national teams, and the Care Quality Commission.

We felt these partnerships were crucial in ensuring that recommendations were driven by those who deliver and receive NHS services, and that this document was relevant and reflective of your experiences.

The outcome of this review is 10 recommendations that have been consolidated into three actions, which collectively have the potential to provide immediate practical support to meet the short- and medium-term challenges outlined. This document is not intended to be static. In fact, it will be refined and iterated as we receive feedback from its users on how it has been used, and where it can be improved.

Over the last year, I have been overwhelmed by the interest in this work which I believe has the capacity to give not only hope, but real benefit to every layer of our health and care system, every staff member and every patient.

Together we can learn and embed process improvement, building clinical leadership for results and in doing so address the unwarranted variation in care.

We look forward to taking the next steps with you on this continuous improvement journey.

Anne Eden, Regional Director South East, NHS England

Review findings at a glance (1)

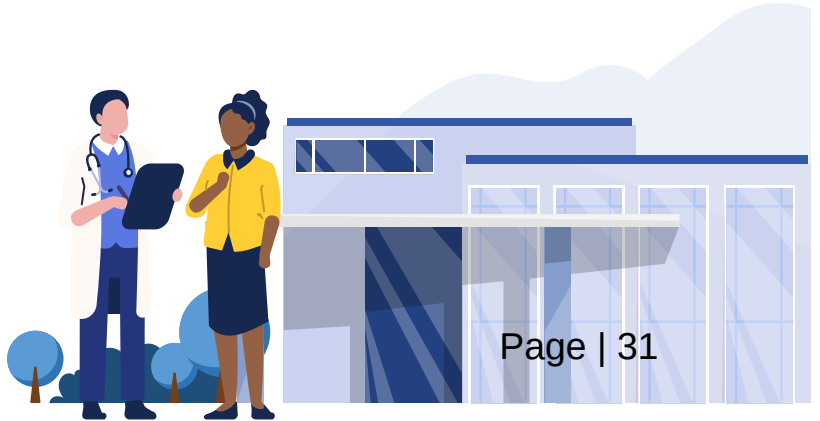
The delivery and continuous improvement (DCI) review considered how the NHS, working in partnership through integrated care systems (ICSs), delivers on its current priorities while continuously improving for the longer term. We know that focusing on improvement, as an essential component of quality, enables us to achieve more consistent, high-quality care. The review team explored how we 'improve with purpose', using all the assets at our disposal: data and evidence, digital transformation and the skills and experience of our health and care workforce.

Having assessed the current approach to delivery-led improvement both within NHS England and more widely, the review team made 10 recommendations which were endorsed by NHS England's Executive Group (outlined in this report). NHS England's Board has now consolidated these recommendations into three actions:

1. Describe a single, shared **NHS improvement approach**. NHS England will set an expectation that all NHS providers, working in partnership with their integrated care boards, will embed a quality improvement method aligned with the improvement approach to support increased productivity and enable improved health outcomes. This will require a commitment from NHS England itself to work differently, in line with the improvement approach and the new Operating Framework.

2. Co-design with our health and care partners a **leadership for improvement programme**, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.

3. Establish a **national improvement board**, to agree the small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work, with national co-ordination and regional leadership. The new board will support more consistent, high-quality delivery of services to improve performance and reduce unwarranted variation.



Review findings at a glance (2)

NHS England's structures and governance

do not yet optimise our ability to focus on a small number of shared national priorities effectively. Creating the new NHS England gives us the opportunity to bring together specialist delivery and improvement resource in a centrally co-ordinated, regionally-led way, with delivery of improvements through systems

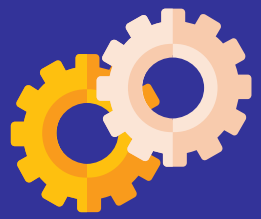
Effective improvement-led delivery of shared national priorities

requires NHS England to invest in a new approach to engaging with clinicians and operational managers at the point of care. We now need to develop a new model for how we tackle improvement challenges system-wide, sharing our learning and good practice more effectively.

A systematic approach to improvement

is embedded in many NHS organisations that deliver consistent, high-quality services with improved patient outcomes. All evidence-based quality improvement methodologies share common principles. We now need to support all leaders across providers and integrated care systems to embed those principles in practice.

Improvement methodology is important



to support a focus on improved quality and better patient outcomes. But it isn't enough. Our quality improvement efforts need to be focused on our most pressing operational and strategic challenges, within an overall focus on quality across planning, improvement and assurance.

There are further opportunities to support our most challenged organisations and systems

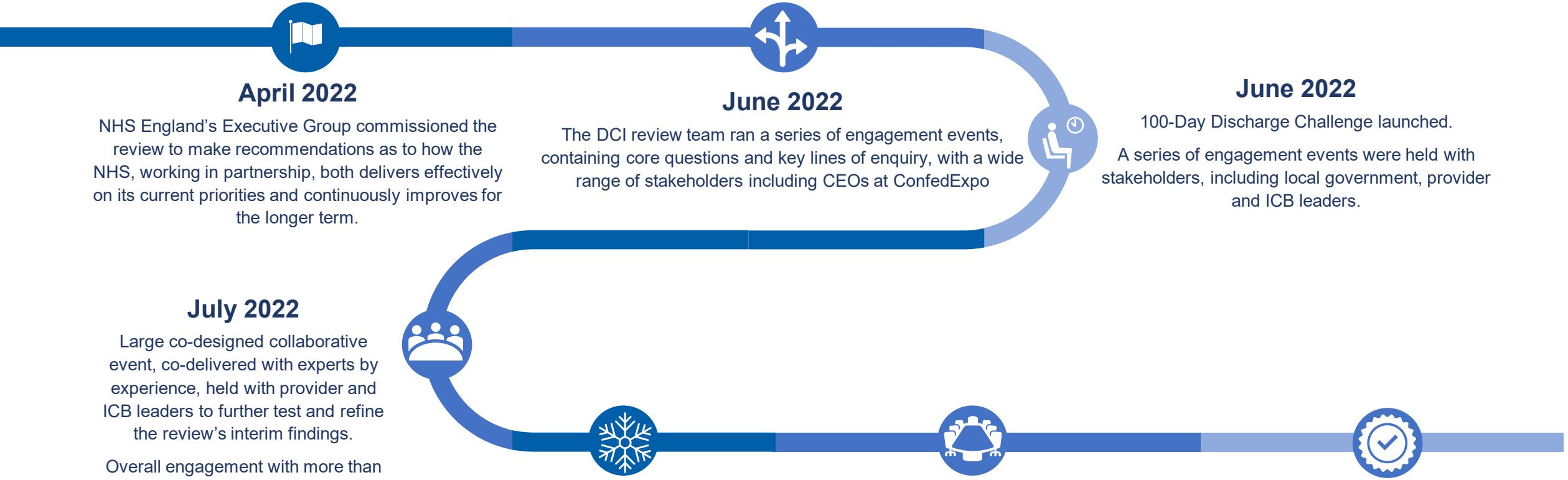
more consistently and effectively. During the DCI review, people told us that NHS England's recovery support programme works well and marks a positive shift from the previous special measures regime. We increasingly need to focus on earlier intervention for support and sustainable improvement.

NHS England can do more to provide credible and practical support for improvement-led delivery.

NHS England has a key role to incentivise a universal focus on embedding and sustaining improvement practice across our providers and integrated care systems. This includes regulatory incentives alongside clearer and more timely offers of support.

Background to the DCI review

In April 2022 Amanda Pritchard requested a review of the way in which the NHS, working in partnership, delivers effectively on its current priorities while developing the culture and capability for continuous improvement. Led by Anne Eden, NHS Regional Director South East, with a steering group chaired by Sir David Sloman, Chief Operating Officer, NHS England, the review team co-developed 10 recommendations with health and care leaders that have been consolidated into 3 actions.



April 2022

NHS England's Executive Group commissioned the review to make recommendations as to how the NHS, working in partnership, both delivers effectively on its current priorities and continuously improves for the longer term.

June 2022

The DCI review team ran a series of engagement events, containing core questions and key lines of enquiry, with a wide range of stakeholders including CEOs at ConfedExpo

June 2022

100-Day Discharge Challenge launched.

A series of engagement events were held with stakeholders, including local government, provider and ICB leaders.

July 2022

Large co-designed collaborative event, co-delivered with experts by experience, held with provider and ICB leaders to further test and refine the review's interim findings.

Overall engagement with more than 1,000 health and care leaders.

Endorsement of the review's final lines of enquiry by NHS England Executive Group.

September 2022

100-Day Discharge Challenge concluded.

Winter Collaborative launched.

October 2022

The review's findings were presented at the NHS England leadership event with ICB and provider chief executives. The review reported its findings and 10 recommendations to NHS England's Executive Group.

February 2023

NHS England's Board consolidated the 10 recommendations into three actions.

The three NHS England actions

Three actions formed from the consolidation of the DCI review's initial recommendations

	NHS improvement approach	Leadership for improvement programme	National improvement board
What is it?	Universal application of one shared high level 'NHS approach to improvement' to draw and build on the best approaches to organisational quality assurance, planning and improvement and to support increased productivity and enable improved health outcomes.	A leadership for improvement programme, commissioned and supported by NHS England, enrolling all providers and systems (including primary care) in it to support a whole-system focus on improving healthcare outcomes with our workforce, patients and communities.	A board that sets the direction for improvement-led delivery across the NHS, working with our partners. The scope and remit of the board will be informed by the new Operating Framework, with a focus on local delivery through system-working, with regional leadership and national co-ordination.
What does it mean?	All NHS providers, working in partnership with their integrated care systems, will embed an improvement method and culture aligned with the NHS improvement approach. This includes acute, community, mental health, primary care and ambulance providers.	It will create a more standardised approach to supporting providers and systems with shared priorities across England. It will help to support our most challenged organisations and systems more consistently and effectively by offering focused board level training.	It will agree a small number of shared national priorities and oversee the development and quality-assure the impact of the NHS improvement approach across all providers and systems.

NHS improvement approach

The NHS improvement approach

NHS England

NHS England will set an expectation that all NHS providers, working in partnership through integrated care systems, will embed a quality improvement method aligned with the NHS improvement approach. This will inform our ways of working across services at every level of place: primary care networks, local care networks, provider collaboratives and integrated care systems. It will require a commitment from NHS England itself to work differently, in line with the new NHS operating framework.

Drivers and enablers:

- Co-production with people and communities
- Clinical leadership
- Workforce, training and education
- Digital transformation (including federated data platform and model health system)
- Addressing health inequalities

Building a shared purpose and vision
Our workforce, trainees and learners understand the direction and strategy of the organisation/system, enabling an ongoing focus on quality, responsiveness and continued learning

Building improvement capability
All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration

Developing leadership behaviours for improvement
A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by our Boards and Executives

Investing in culture and people
Clear and supported ways of working, through which all staff are encouraged to lead improvements

Embedding a quality management system
Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence

Context: the evidence for improvement-led delivery

What is improvement-led delivery?

Improvement-led delivery involves a whole-system (or whole-organisation) focus on quality, using evidence-based quality improvement methods to increase productivity and deliver better health outcomes for patients and communities. It is underpinned by the use of data and measurement to achieve these outcomes.

Improvement-led delivery and people and communities

In organisations where improvement-led delivery has been embedded, the needs of people and communities have remained at the centre and resulted in the following:

- **Increased engagement:** People (patients and staff) have been involved in new improvement projects focused on organisational priorities, with outcomes informing the future of service provision. This has contributed to reduced health inequalities and PALS complaints and improved feedback.
- **Increased patient awareness:** Results of improvement initiatives are made visible to patients and in turn accelerates implementation.
- **Evaluation of improvement ideas:** Patients are able to support testing and evaluation of improvement ideas, before they are delivered more widely.

NHS University Hospitals Sussex NHS Foundation Trust

University Hospitals Sussex NHS FT fall reduction programme oversaw a 30% reduction in in-hospital falls.

NHS East London NHS Foundation Trust

Increase in accepted referrals for early intervention psychosis from 21% to 62% using improvement principles.

Improvement-led delivery and our health and care workforce

Our health and care workforce are tired, having supported people and communities through one of the toughest periods in the NHS's history. Organisations where improvement-led delivery has been embedded have noted the following:

- **Empowerment:** The workforce, including clinical leaders, have been engaged and equipped with the tools, routines and autonomy to drive improvements.
- **Purpose and direction:** The workforce is aligned in how their work feeds into the organisation and / or system's strategy, contributing to improved staff survey scores.
- **Improved staff morale:** They are encouraged to work on a small number of priorities that align with national and regional priorities.

NHS Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS FT finished in the top 5 and 3 nationally in the NHS Staff Survey for questions related to empowerment to make changes and improve.

NHS Surrey and Sussex Healthcare NHS Trust

SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.

What is the evidence?

Improvement-led delivery is a long term approach to delivery that facilitates stronger organisational governance, productivity and positive cultural change over time. Many parts of the NHS have a long tradition of embedding approaches focused on quality improvement:

Alder Hey Children's NHS Foundation Trust

- Jumped from a baseline patient experience score of 59% at the beginning of the approach in 2020 to 92% in August 2022.
- 20% reduction in administration and prescribing errors for 2021-2022.
- HR time-to-hire fell from 68 to 28 days.

Surrey and Sussex Healthcare NHS Trust

- Consistently rated "Outstanding" by CQC since 2019.
- SASH+ improvement work is embedded across the organisation with leaders ranging from AfC Band 4 to executives able to train and coach their own staff.
- Collaborative quality improvement award in 2021 for their ICU clinic, increasing patient experience.

Berkshire Healthcare NHS Foundation Trust

- Rated "Outstanding" by the CQC since March 2020. CQC commented that 'staff across the trust felt valued and there was a real focus on doing what was best for staff, patients and carers'.
- NHS Staff Survey results were in the top 20 percent of scores.
- Reduced prone restraint use in adult acute and children settings by 61% in 15 months.

University Hospitals Sussex NHS Foundation Trust

- Transitioned from "Quality / Financial Special Measures" to "Outstanding" on all sites in all domains in 2019.
- The CQC noted exceedingly high 'buy in' from staff.
- Fall reduction programme oversaw a 30% reduction.
- Reduced 24 hour delayed discharges by as much as 75%.

East London NHS Foundation Trust

- Consistently rated "Outstanding" by CQC.
- A Total Quality Management System has been embedded. This applies across quality planning, assurance and improvement.
- Increase in accepted referrals for early intervention psychosis utilising improvement methods.

The Leeds Teaching Hospitals NHS Trust

- Rated "Good" by the CQC, improved from "requires improvement".
- Transitioned from a £100m deficit to a £19m surplus.
- 26% reduction in falls across the organisation - equating to approximately 65 falls per month and 780 falls per year.

Appendices

These DCI review's 10 recommendations were presented to NHS England's Executive Group in October 2022

Create a more standardised approach to shared priorities across England

1. NHS England's Executive Group will agree a small number of more consistently executed priority improvement initiatives, offering national co-ordination and regional leadership to support delivery.
2. NHS England will consolidate capability and expertise into a national priority improvement function, whose role is to co-ordinate action on a small number of pan-national improvement priorities on a rolling basis.
3. NHS England will test the model for the new priority improvement function through delivery of a winter collaborative. Action co-ordinated through the winter collaborative will be codified into more standardised approaches to delivery and improvement to support the spread and scale of learning.

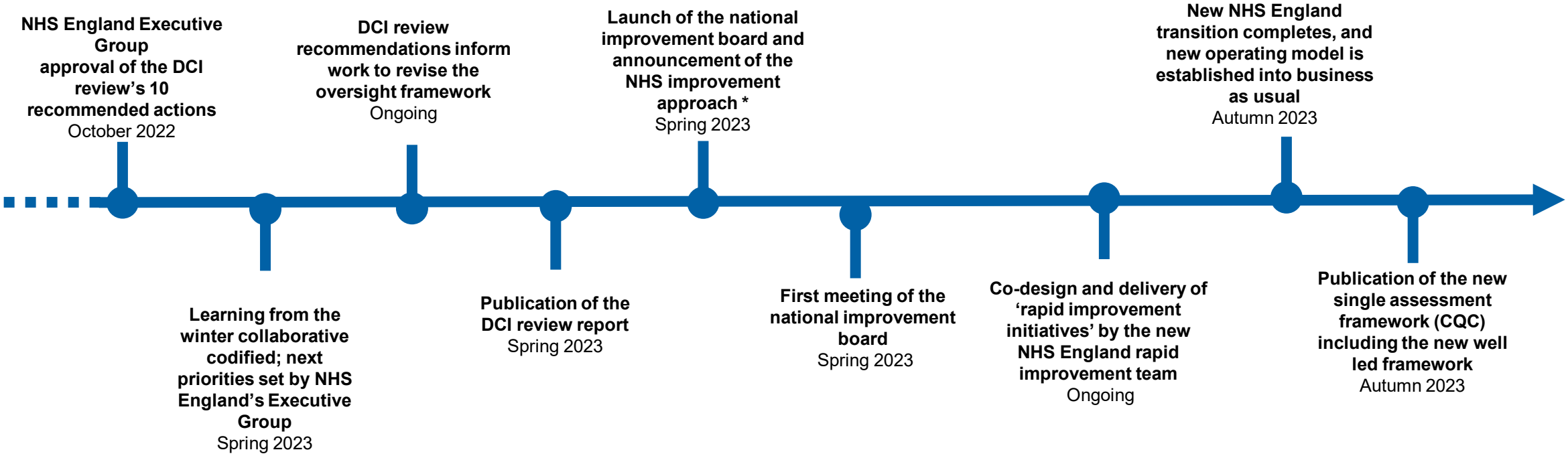
Embed continuous improvement-led delivery across all providers and integrated care systems

4. NHS England will set an expectation that all NHS providers, working in partnership with integrated care boards, will embed a quality improvement method aligned with the NHS improvement approach.
5. NHS England will collaborate with partners to co-develop leadership development products that support health and care boards, executives and the wider workforce to embed the NHS improvement approach in their organisations and systems.
6. NHS England will work with the CQC to align the revised CQC well-led with the improvement approach.
7. NHS England will critically review the NHS oversight framework, to incentivise providers and systems to embed improvement-led delivery.

Support our most challenged organisations and systems more consistently and effectively

8. NHS England's Support for Challenged Systems team will work with and through the regions to more consistently co-ordinate intensive support. This will include continued collaboration with other regulators and royal colleges to ensure consistent support and no duplication.
9. Further develop peer support between providers and systems, including through enhanced support for provider collaboratives programmes and pre-existing provider peer support networks.
10. NHS England will review the balance of national and regional resources between intensive support, pathway programmes and general capacity building. This will include an assessment of how national and regional teams more consistently support organisations in segment 3 and offer longer-term support to organisations exiting segment 4.

Proposed timeline for implementing the three actions



*** 19 April 2023: Publication of this Delivery and Continuous Improvement Review at NHS England's NHS leadership event with ICB and trust CEOs**

DCI review method and engagement process

The review team gathered evidence and insights directly from more than 1,000 people across the health and care system. Participants who have provided their insights and feedback include:

- Lived experience partners through NHS England's experience of care team
- ICB chief executives and non-executive directors (NEDs)
- Provider chief executives and NEDs
- Clinical leaders and people working at the point of care, such as nurses, GPs, consultants, and pharmacists
- Strategic roles including operational, improvement and transformation specialists
- ALB partners and collaborators, such as AQUA, CSUs and Health Data Research UK
- Networks, think tanks and academics, such as Q community, The King's Fund, and The Health Foundation.
- National bodies, such as CQC, local government representatives, and NHS Confederation
- Regional groups, such as local health and social care partnerships, and Academic Health Science Networks
- NHS England national and regional teams

Emerging insights were reported to the review's fortnightly steering group chaired by Sir David Sloman and Anne Eden.

During the course of the review, we provided inputs into several concurrent work programmes, seeking to align our emergent findings where appropriate. These included:

- The operating framework programme
- The Creating the new NHS England change programme
- Finance and productivity board
- NHS England business planning and guidance

The review team did not undertake original quantitative research or analysis. It focused on collating and considering existing research and evidence to inform our recommendations.

While we have set out implementation plans to sit alongside these recommendations, we recognise that:

- our recommendations are closely interdependent with the ongoing NHS England change programme, which will shape how NHS England's operating framework is realised.
- full implementation of our recommendations across the NHS (and, in time, health and care systems) will require ongoing co-design between national and regional teams with leaders in systems and providers as well as wider partners, using a collaborative approach centred on learning.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

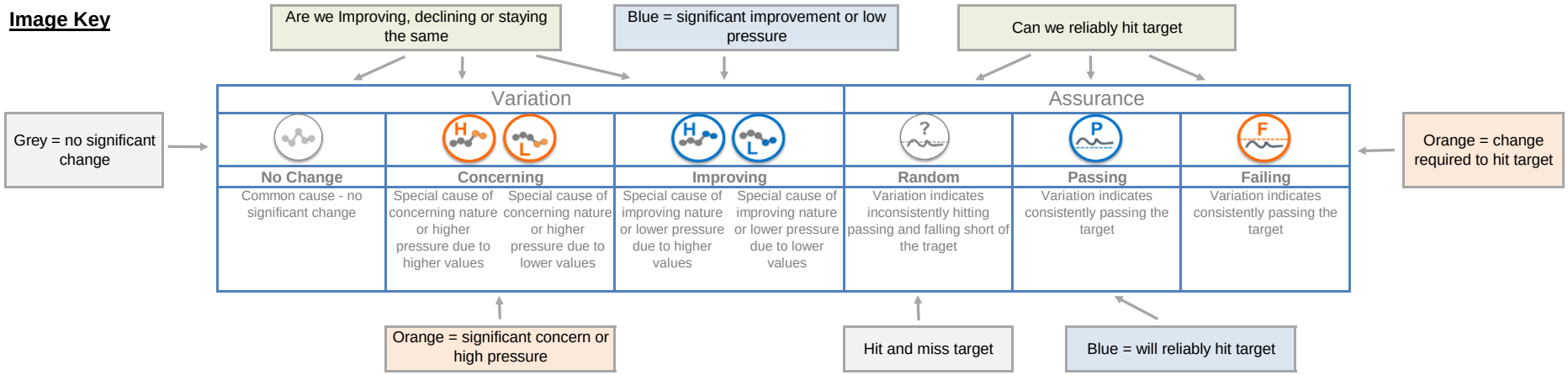
April 2023

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

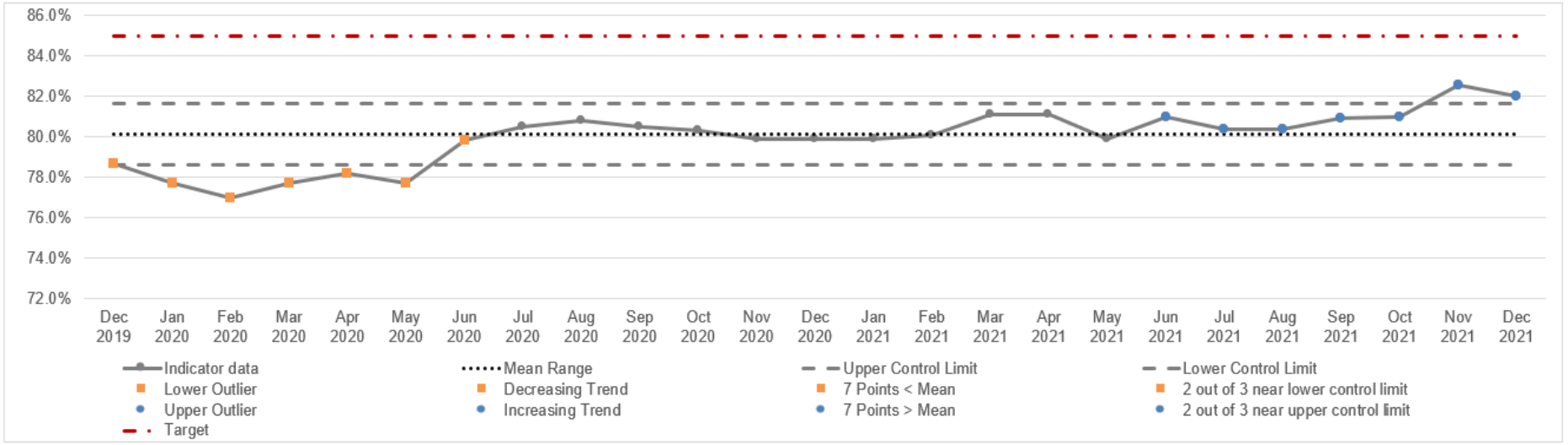
York and Scarborough Teaching Hospitals NHS Foundation Trust

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



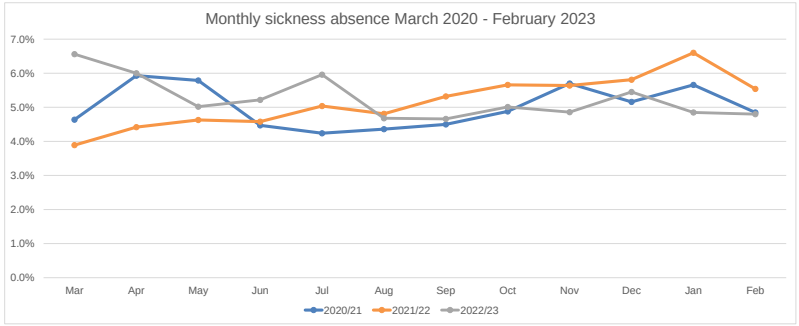
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

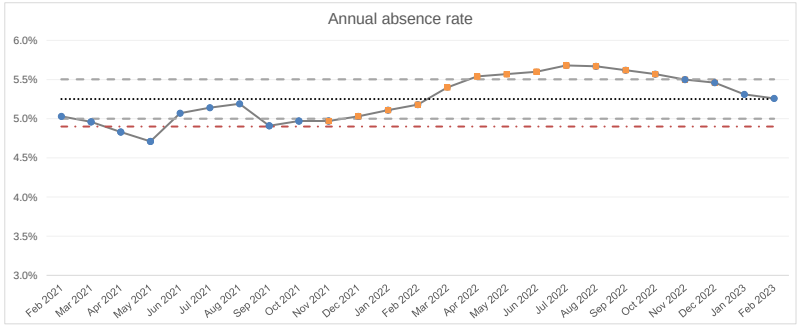
OUR PEOPLE - Sickness Absence and Staff Survey

York and Scarborough Teaching Hospitals NHS Foundation Trust

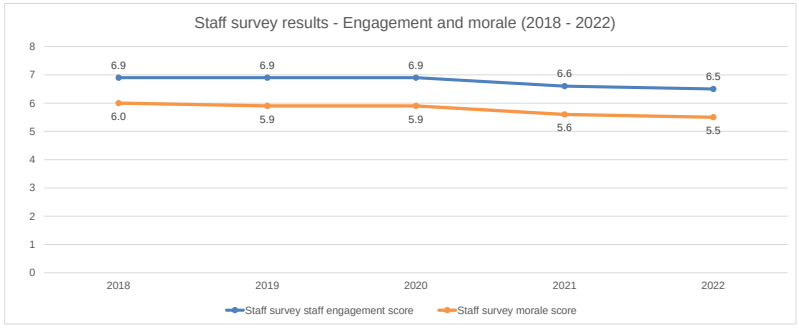
REPORTING MONTH : MARCH 2023



Feb 2023
4.80%
Target
No Target
Variance
Assurance



Dec 2022
5.46%
Target
4.90%
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



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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 Feb 2023 (4.80%) is lower than that seen last year (5.54%).
Annual absence rate: The indicator was showing special cause concern from November 2021 to October 2022, being above the upper control limit from April 2022. Recent months are showing improvement towards the mean. The target is slightly below the lower control limit, so is showing as consistently failing target.
Staff Survey Results: The staff engagement and staff morale scores are showing a gradual decreasing trend compared to previous years (6.5 and 5.5 respectively, against scores of 6.9 and 6.0 for the 2018 staff survey)

Operational Update

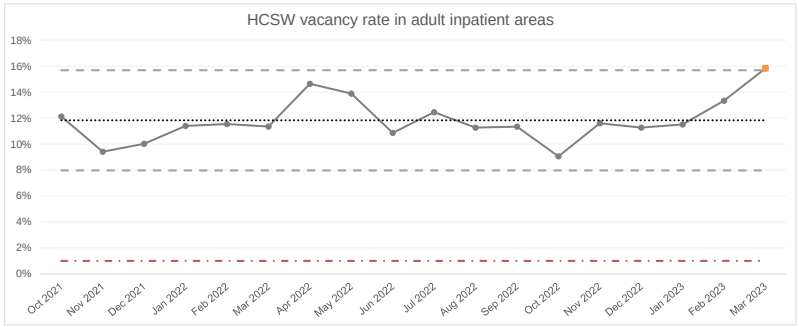
Both the rolling 12 month annual absence rate and the monthly absence rate reported for February 2023, were lower than the rates reported for January 2023.

Sickness absence rates are a good indication of levels of engagement within the workforce, our recent staff survey results show that, whilst the average engagement score within other Acute Trusts has remained static ours has declined slightly. The decline in the engagement score is mainly as a result of responses in relation to advocacy, only 47% of employees would recommend the Trust as a place to work and only 46% would be happy with the standard of care provided for a friend or relative. A Trust wide staff survey action plan will now be produced and Care Groups, Corporate Services and YTHFM will be asked to produce local action plans. In addition, it has been agreed to make an investment required to run the NHSE Culture and Leadership programme (CLP). The project support for this will come from current resources, rather than making an additional financial investment. The CLP is a 2-year continuous improvement programme, which focuses on developing a compassionate and inclusive culture through collective, compassionate, and inclusive leadership.

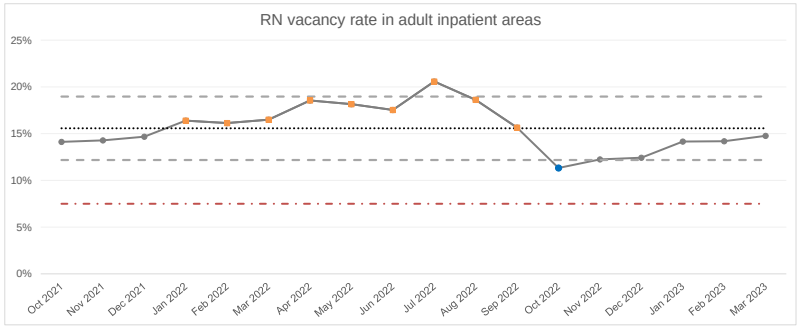
OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

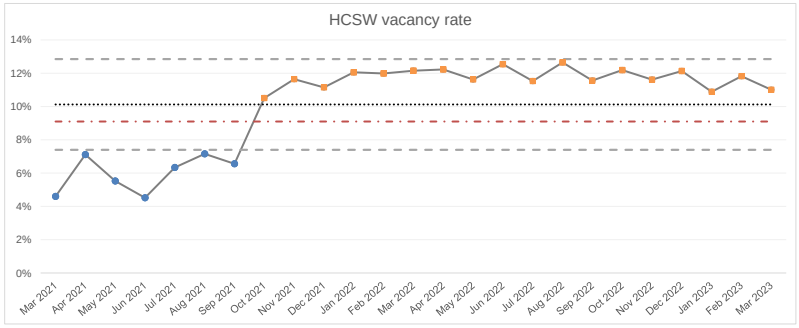
REPORTING MONTH : MARCH 2023



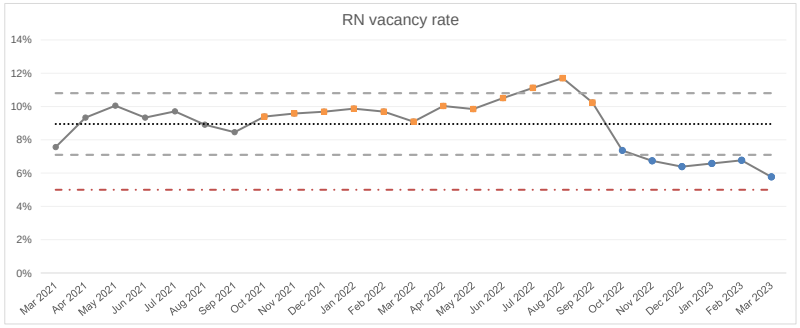
Mar 2023	Target	Variance	Assurance
15.83%	1%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Mar 2023	Target	Variance	Assurance
14.77%	7.5%	Common cause - no significant change	Variation indicates consistently falling short of the target



Mar 2023	Target	Variance	Assurance
11.01%	9.10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	Target	Variance	Assurance
5.77%	5%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

Data Analysis:

HCSW vacancy rate in adult inpatient areas: The indicator is currently showing special cause variation above the upper control limit for Mar 2023, 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 currently showing common cause variation with Oct 2022 being below the lower control limit, please note the vacancy rate is shown from Oct 2021 only. July 2022 was 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. The target is 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 from Nov 2022. The months of Jul and Aug 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

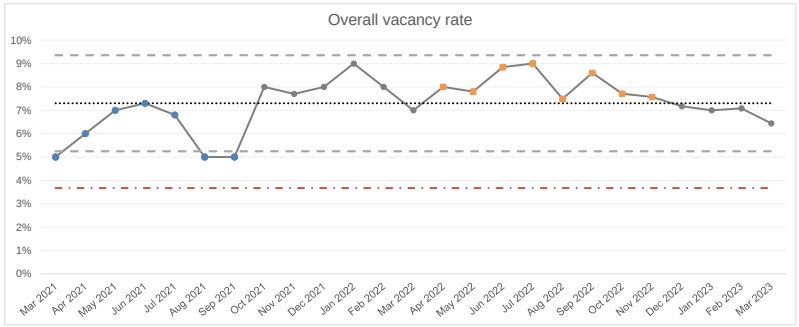
The Trust is on track to be the first organisation from the ICS Kerala recruitment collaborative to on-board applicants from the event in November. Our first cohort of eight nurses are due to arrive week commencing 24 April and will be joining a group of seven Trust HCSW's to undertake their OCSE training. Two AHP's recruited from Kerala have confirmed start dates with the Trust of 1st May, with a further two expected in the following weeks/month.
NHSE has confirmed they are supporting our bid for funding to support the recruitment of 90 internationally trained nurses between April – November 2023, generating £450k in funding.
NHSE has confirmed that we have met our target of international nursing recruitment in 2022/23, with 134 nurses recruited. The Trust is on track to exceed our international AHP recruitment target of 18 by 30th June 2023 (17 have arrived to date) and has been recognised as the organisation with the highest level of international AHP's on-boarded in the region. The organisation is set to achieve our target to recruit six international midwives, with four in post and two planned to commence in the coming month(s).

A HCSW recruitment event was held on 15th February and so far, 21 have started in posts at York and 12 in Scarborough with a further 17 booked onto induction at York on 24th April, although these numbers are expected to increase. Across York and Scarborough, there are currently 35 HCSWs in the recruitment pipeline. Generic adverts have just closed for both main acute hospital sites with confidence that this will result in 15+ posts recruited to. Further HCSW events are planned for 15th May (York) and 13th June (Scarborough).

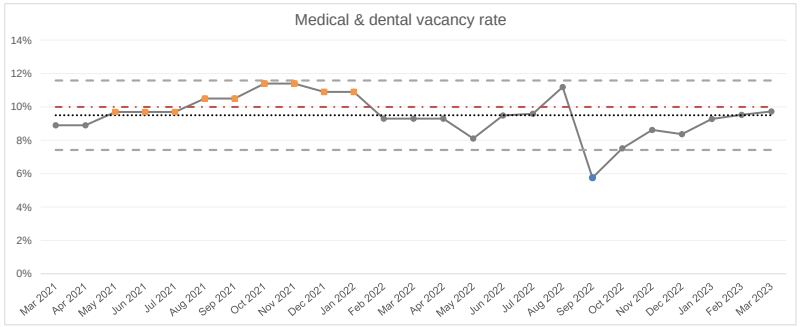
OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

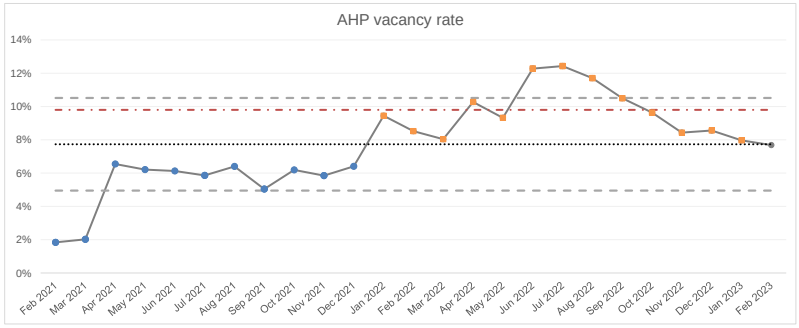
REPORTING MONTH : MARCH 2023



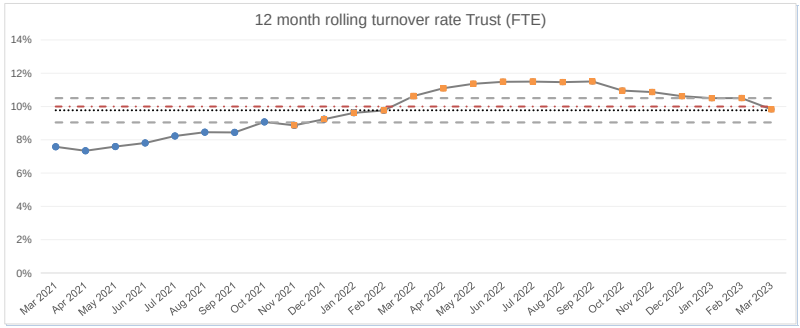
Mar 2023	Target	Variance	Assurance
6.44%	3.67%	Common cause - no significant change	Variation indicates consistently falling short of the target



Mar 2023	Target	Variance	Assurance
9.7%	10%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Feb 2023	Target	Variance	Assurance
7.7%	9.80%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	Target	Variance	Assurance
9.83%	10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

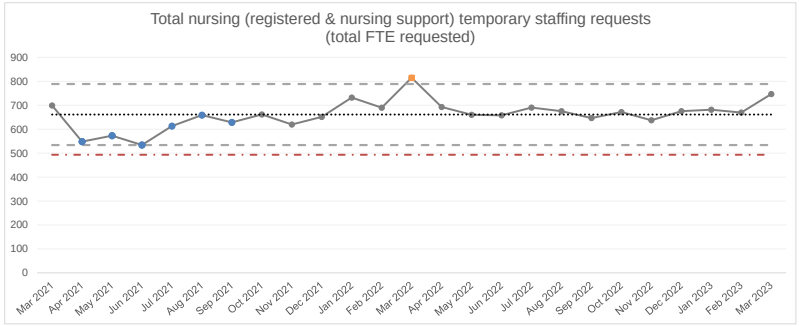
Data Analysis:

Overall vacancy rate: The indicator was showing special cause concern from Apr to Nov 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 Jun-Sep 2022. The indicator has returned back towards the mean and is no longer showing concern (Mar 2023 is unavailable). 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 an increasing trend. The data points have been above the upper control limit from Mar 2022 but are now showing a consistent decreasing trend back towards the mean. The target is slightly above the mean.

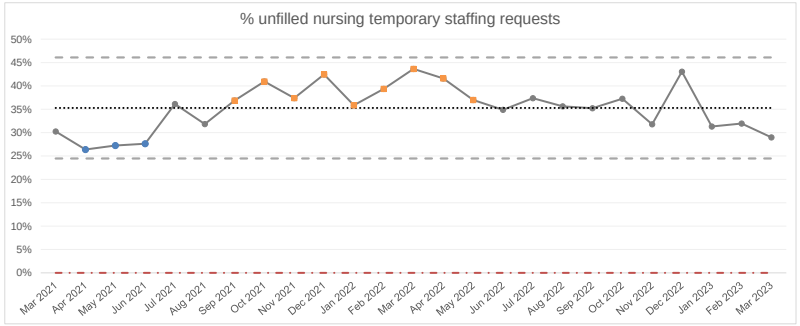
OUR PEOPLE - Temporary Staffing

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

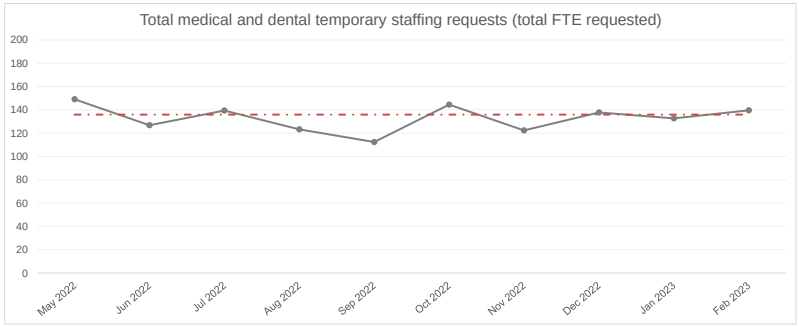
REPORTING MONTH : MARCH 2023



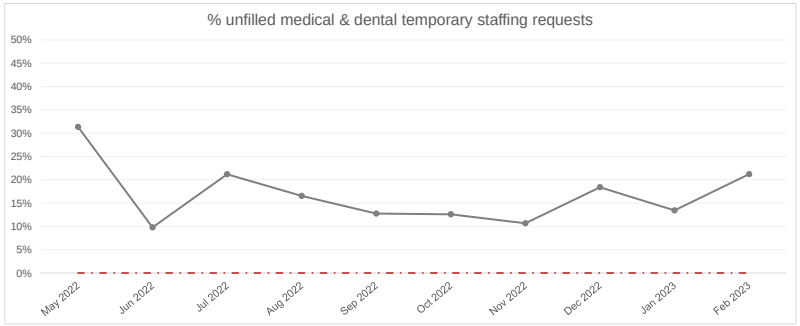
Mar 2023
747.02
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Mar 2023
28.99%
Target
0%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Feb 2023
139.59
Target
135.93
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant



Feb 2023
21.20%
Target
0%
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant

Data Analysis:

Total nursing (registered & nursing support) temporary staffing requests (total FTE requested): The indicator is showing special cause concern above the upper control limit in March 2022. It is showing common cause variation for most recent months, 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

The winter incentives for the bank have been extended until 16th April to cover the Easter holidays and junior doctor's industrial action.

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 retrospectively. There were 202 flexibilty payments made in March 2023 (for shifts worked in February). This was the lowest number of flexiblity payments made in any month where this incentive has been offered. The highest number of flexiblity payments made over the time the incentive has been available was 453. These payments were made in February, for shifts worked in January.

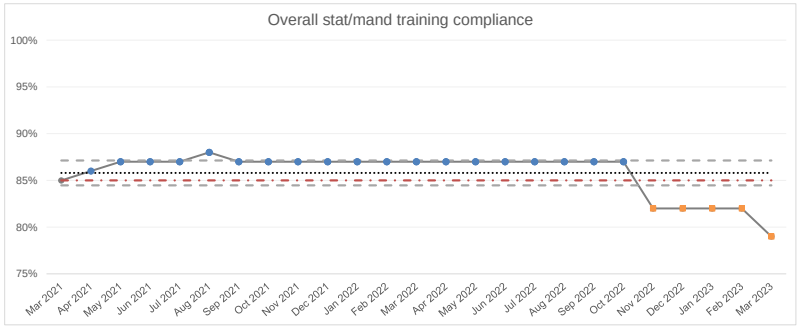
From 1st December allocation on arrival shifts have been offered and paid at double time for bank workers. On average, since the start of this incentive being offered, 346 allocation on arrival shifts have been filled across all sites each week. In the last four weeks for which this data is currently available (from week commencing 27th February), on average there have been 415 allocation on arrival shifts filled each week.

Thornbury agency use remained high in March with 433 shifts being filled by them. NHS England continue to scrutinise the Trust's off framework agency use and are working with us to develop action plans to remove the reliance on off framework supply.

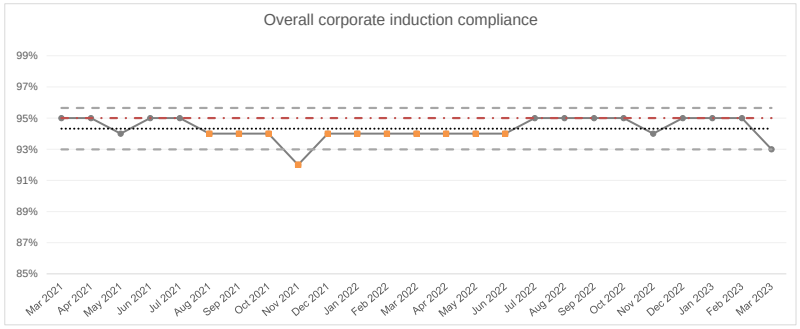
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

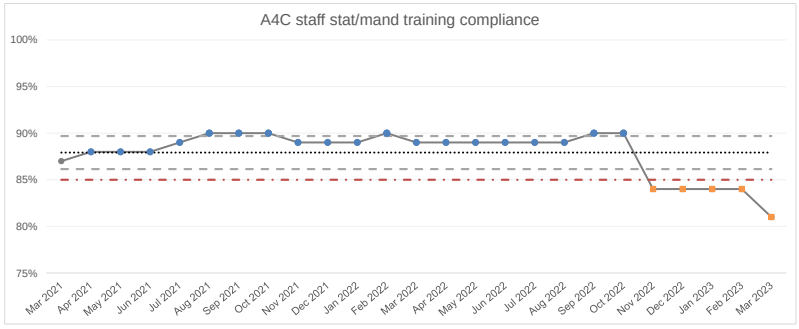
REPORTING MONTH : MARCH 2023



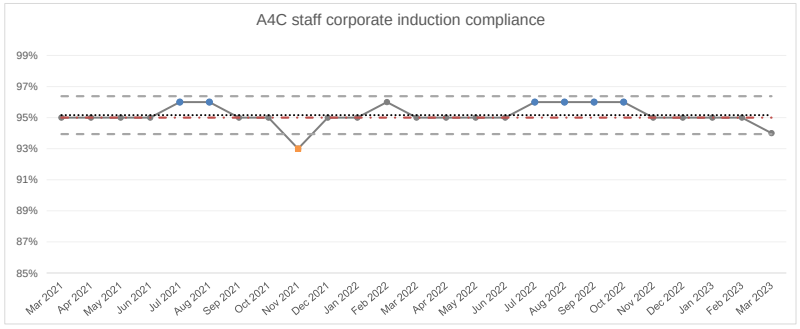
Mar 2023	Target	Variance	Assurance
79%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	Target	Variance	Assurance
93%	95%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	Target	Variance	Assurance
81%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently passing the target



Mar 2023	Target	Variance	Assurance
94%	95%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

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. Nov 2022 to Mar 2023 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 and Mar 2023.
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 2022 to Mar 2023 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 largely been met since Nov 2021, with the exception of Mar 2023.

Operational Update

Following the Serious Incident involving Learning Hub which occurred at the start of February, all Statutory and Mandatory Training programmes are now available again for completion by staff. The Trust has also been successful in recovering records of staff's completed Statutory and Mandatory Training up to and including the end of January 2023.

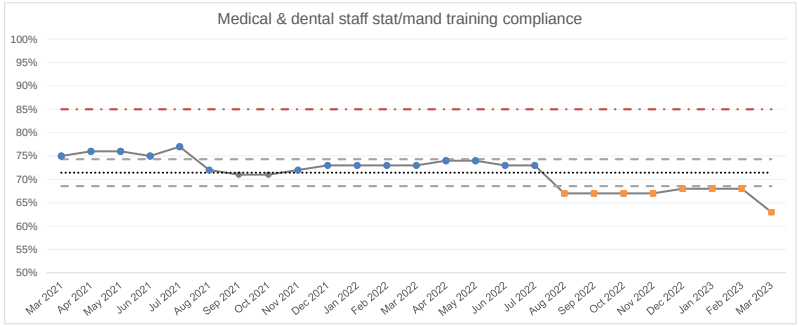
Due to the period of time for which online learning has been unavailable, it is no surprise that training compliance rates have fallen since the last report at the end of January. The overall level of compliance is now 79%, down 3%. Although this will take time to recover, the aim is for the Trust to get back to at least 82% by the end of June.

Corporate Induction completion has been similarly affected, with compliance now at 93%; however, it is anticipated compliance with the 95% target will be recovered more quickly. Plans are progressing to reintroduce generic face to face inductions.

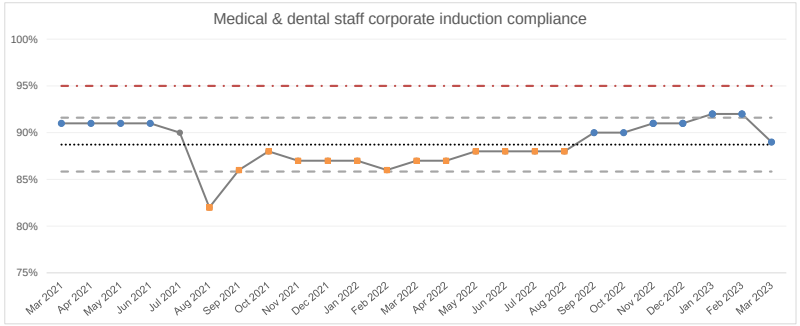
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : MARCH 2023



Mar 2023
63%
Target
85%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Mar 2023
89%
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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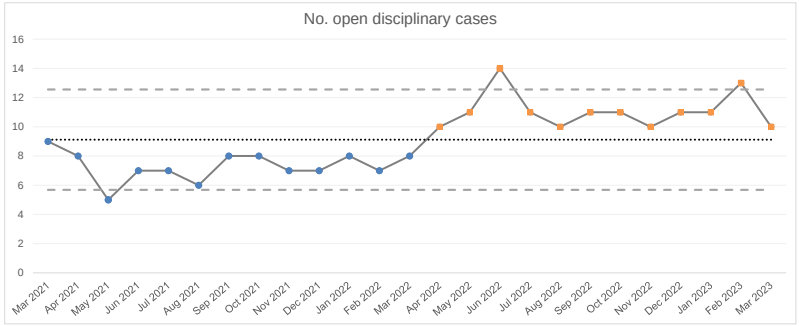
Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

Medical & dental staff stat/mand training compliance: The indicator is consistently failing target. Compliance from Aug 2022 is 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 data points showing above the mean since Sep 2022.

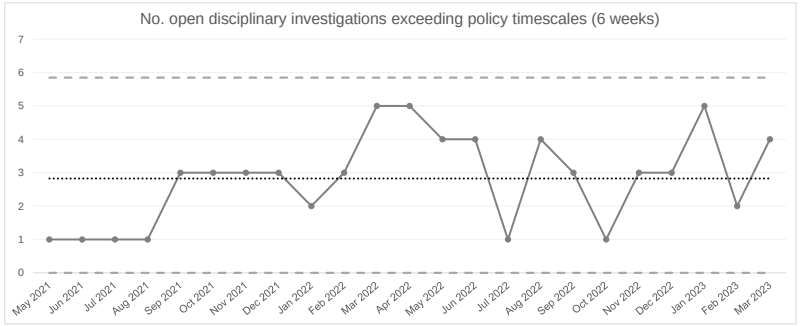
OUR PEOPLE - Employee Relations Activity

York and Scarborough Teaching Hospitals NHS Foundation Trust

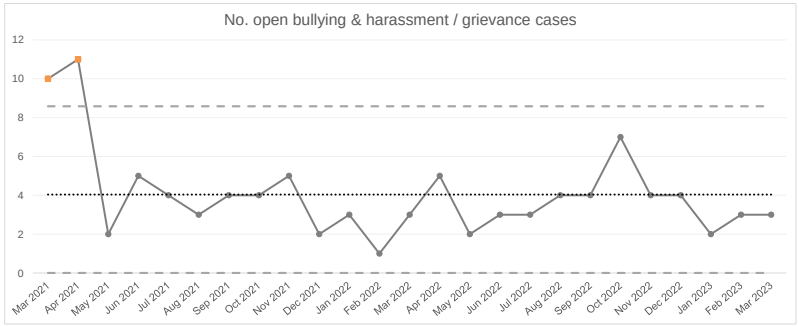
REPORTING MONTH : MARCH 2023



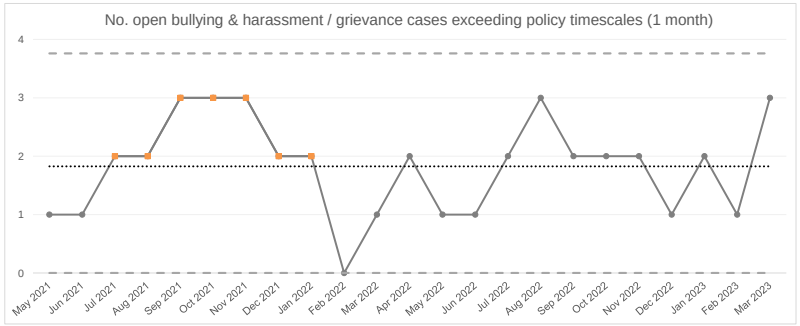
Mar 2023	Target	Variance	Assurance
10	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Mar 2023	Target	Variance	Assurance
4	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Mar 2023	Target	Variance	Assurance
3	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Mar 2023	Target	Variance	Assurance
3	No Target	Common cause - no significant change	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 Apr 2022 and special cause concern above the upper control limit in Jun 2022 and Feb 2023.
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 some degree of variation around the mean.
No. open bullying & harassment / grievance cases exceeding policy timescales (1 month): The indicator is currently showing common cause concern after a previous run above the mean from Jul 2021 to Jan 2022, although please note the figures are shown from May 2021 only.

Operational Update

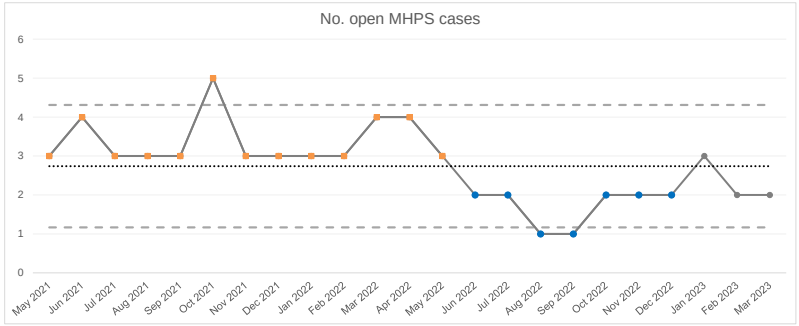
Policy timescales have not been met on a number of cases, from the ongoing disciplinary investigations, two cases are one week overdue and at the time of writing, the report was expected to be submitted during week commencing 10th April. One investigation report was submitted within time but was sent back to the investigation team on review for further information.

A number of grievances have run over the 30 days for resolution, two of these are due to investigations taking place prior to the case being considered at hearing and both hearings are now scheduled, the other case has been delayed due to sickness absence from the individual who submitted the concerns.

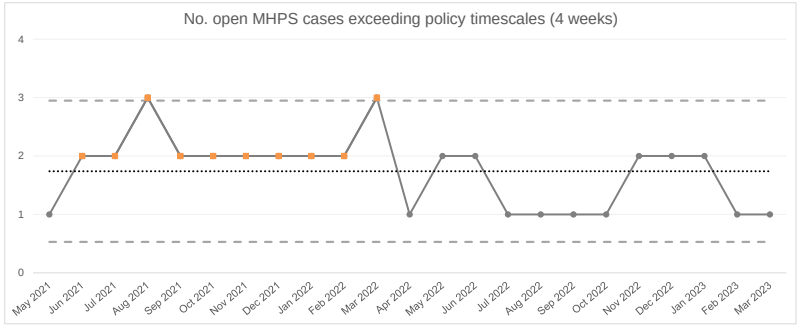
OUR PEOPLE - Employee Relations Activity (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : MARCH 2023



Mar 2023
2
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Mar 2023
1
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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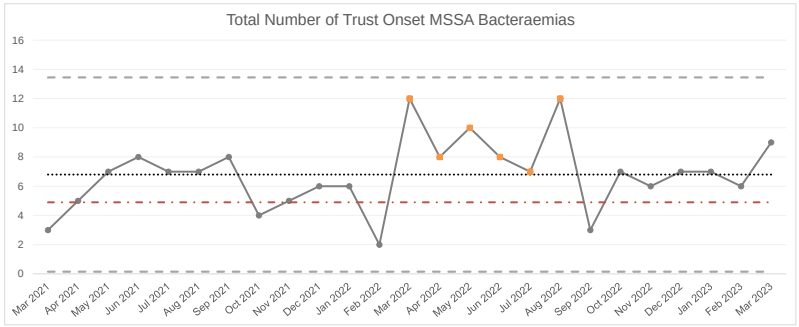
Data Analysis:

No. open MHPS cases: The indicator is showing common cause variation after a seven-month period of special cause improvement, with Aug and Sep 2022 below the lower control limit. 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.

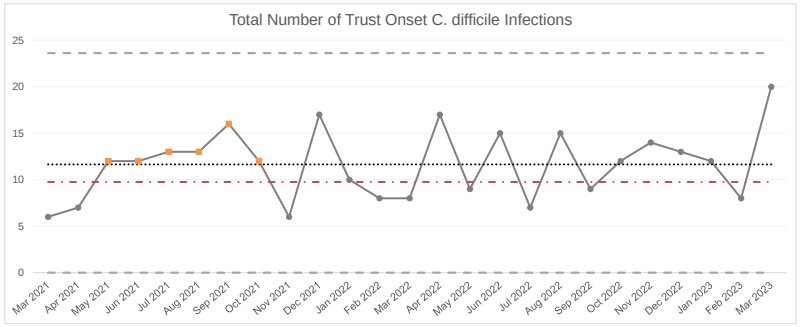
QUALITY AND SAFETY - Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

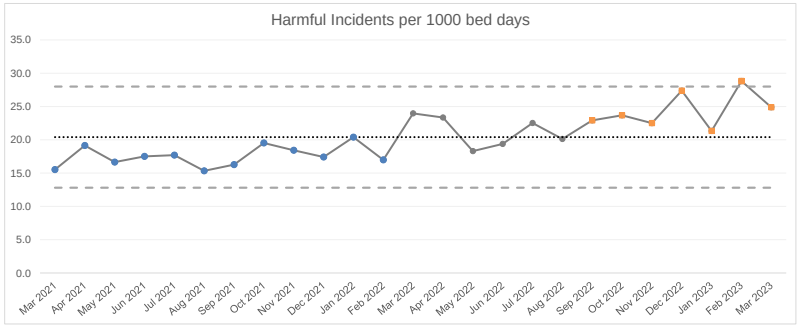
REPORTING MONTH : MARCH 2023



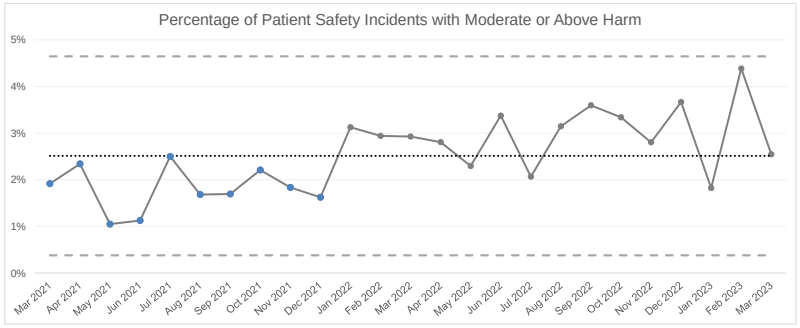
Mar 2023	9
Cumulative 12-month Target	59
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	20
Cumulative 12-month Target	117
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	24.9
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



Mar 2023	2.5%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant

Data Analysis:

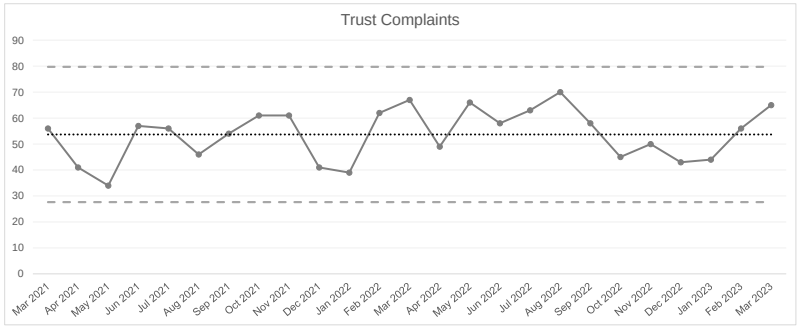
Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA has shown a trend above the mean from Mar to Aug 2022, however is now showing common cause variation around the mean. The internal target of 59 has been corrected on the chart.
Total Number of Trust Onset C. difficile infections: The number of infections of patients with C.difficile is currently showing common cause variation, with some degree of variation around the mean. There has been a sharp increase in Mar 2022 but still below the upper control limit.
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 Sep 2022, with Feb 2023 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 currently showing common cause variation, with Feb 2023 being close to the upper control limit.

Operational Updates:

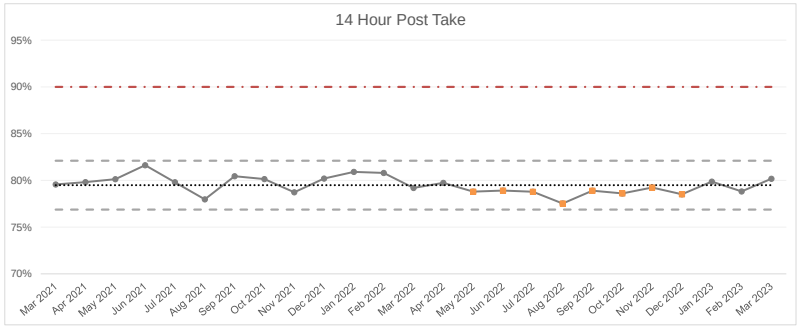
Total Number of Trust Onset MSSA Bacteraemias
There has been a total of 91 hospital attributed cases of MSSA bacteraemia since Q1 of 2022-23 against an agreed internal target of 59 cases. There were 22 cases in Q4. The incidence shows no improvement from the previous 2 years. Staff practices around cannula management were identified as issues requiring improvement in the prevention of Staphylococcus aureus (SA) bacteraemia. A SA Bacteraemia working group formed in Q2, continued to meet throughout Q3 and Q4 focussing on Aseptic Non-Touch Technique training for staff, Visual Inspection of Phlebitis (VIP) score for cannula and cannulation equipment.

Total Number of Trust Onset C. difficile infections
Compounding factors associated with the high incidence of C.difficile in the organisation include issues around staff performance, deteriorating clinical environments, and competing priorities for side rooms. The use of temporary staff due to staff shortages has revealed the lack of understanding of trust guidance in C.difficile Post Infection Reviews (PIRs). High operational pressures are also an additional strain on a depleted workforce with implications on good practice. Worn and tired clinical environments are a risk of environmental reservoirs for microorganisms such as C.dificile spores. Mitigation to fully decant areas and provide terminal cleans and HPV is also challenging due to not having had dedicated areas to decant clinical areas into for a very long time. An outbreak of C.difficile in York involving 5 patients was partly associated with environmental factors. Limited side room capacity results in delayed isolation of patients with diarrhoea thereby increasing the risk of environmental contamination. Competing priorities for side rooms during winter is made worse due to respiratory viruses that also require isolation. A replacement plan for mattresses continued in Q4 following identification of contaminated mattresses; and a business case for a full mattress replacement was approved in Q4. Installation of new mattresses is expected to start in April 2023. Contaminated mattresses are another demonstration of the impact of high throughput of patients and staff shortages, where mattresses are not being checked between patients. A draft of the CDI Improvement plan was developed in Q4 and shared with CGs to agree actions.

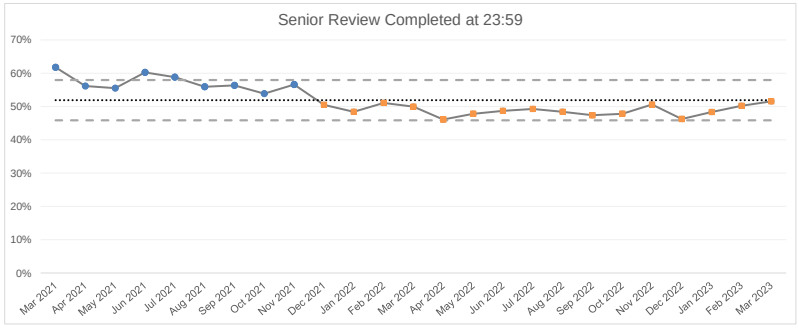
Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
There are ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams. The pressure on services remains significant particularly on planned care with the impact of industrial action in recent weeks. 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 / capacity,national issues with staff shortages and recruitment and retention. Staffing challenges are recognised and various measure in place to mitigate risks as much as possible. 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 addressed and harm levels amended retrospectively in line with local and national guidance to ensure consistency with reporting across sites.



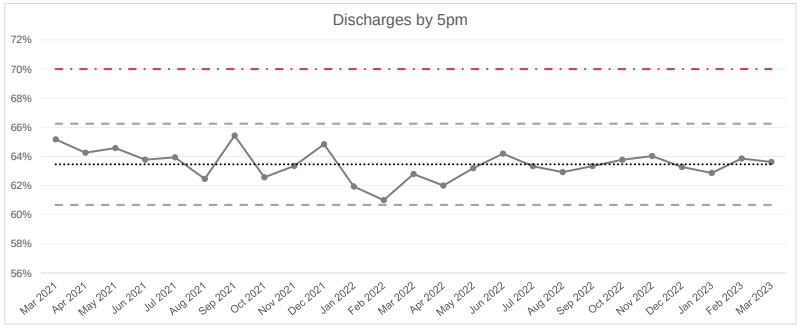
Mar 2023	65
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Mar 2023	80.2%
Target	90%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



Mar 2023	51.5%
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Mar 2023	63.6%
Target	70%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target

Data Analysis:

Trust Complaints: The number of Trust complaints is currently showing common cause variation.
14 Hour Post Take: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target. A run below the mean has been seen since May 2022 to Dec 2022 but is currently showing common cause variation.
Senior Review Completed at 23:59: Special cause concern is showing with a run below the mean since Dec 2021. Recent months have risen back towards the mean.
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 around the mean.

Operational Updates:

Trust Complaints
Challenges: Increased number of complaints across care groups. People tell us that it is difficult to get through to departments and wards on the numbers they are given and this has led to a sustained increase in the number of calls to the complaints and concerns team.
Key Risks: Care groups still struggling to address complaints in timely way, with the exception of CG2.
Actions: No change from position last month.

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. An effective process and review policy for the ED is being considered but has yet to be agreed / finalised.
- 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 and further assurance has been requested in the form of an agreed monitoring framework and audit plan, particularly from C5 where MEWS compliance has been low.

TPR: Icon Summary Matrix (Priority)

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

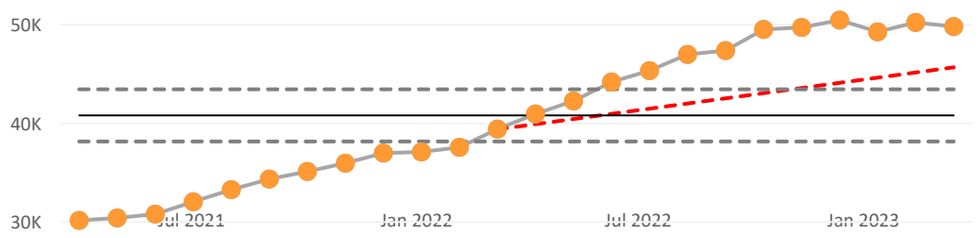
All

VariationIcon	P	?	F	○	Total
Improvement			2		2
H					
L			2		2
Common Cause		2	2		4
~		2	2		4
Concern	1		1		2
H	1		1		2
L					
Neither					
↗					
↘					
Empty					
○					
Total	1	2	5		8

MetricName	Date	Variation	Assurance	Target	Latest Value
Ambulance handovers waiting >60 minutes (%)	2023-03	~	F	10	27
ED - Total waiting 12+hours - % of all type 1 attendances	2023-03	H	F	8	20
ED: Median Time to Initial Assessment (Minutes)	2023-03	~	?	18	16
Number of patients waiting 63 or more days after referral from cancer PTL	2023-03	~	?	121	162
Proportion of patients discharged before 5pm (70%)	2023-03	~	F	70	64
RTT Total Waiting List	2023-03	H	P	45589	49717
RTT Waits over 104 weeks for incomplete pathways	2023-03	L	F	0	0
RTT Waits over 78 weeks for incomplete pathways	2023-03	L	F	0	192

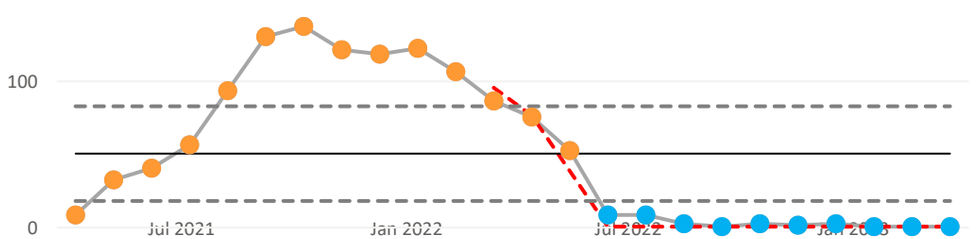
TPR: Elective Recovery Priority Metrics

MetricName	Assurance	Variation
RTT Total Waiting List	P	H



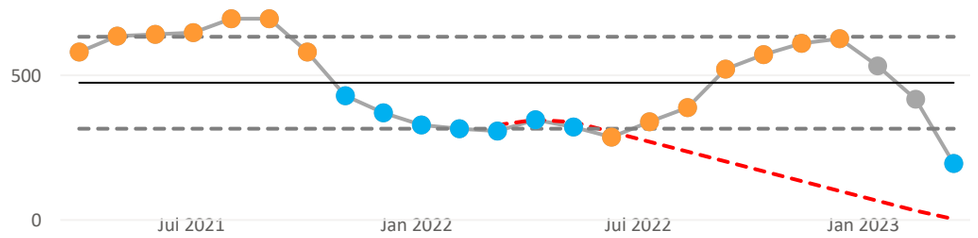
LATEST MONTH
50K
Target
45.6K

MetricName	Assurance	Variation
RTT Waits over 104 weeks for incomplete pathways	F	L



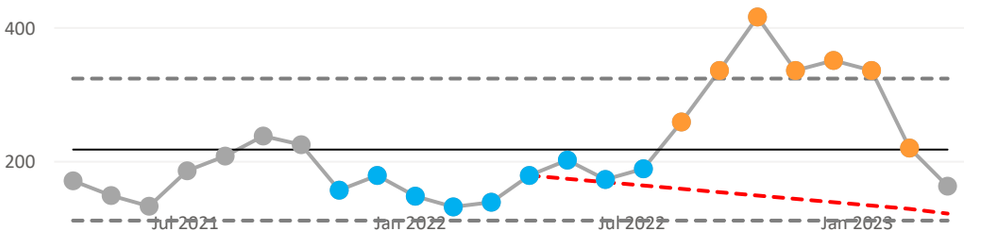
LATEST MONTH
0
Target
0

MetricName	Assurance	Variation
RTT Waits over 78 weeks for incomplete pathways	F	L



LATEST MONTH
192
Target
0

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



LATEST MONTH
162
Target
121

DATA ANALYSIS:

- **RTT Total Waiting List:** The indicator is showing deteriorating performance, with a series of points above the mean since Apr 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, since Jan 2023 there have been 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 has improved over the last few months bringing the value much closer to the target and under the lower control limit for the latest month. The national target is to reduce the number of 78+ week waiters to zero by March 2023.
- **Number of patients waiting 63 or more days after referral from cancer PTL:** The indicator was showing variation within the upper and lower control limit since Sep 2020 to Aug 2022. The value has since been above the upper control limit but has shown significant improvement for the last 2 months and is now showing under the mean.

TPR:

Narrative for Elective Recovery Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Challenges: The Trust is in Tier 1 Elective Recovery support (national intervention). The Trust is off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 16x against a target of 121 for March. This does however represent a significant improvement on the end of January position (335). 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.	Actions: 1. The Intensive Support Team and EY Consultancy continue to work with the Trust on a number of workstreams. The teams are working to support the Trust on a range of issues including governance, speciality recovery planning, skills and development of the teams and data to support operational teams. 2. The Tier 1 regime has refocussed to a fortnightly meeting with the Chief Executive, Medical Director and Chief Operating Officer as the end of March target approaches. The Trust had 193 RTT 78 week waiters remaining at the end of March below the planned revised trajectory of 243. 3. “Back to Basics” Programme for operational managers launched early April at an event at the Community Stadium. 4. The 50-week theatre SLA has been agreed and is due to go live in May 2023. 5. The Short Form Business Case for additional theatre and outpatient procedures facilities (TIF2) has been approved by the national team. 6. Waiting List Harms Task and Finish Group established. 7. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with patient specific information underway.

TPR:

Narrative for Elective Recovery Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Risks: Potential further COVID-19 variants and/or waves. Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work. Theatre staffing vacancy, retention, and high sickness rates. Four-day industrial action in April by BMA Junior Doctors following the ballot action.	Mitigations: Tier 1 weekly meetings with National Team on elective recovery. Trust continues to utilise the nationally provided Digital Mutual Aid System (DMAS) to offer long waiting patients who are willing to travel an alternative provider. At the time of this report ten patients have been accepted by alternative providers with five treated. DMAS now live for non-admitted and diagnostic patients, the Trust is exploring the opportunities this will bring. Weekly Elective Recovery Meetings in place for long wait RTT patients. 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.

TPR: Health Inequalities (RTT)

RTT PTL by Ethnic Group
At end of March 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	22	33,412	98.15%	94.34%
Black, Black British, Caribbean or African	24	73	0.21%	0.94%
Mixed or multiple ethnic groups	23	157	0.46%	1.26%
Asian or Asian British	23	276	0.81%	2.97%
Other ethnic group	20	123	0.36%	0.49%
Unknown	22	12,343	-	-
Not Stated	21	3,240	-	-
Grand Total	**22**	**49,624**	**-**	**-**

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding not stated and unknown.

RTT PTL by Indices of Multiple Deprivation (IMD) Quintile
At end of March 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	22	5,819	12.06%	8.88%
2	22	6,728	13.94%	13.59%
3	22	10,152	21.04%	20.94%
4	22	10,526	21.81%	20.68%
5	22	15,031	31.15%	35.90%
Unknown	17	1,368	-	-
Grand Total	**22**	**49,624**	**-**	**-**

Data source for trust catchment area: Public Health England NHS Acute Catchment Areas.
*Proportion on waiting list excluding unknown.

Highlights For Board To Note:

As per the 2022-23 national planning mandate, RTT Waiting List data has, in order to identify any potential health inequalities, been split to view Ethnic Groups and IMD Quintile.

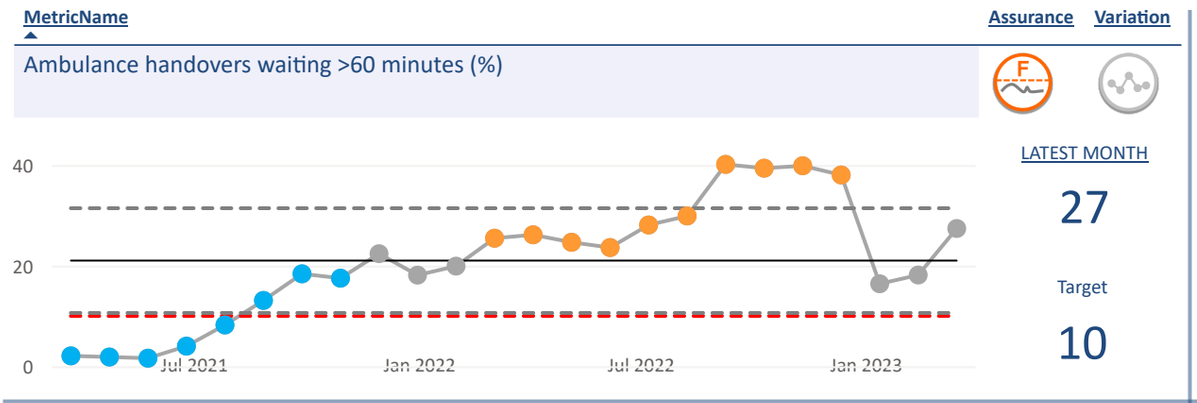
The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation. IMD is a combined measure of deprivation based on a total of thirty seven separate indicators that are grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

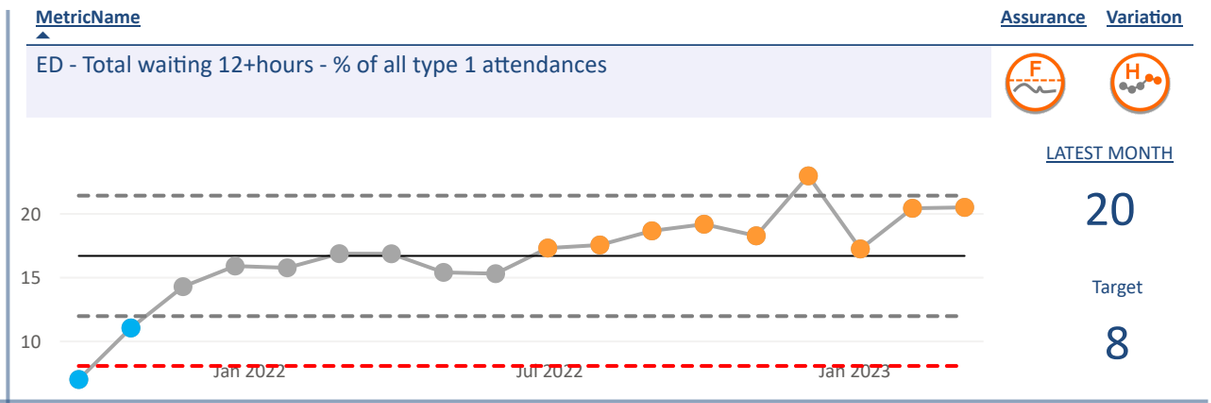
IMD quintiles range from one to five, where one is the most deprived. Please note that IMD quintiles are not available where we have no record of a patient postcode, the postcode is not an English postcode or is an unmatched postcode.

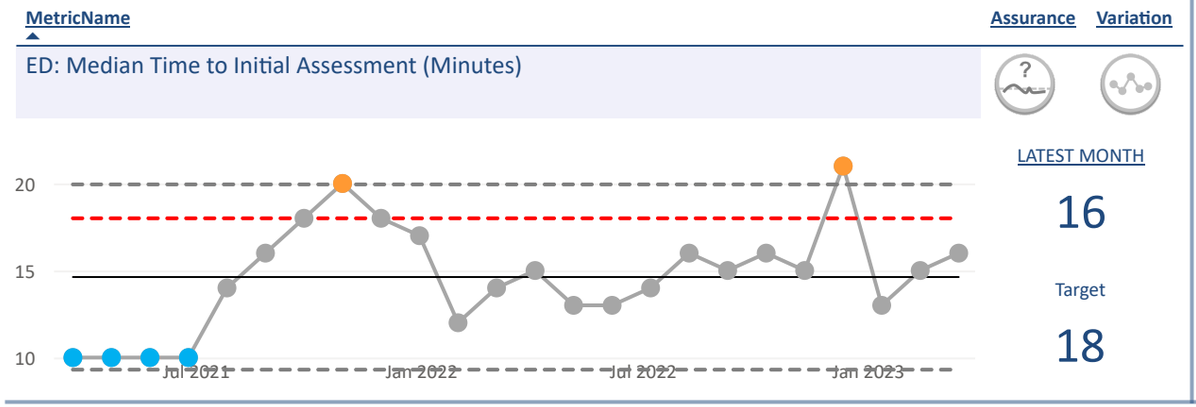
Ethnic codes have been grouped as per the 2021 census. Any patient where Ethnic Group is either 'Unknown' or 'Not Stated' is excluded from the PTL proportions. Areas to take into consideration when interpreting the data include the lack of available site split for Trust Catchment, and the variation that Clinical Prioritisation can bring to weeks waiting.

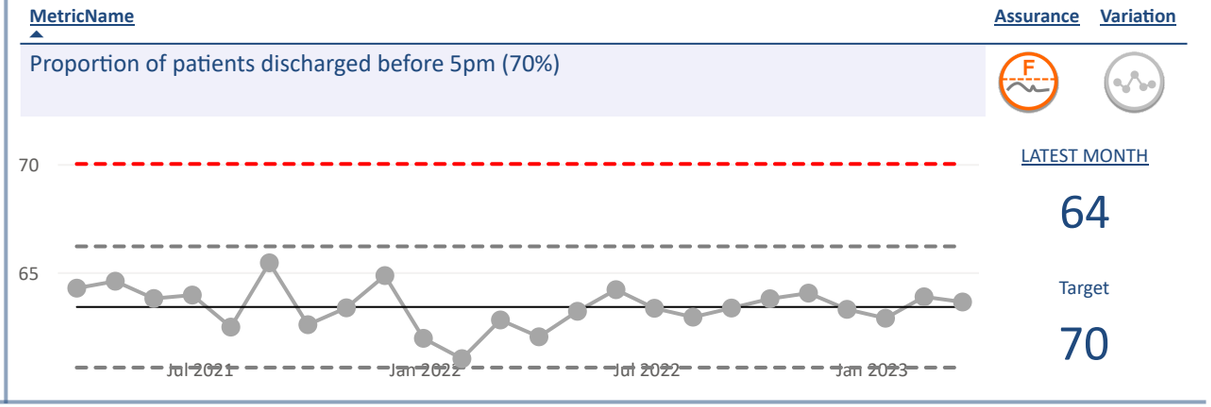
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

TPR: Acute Flow Priority Metrics









DATA ANALYSIS:

- **Ambulance handovers waiting >60 minutes (%):** The indicator is generally showing deteriorating performance over the last year with a series of points above the mean since Mar 2022 to Dec 2022. The target has not been reached since Aug 2021. There was significant improvement for Jan 2023 coming below the mean but the value has gone up since.
- **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. There has been a significant improvement for Jan 2023 coming below the mean, but the value has gone up since.
- **Proportion of patients discharged before 5pm:** The indicator is showing common cause variation. 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 an updated completion date of June 2023 rather than the anticipated March 2023 due to a delay in the dekivery of building materials. High number of patients without a 'Right to Reside' (204 on 12th April 2023) in acute inpatient beds affecting flow and ability to admit patients from ED in a timely manner. Additionally this is impacting Community Hospital inpatients beds (15 patients on 12th April 2023) and community response teams. High number of patients with COVID-19 in inpatient beds, 143 on 12th April. The need to manage high risk patients separately and cohort COVID-19 positive patients due to Infection Prevention Control (IPC) requirements creates flow (bed) issues and impacts on the Trust's ability to admit some elective patients. Staffing constraints (sickness, vacancies, use of agency and bank staff).	Actions: 1. 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. 2. Work is progressing on the ED build at Scarborough and is due for completion in 2024, with project resource identified to support the development of the revised acute care clinical model with all specialities. 3. The 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. Recruitment to the Programme team has progressed and the two Programme Managers, Deputy Programme Manager and two Project Managers start in April. The programme team will be working across the four priority programmes for the organisation. UEC, Elective Recovery, Maternity and People and Culture. The Programme metrics have been revised for April in line with national standards and workstream metrics developed which will be part of a new internal UEC dashboard. The milestone plan has been developed in line with planning submissions on the ECS trajectory showing key delivery points in the summer and October ahead of winter. Additionally, work has continued with the QI team to explore joint working opportunities and avoidance of duplication whilst progressing shared approaches. Each workstream has continued to be developed with key updates as below: 3.1 Urgent Care: Formal confirmation on the procurement and contracting process is awaited from the ICB. Additionally, stakeholder workshops have commenced with clinical teams and partners including YAS, Totally and Nimbus and across all Places: York; Selby; & Scarborough. The due diligence process has been commenced to review risks and opportunities for the Trust in preparation for a detailed Board paper.

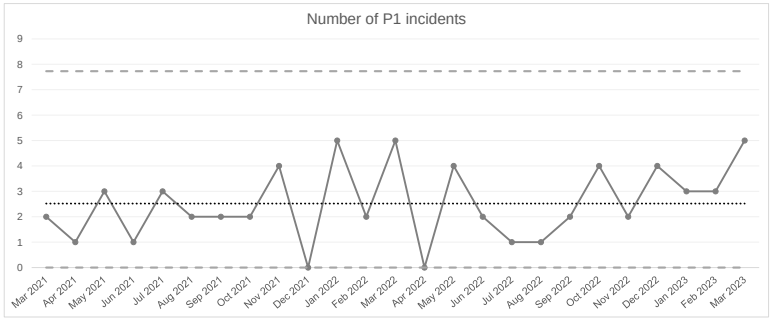
Challenges & Risks	Actions & Mitigations
	3.2 Children and Young people Integrated Care and Assessment: Conversation has progressed to include North Yorkshire GPs to identify the opportunities to work together to provide integrated urgent care models for Children and Young People. The York work on understanding behaviours and population has been summarised and although the CAT hub is not currently funded beyond March other integrated models of care are being explored. A public health summit is being scheduled for June which will bring together all system partners to discuss and agree the next steps for integrated care. 3.3 Virtual Ward: The focus of the March UEC Programme Board was Virtual Wards. An agreement was made for a single virtual hospital approach for the organisation with explicit focus on delivery of care for patients that would otherwise be treated in hospital. A commitment was made to identify a number of pathways that will provide a critical mass of patients to sustain a virtual ward model of care. Some surgical specialties may have very small numbers of patients but will still be able to access the infrastructure. Diagnostics, Acute Medicine, Respiratory and Paediatrics pathways will be further developed with a plan to test some specific diagnostic pathways before the summer. The national requirement is to have the full plan in place by December 2023. 3.4 SDEC: The ECIST missed opportunity audit has taken place looking at the criteria to admit in York EAU. The findings report will be received in April; initial feedback identified opportunities to create more direct access to SDEC (already in the programme plan). SDEC has now been confirmed as one of three priority areas for the Collaborative of Acute Providers; we will work as part of the ICS group to explore all opportunities and share learning. 3.5 Discharge: The ECIST criteria to admit audit has taken place in York (Scarborough in April) which has provided useful context to further develop the Discharge framework/Internal Professional Standards. The ECIST Clinical Lead and Improvement Manager will continue to work with the organisation to develop and embed this approach. Further internal stakeholders have also been involved including CGDs, Deputy Chief AHP and Head of Site Operations. 3.6 7-day standards: The Internal audit completed on standards 2 and 8 requires recommendations to be agreed, a meeting is scheduled with CGDs in early April to link this to the development of the Discharge Framework/Internal Professional Standards. Standard 5 assessment continues with information from the Radiology Information System to clarify compliance with the standard.

Challenges & Risks	Actions & Mitigations
	3.7 Access to post hospital care: Initial system conversations have taken place with additional resource brought into the York Place team to explore opportunities in this pathway. The next steps in April are to agree timescales and outcomes on this workstream. The system plan continues to be developed with partners covering all three areas of pre-hospital, in hospital and transfer of care. A monthly partnership session has been established to support further development and delivery of the plan for both York and North Yorkshire Places. 4. Continued focus on the 100-day Discharge Challenge to optimise discharge planning and flow. Ongoing engagement with system partners. A pan-Trust discharge framework is being developed as part of the wider system plan. 5. CIPHER cohorting contract in place since December 2022 funded by NY and York place. Scarborough (ambulance clinical handover and PTS discharge) and York (ambulance clinical handover working with VCS-PTS) has now been extended to March 24 with confirmed ongoing funding.
Risks: Staffing gaps in both medical and nursing workforce 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 although implementation of CIPHER has seen significant improvements Inability to meet patient waiting times in ED due to flow constraints at both sites. Staff fatigue. Four-day industrial action in April by BMA Junior Doctors following the ballot action.	Mitigations: Ongoing daily review of medical and nursing staffing to ensure appropriate skill mix. Weekly meeting to progress the Rapid Quality Review Action Plan. Urgent Care System Programme Board established across the Integrated Care System. Ambulance Handover Plan in place and updated SOP for escalations, cohorting and diversion requests. Plans in place to mitigate impact of industrial action.

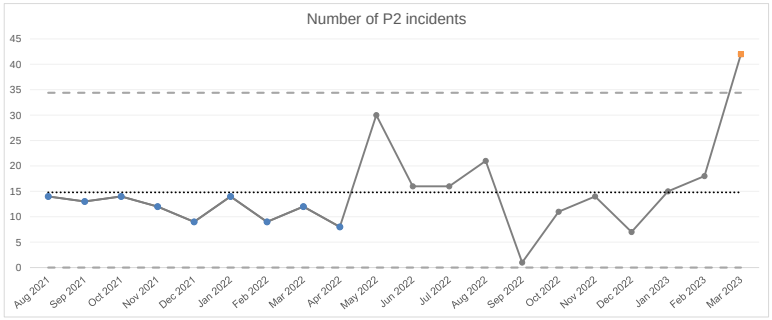
DIGITAL - Digital Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

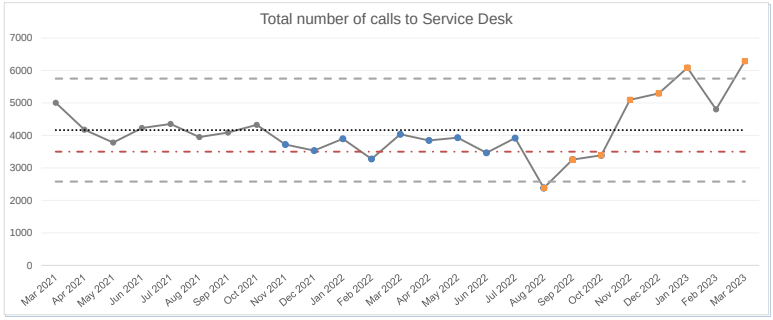
REPORTING MONTH : MARCH 2023



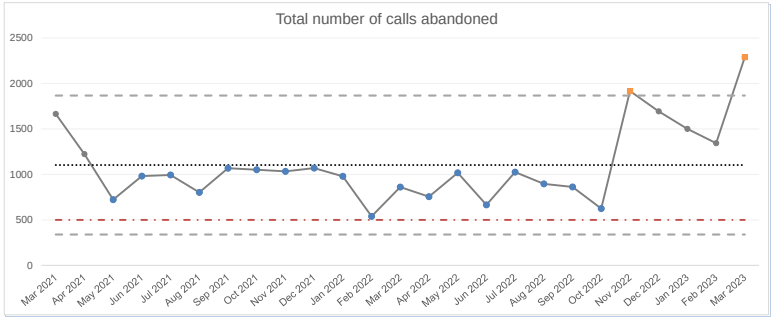
Mar 2023	Target	Variance	Assurance
5	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Mar 2023	Target	Variance	Assurance
42	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Mar 2023	Target	Variance	Assurance
6286	3500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Mar 2023	Target	Variance	Assurance
2289	500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

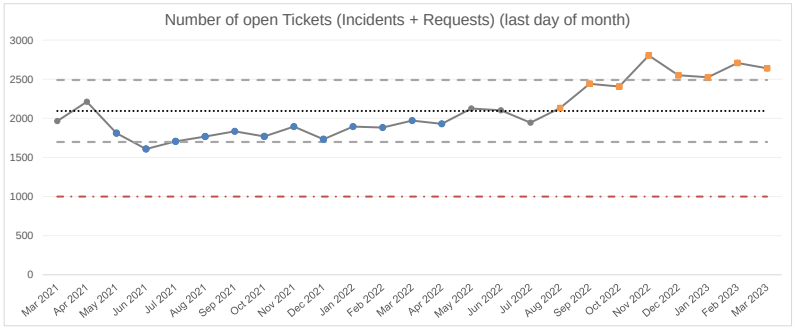
Data Analysis:

Number of P1 incidents: The indicator is currently showing common cause variation, the last four months have been above the mean.
Number of P2 incidents: The indicator is currently showing special cause concern, with a sharp increase in P2 calls in Mar 2023 above the upper control limit. A wider degree of variation around the mean has been seen in the last year.
Total number of calls to Service Desk: The indicator is showing special cause concern due to an increasing trend from Aug 2022. Jan 2023 was above the upper control limit, Feb 2023 was closer to the mean but has since risen above the upper control limit again in Mar 2023. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. The months from Nov 2022 to Mar 2023 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 above the upper control limit. Improvement was seen in recent months, but Mar 2023 was yet again above 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.

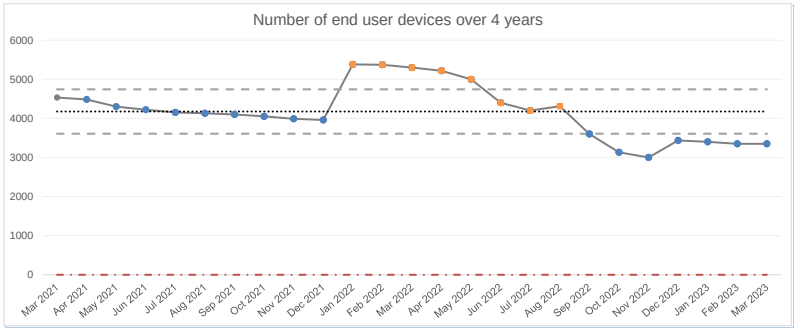
Operational Update:

P1 incidents:
3/3 - Malton Phone system inbound lines - numbers diverted to SGH switchboard and then moved off the faulty Malton circuit and come into our system via links at Scarborough
17/3 - Cisco Finesse faults affecting Telephone Call Queue systems used by Patient Contact Centre, Single Point of Access and IT Service Desk
20/3 - Always on VPN system issues preventing remote connections
24/3 - Huntleight Foetal Monitoring system - issues with central monitoring station, but devices worked in each room. NB only Mon-Fri support service from provider
28/3 - Smoothwall Proxy server issues prevented access to external web services

Total number of calls / number of abandoned calls
- Increase due to user impacting P1 incidents, and planned changes to 900+ Shared Mailboxes for NHSmail migration
- Response times/abandon rates spike during P1 incidents. Compounded by staffing levels for training/leave/absence



Mar 2023
2640
Target
1000
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



Mar 2023
3350
Target
0
Variance
Special cause of improving nature or lower pressure due to lower values
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 from Sep 2022 all data points have been above the mean and therefore is showing special cause concern. From Nov 2022 all data points have been 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 five months. The number of end user devices (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 2022 onwards, with 3350 devices now over 4 years old.

Operational Update:

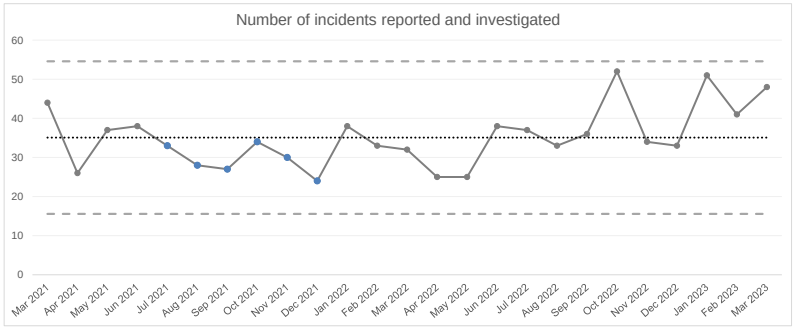
Number of open calls (last day of the month)
- Peak at 31/3/23 of 2,640 had fallen to 2484 by 6/4. **38%** are deferred and awaiting replies/action by users, or delivery of equipment.
- Service Desk Staff levels increased in March and will focus on review/closure of deferred tickets.
- Continued elevated demand for support relating to NHSmail project, with 900+ Shared Mailboxes migrating during this period.
- Team leads are reviewing their open call queues with Sam Coombs to identify opportunities to improve ticket management and establish service levels to implement on new ticket system

Number of End User Devices over 4 years
The 237 machines that we have engaged users has identified no return of machines. Formulating a policy that remote IT equipment (i.e. laptops) to come onsite once every 30 days to ensure they recieve the correct patches.

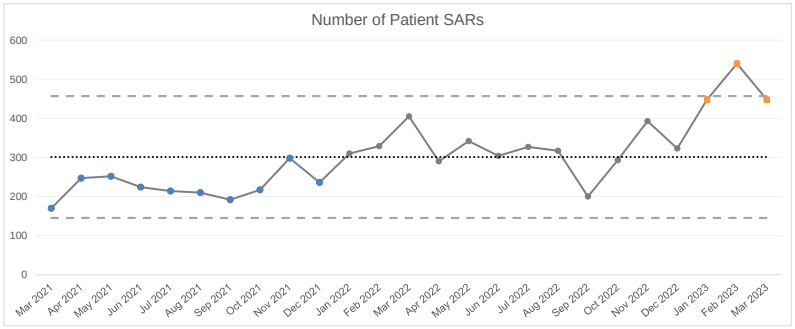
DIGITAL - Information Governance Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

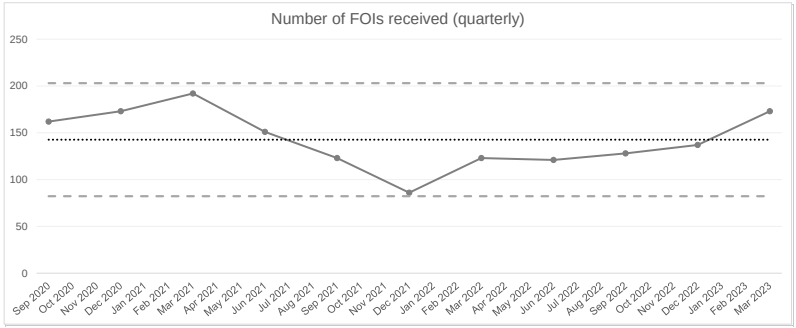
REPORTING MONTH : MARCH 2023



Mar 2023
48
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Mar 2023
448
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



Mar 2023
173
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

Number of incidents reported and investigated: This indicator is showing common cause variation, however Oct 2022 and Jan 2023 saw an increase closer to the upper control limit.
Number of Patient SARS: This indicator is currently showing special cause variation with Jan to Mar 2023 close to or above the upper control limit (Mar: 448 SARs).
Number of FOIs received (quarterly): This indicator is showing common cause variation, with the latest trend rising above 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)

Finance Performance Report : Mar-2023

Executive Summary

Trust Strategic Goals:

[x] to deliver safe and high quality patient care as part of an integrated system

[x] to support an engaged, healthy and resilient workforce

[x] to ensure financial sustainability

Purpose of the Report:

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

Executive Summary:

Key discussion points for the Board are:

Financial Position – March 2023 (Month 12)

1. Income and Expenditure Position

The Trust ended the 2022/23 financial year with an adjusted surplus of £147k. This compares with the annual financial plan agreed by the Board of an adjusted balanced I&E position and means that the Trust has delivered its annual financial plan in 2022/23.

The details in the table on the following page are reflective of the position to be included in the Trust's annual accounts. These differ slightly to the £44k I&E surplus reported to the Digital, Performance & Finance Assurance Committee on 18 April 2023 due to adjustments made after that meeting. The adjustments are summarised below:

	£000
I&E position reported to the Digital, Performance & Finance Assurance Committee	44
Adjusted for:	
- Revised NHSR costs	33
- Centrally procured inventory costs not adjusted for	70
I&E position reported to the Board of Directors	147

The Board should note that for the purposes of assessing the Trust's financial performance NHSE make a series of adjustments to its normal operating surplus/(deficit). As at March 2023 the Trust is reporting a £10.7m operating surplus for the year, however after NHSE required adjustments to remove the net I&E impact of donated assets; peppercorn depreciation; an adjustment to remove the net impact of DHSC centrally procured inventories (primarily PPE); and a technical adjustment known as impairments to exclude the impact of any revaluation of fixed assets, an adjusted I&E financial position of £147k surplus is reported.

Income and Expenditure Account

	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
NHS England	75,290	75,290	97,312	22,022
Clinical commissioning groups	530,224	530,224	563,017	32,793
Local authorities	4,793	4,793	4,796	3
Non-NHS: private patients	514	514	507	-7
Non-NHS: other	1,342	1,342	2,521	1,179
Operating Income from Patient Care Activities	**612,163**	**612,163**	**668,153**	**55,990**
Research and development	1,765	1,765	2,618	853
Education and training	25,135	25,135	25,493	358
Other income	49,233	49,233	51,643	2,410
Other Operating Income	**76,133**	**76,133**	**79,754**	**3,621**
Employee Expenses	-445,061	-445,061	-499,844	-54,783
Drugs Costs	-61,987	-61,987	-67,928	-5,941
Supplies and Services - Clinical	-74,575	-74,575	-67,775	6,800
Depreciation	-18,291	-18,291	-17,738	553
Amortisation	-1,521	-1,521	-1,769	-248
CIP	-1,115	-1,115	0	1,115
Other Costs	-67,660	-67,660	-75,115	-7,455
Total Operating Expenditure	**-670,210**	**-670,210**	**-730,169**	**-59,959**
OPERATING SURPLUS/(DEFICIT)	**18,086**	**18,086**	**17,738**	**-348**
Finance income	30	30	974	944
Finance expense	-975	-975	-850	125
PDC dividends payable/refundable	-8,014	-8,014	-7,885	129
NET FINANCE COSTS	**9,127**	**9,127**	**9,977**	**850**
Other gains/(losses) including disposal of assets	0	0	-5	-5
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0
Movements in fair value of investments and liabilities	0	0	709	709
Corporation tax expense	0	0	0	0
Surplus/(Deficit) for the Period	**9,127**	**9,127**	**10,681**	**1,554**
Remove Donated Asset Income	-9,607	-9,607	-9,958	-351
Remove Donated Asset Depreciation	452	452	565	113
Remove Donated Asset Amortisation	28	28	28	0
Remove Peppercorn Depreciation	0	0	11	11
Remove net impact of DHSC centrally procured inventories	0	0	-471	-471
Remove Impairments	0	0	-709	-709
Remove Gains/(losses) from transfers by absorption	0	0	0	0
NHSI Adjusted Financial Performance Surplus/(Deficit)	**0**	**0**	**147**	**147**

2. Cost Improvement programme

The Trust's cost improvement programme has over-delivered against the annual target of £32.4m by £1.1m, although a significant proportion of the overall delivery is non-recurrent and will present a significant challenge for 2023/24.

3. Current Cash Position

The Trust ended the financial year with a cash balance of £50.4m.

4. Current Capital Position

The Trust has spent £91m against a total capital programme for 2022/23 of £86.5m; due to additional PDC allocations received late in the year.

Recommendation:

The Board of Directors is asked to discuss and note the March 2023 financial position for the Trust.

Author(s): Graham Lamb, Deputy Finance Director

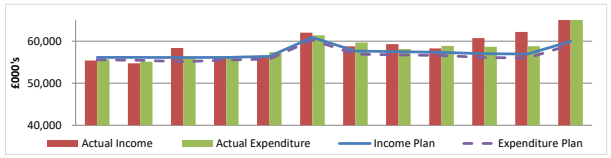
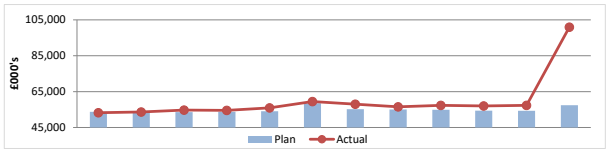
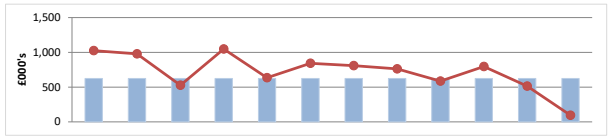
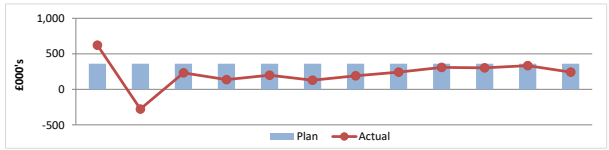
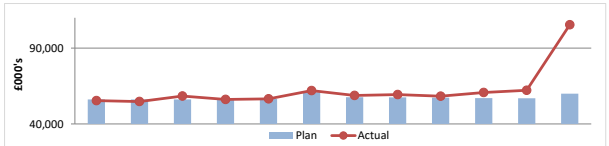
Director Sponsor Andrew Bertram, Finance Director

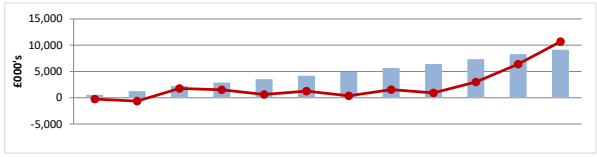
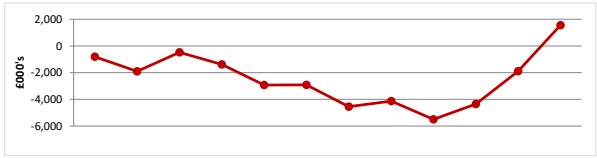
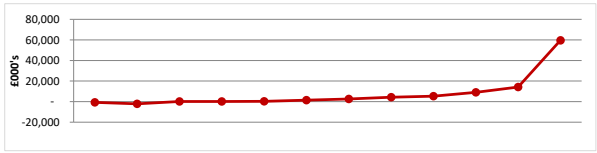
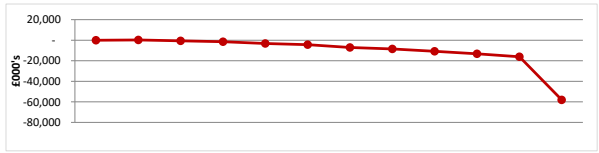
Date: Apr-2023

TRUST BOARD REPORT : March-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

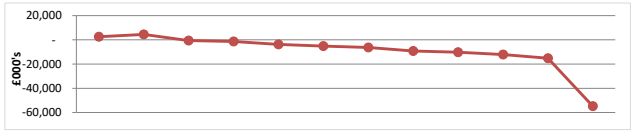
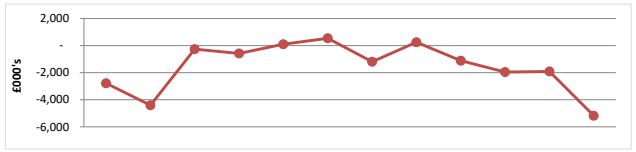
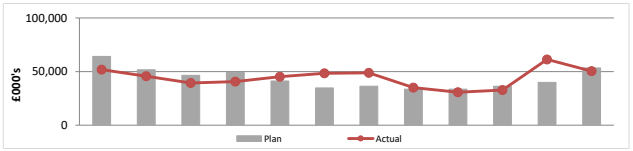
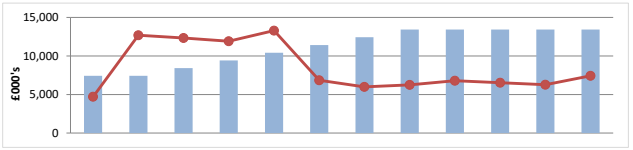
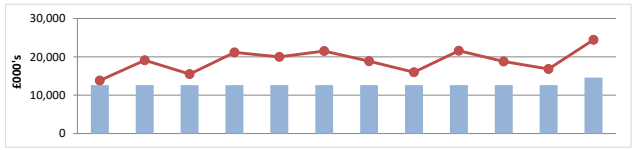
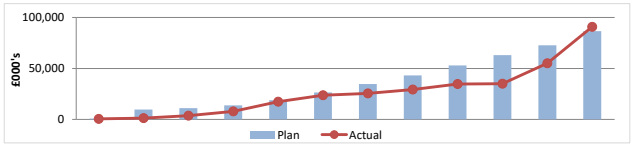
Mar-23	METRIC:	PLAN:	
£10,681	6.01 Income and Expenditure	£9,127	
£100,965	6.02 Operational Expenditure against Plan (exc. COVID)	£57,413	
£95	6.03 COVID-19 'Inside the Envelope' Expenditure	£624	
	Monthly % Covid Spend of Operational Spend:	0.1%	
£242	6.04 COVID-19 'Outside the Envelope' Expenditure	£360	
£105,359	6.05 Income against plan	£59,980	

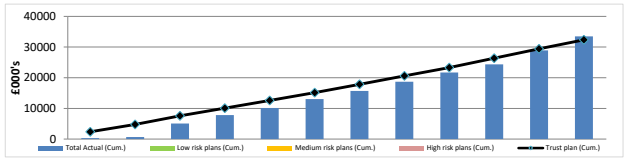
	METRIC:	PLAN:	
£10,681	6.06 Cumulative net actual Income and Expenditure surplus/(deficit)	£9,127	
£1,554	6.07 Cumulative net Income and Expenditure surplus/(deficit) variance to plan	£0	
£59,611	6.08 Cumulative Income Variance to Plan	£0	
-£58,057	6.09 Cumulative Expenditure Variance to Plan	£0	

TRUST BOARD REPORT : March-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Mar-23	METRIC:	PLAN:	
-£54,783	6.10 Cumulative Pay Expenditure Variance to Plan	£0	
-£5,176	6.11 Cumulative Non-pay Expenditure Variance to Plan	£0	
£50,348	6.12 Cash Position	£53,435	
£7,417	6.13 Debtors	£13,424	
£24,436	6.14 Creditors	£14,605	
£90,848	6.15 Capital	£86,513	

	METRIC:	PLAN:	
£33,471	6.16 Efficiency programme - delivery against plan and forecast delivery	£32,357	
Delivery ytd:			
Recurrent	£15,667	-1,114	
Non Recurrent	£17,804		
£33,471	6.17 Efficiency programme - planning position full year	£32,357	

Planning (Gap)/Surplus

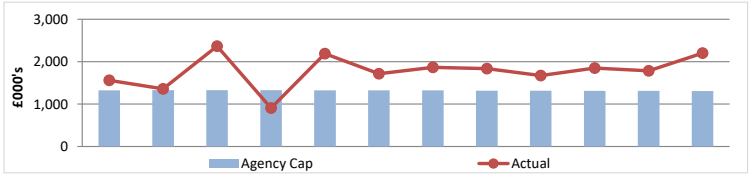
	March £'000	EOY £'000	Comments
Target	**32,357**	**32,357**	
PLANS			
Low Risk	33,471	33,471	
Medium Risk	0	0	
High Risk	0	0	
Total Plans	33,471	33,471	
Planning (Gap)/Surplus	**1,114**	**1,114**	
Actions			**New Plans** - continue to work with CG's to identify u/spends; opportunities presented in Model Health System (more likely medium/longer term)

TRUST BOARD REPORT : March-2023

SUMMARY INCOME AND EXPENDITURE POSITION

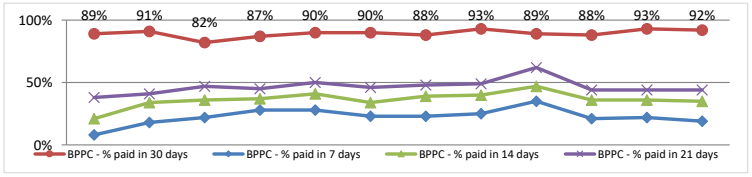
STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Mar-23	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
£2,200	6.24 Agency Spend against Agency Cap	£1,307



BPPC Performance

Within 30 days		Within 7 days
92%	6.25 BPPC - % paid in 30 days	19%
	6.26 BPPC - % paid in 7 days	
Within 14 days	6.27 BPPC - % paid in 14 days	Within 21 days
35%		44%
	6.28 BPPC - % paid in 21 days	



Highlights for the Board to Note:

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

Other Financial Issues:

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

6.24 showing our agency spend against the 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 92% of suppliers being paid within 30 days.

Research & Development Performance Report : Mar-2023

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 3882 patients into clinical trials so far this financial year, against a target of 3506, so we have exceeded our accrual target!
- We have submitted two grants this month to try and win some funding
    - Jamie Watkins Pre-doctoral Clinical and Practitioner Academic Fellowship (PCAF) Round 6 | NIHR
    - James Turvill NIHR bid The diagnostic accuracy of colon capsule endoscopy NIHR first round £3.5Million
- There is also a capital bid going in currently to try and prepare our two main sites ready for the influx on vaccine clinical trials that are anticipated after the government signed an agreement with the commercial company Moderna – to make the UK priority country for vaccine trial delivery
- We have been kindly offered 4 research PAs from HYMS and we have contacted interested staff with the application process with a deadline of 28th April for replies
- Dr Luke Bridge has been appointed Care Group Research Lead in CG1 with Dr Chris Hayes as Deputy Care Group 1 Research Lead
- Because of continued collaboration with York St John University we have advertised our next fee waivered PhD opportunity.
- We are also about to do something similar with University of York which is very exciting (Biomedical Sciences)
- We have had exciting conversations with the new Institute for Health at the University of York St John under Professor Garry Tew, who has agreed to be the Academic Lead for the MLTC Hub at Scarborough
- We have met with University of York colleagues and agreed to submit an NIHR Research for Patient Benefit bid to evaluate the new Acute Care Model at Scarborough

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: Apr-2023

TRUST PRIORITIES REPORT : March 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2022-23	493	570	226	239	217	362	777	222	224	259	171	122	3882
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 March 2023

Care Groups	Accruals Running Total 22/23
CG1 Total	522
CG2 Total	189
CG3 Total	427
CG4 Total	156
CG5 Total	63
CG6 Total	128
RP's Total	732
Cross Trust Studies Total	1665
ACCRUAL TOTALS	3882

Accruals Still Required	0
Trials Open to Recruitment	104

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	36%	18%	*Weighted 11*
Observational	51%	55%	*Weighted 3.5*
Large Interventional	4%	3%	*Variable weighting by study*
Large Observational	4%	18%	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	6%
Non Commercial	94%

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

APPENDIX : National Benchmarked Centiles

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : MARCH 2023

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 12/04/2023
* 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%)	Mar-23	63.6%	70%	82	23/121	*Feb 23
	UEC	ED: Median Time to Initial Assessment (Minutes)	Mar-23	16	18	28	87/120	*Jan 23
	RTT	RTT Total Waiting List	Mar-23	49717	45589	32	116/170	*Jan 23
	RTT	RTT Waits over 104 weeks for incomplete pathways	Mar-23	0	0	100	1/170	*Jan 23
	RTT	RTT Waits over 78 weeks for incomplete pathways	Mar-23	192	0	16	143/170	*Jan 23
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Mar-23	9	59 (12-month)	7	128/137	*Dec-22
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Mar-23	20	117 (12-month)	25	103/137	*Dec-22
	Patient Experience	Trust Complaints	Mar-23	65	No Target	23	162/210	*Q4 21/22

Report to:	Board of Directors
Date of Meeting:	26 April 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 Q4 Board Assurance Framework and to note the current Corporate Risk Register.

Specifically, to note and discuss:

- All BAF risks have been reviewed by the Executive Director owners for Q4 2022/23; and,
- The CRR has been updated for April reporting.

Recommendation:

The Board of Directors is asked to approve the Q4 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	05/04/23	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 April.

2. 2022/23 Board Assurance Framework

The Trust's 2022/23 Board Assurance Framework has had its risks reviewed and challenged over the year both at the Risk Committee on a monthly basis, the Board of Directors on a quarterly basis and for assurance at the 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.

Movements for April include:

New Risks

- 14 - Deterioration of reinforced autoclaved aerated concrete (RAAC) Pathology Roof Scarborough
- 15 - Risk of routine patients referred to Paediatric SLT having delayed assessment and intervention.

- 18 - CQC Section 31 Notice Served on The Trust

Risk deescalated from the CRR

- T&O risk: Failure to offer an effective arthroplasty service deescalated to Care Group ownership (From 3x5 Significant to 3x4 High)

Revised risks

- 16 - Failure to observe IPC policies and guidance
- 17 - Impact of built environment on infection prevention and control

The CRR for April 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. Proposals for the Trust's risk appetite position are under development and will be reported to the May Board of Directors via the Risk Committee.

Trust Priorities; Quality and Safety

Risk description	PR1 - Unable to deliver treatment and care to the required standard	**Causes** *What has to happen for the risk to occur?*	- Insufficient workforce resources - Professional competency of clinical staff - Lack of funding - Inadequate buildings and premises - Lack of space - Inadequate or aged medical equipment
		Consequences *If the risk occurs, what is its impact?*	- Potential patient harm - Increased financial costs - Reputational damage - Regulatory attention

Risk Rating	Gross	Net	Target	Risk Appetite Assessment	Committee Oversight: Quality & Safety Assurance Committee	
Likelihood	4	4	3	Risk Appetite: Exceeding		
Impact	5	4	2	Date to achieve target score: Year-End Review	Risk Owner:	Chief Nurse
Overall risk rating	20	16	6		Links to CRR:	3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18

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 and duiscussed at every Board of Directors and Quality & Safety Assurance Committee - Minutes and actions of papers April- June, 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
Ongoing Implement Workforce & OD Strategy (Being Renewed)	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
Ongoing 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 Bank only training for non-medical is at 77% (dropped due to LH incident) and Medical is at 41%.	-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

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 Completed)	Polly McMeekin	**May-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:**	**Risk Owner:**	**Medical Director**
Overall risk rating	25	20	12		**Links to CRR:**	**3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18**

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-March 2022/23 - Learning from deaths and 6 monthly Cancer Harm report to QPaS - Patient experience report Q1-Q3 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**

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: June 2023**	**Risk Owner:**	**Chief Operating Officer**
Overall risk rating	20	16	12		**Links to CRR:**	**3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 17**

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**
1. Oversight of performance	None identified	Board and DPF Committees Oversight & Assurance meetings and other governance forums	TPR reported and discussed at every Board, 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 Q3 & Q4 Oversight & Assurance meetings and Care Groups	None identified
A. Implementation of the Performance Management Framework	None identified	Board and DPF Committees Oversight & Assurance meetings and other governance forums	- Minutes of Q4 & Q1 Oversight & Assurance meetings - Minutes and actions of papers April- June (IBR) and TPR July-December (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) EY review of performance Management Framework as part of Tier 1 actions	None identified

B. Implementation of surge plans	None identified	- Scenario testing of surge plans (Winter resilience) Lessons learned paper to Exec Committee and Board - Silver and Gold Command standard operating procedures	- Results of scenario testing. Minutes of March Board & March Exec Committee were lessons learnt were presented - OPEL 4 daily calls assurance to YAS and NHSEI on Ambulance turnaround when required - Bronze/Silver/Gold Command enacted for	None identified
C. Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
D. Implementation of winter plans, resilience plans and surge 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
E. Delivery of Building Better Care programme. Established as Elective Recovery Board UEC Board, Maternity Transformation Board People & Culture Committee	Programme completed	Programme structure established Transitioned to BAU.	- April-Sept Transformation Committee reports and minutes inc KPIs Closing report to Execuive Committee May 2023	- None identified
F. Monitoring the effectiveness of waiting lists	None identified	- Elective recovery planning and monitoring of waiting lists - ERB	- Reporting on progress of meeting waiting lists, via Tier 1 meetings and DPF Committee & Board	- None identified
G. Urgent Care working at place	None identified	- Collaboration of Acute Providers	- Engagement and participation at Collaboration of Acute Providers for elective recovery	- None identified
H. 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 2023/24 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	**Jun-23**
Rapid Quality Review System action plan	Weekly place based monitoring meeting of actions and performance trajectories. Monthly ICB assurance meeting.	Melanie Liley	**Jun-23**

Trust Priorities; Our People

Risk description	PR4 - Inability to manage vacancy rates and develop existing staff predominantly due to insufficient domestic workforce supply to meet demand	**Causes** *What has to happen for the risk to occur?*	- Insufficient supply of workforce - Lack of succession planning - Limited career opportunities - Operational pressures (inc Covid impact on staff absence/redeployment/release) - Inadequate buildings and premises
		Consequences *If the risk occurs, what is its impact?*	- Deterioration of staff wellbeing - High attrition rates - Increased financial costs from interim arrangements - Potential patient harm - Reputational damage - Regulatory attention

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: People and Culture Assurance Committee**	
Likelihood	5	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: June 2023**	**Risk Owner:**	**Director of Workforce and OD**
Overall risk rating	25	20	12		**Links to CRR:**	**3, 7, 9, 11, 13, 15, 16, 18**

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); Relaunched reward and recognition awards (Sept 22); ceased command and control structure; Implement E,D & I gap analysis.	Simon Morritt	**Jun-23**

Working Life (fixing the basics)	Rest areas identified – bid to be submitted to NHS Charities (June); transparent & equitable local pay (to be agreed); Medical rostering roll-out; New intranet to be implemented	Polly McMeekin	**Jun-23**
Recruitment	International nurse recruitment (90 by Jan 23);	Polly McMeekin	**Mar-24**
Workforce Plan	Clinical Establishment review continues (Nursing complete - AHP to be completed by Mar 24); Develop further alternative roles ; Increase Apprenticeship levy spend	Polly McMeekin	**Mar-24**

Trust Priorities; Our People - Quality & Safety - Elective Recovery - Acute Flow

Risk description	PR 5 - Financial risk associated with delivery of Trust and System strategies	**Causes** *What has to happen for the risk to occur?*	- Insufficient financial allocation distributed via the Humber and North Yorkshire Integrated Care Board - Failure of the Trust to manage its finances
		Consequences *If the risk occurs, what is its impact?*	- Inadequate revenue funding to meet the ongoing running costs of service strategies - Inadequate capital funding to meet infrastructure investment needs at the Trust - Inadequate cashflow to support operations - Net carbon zero objectives addressing environmental hazards not achieved - Imposition of financial special measures or licence conditions

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Finance and Performance Assurance Committee**	
Likelihood	5	4	2	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to achieve target score: March 2024**	**Risk Owner:**	**Director of Finance**
Overall risk rating	25	16	6		**Links to CRR:**	**4, 6, 8, 9, 14, 17, 18**

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.	Draft plan approved at March Board. As plan is still in deficit, work continues with NHSE and the ICB to address outstanding issues.	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	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	Draft plan submitted and submitted and current I&E forcast deficit is being worked on with NHSE and ICB.	A Bertram	**Apr-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	**Apr-23**
Model Elective Recovery Fund costs and income earning potential to maximise funded elective recovery activity.	Draft plan prepared and elective recovery work under way with the Care Groups.	A Bertram	**Apr-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	**Apr-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: November 2023**	**Risk Owner:**	**Chief Digital and Information Officer**
Overall risk rating	20	16	9		**Links to CRR:**	**4, 5, 6, 7, 8**

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 which we are working to resolve

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	**Nov-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:**	**6, 9, 12, 18**

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 during 2022/23	Progress to be reviewed end of Q4 2022/23 - under review	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 - under review	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:**	**6**

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 submitted for Scarborough Hospital, but unfortunately the programme was oversubscribed and the bid failed. Further bidding oppurtunities are expected and will be monitored. No dates are available yet.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	**June-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	**June-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. This has now been approved and goes live on 12 June 2023	Head of Sustainability	**June-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	**June-23**
Sustainable Design Guide to be reviewed when Net Zero Carbon Guide published	Awaiting Net Zero Carbon Guide from NHSE	Head of Capital Projects	**June-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	**June-23**

Corporate Risk Register April 2023

BAF Ref	CRR ID	Title	Opened	Description	Current Mitigation	Gaps In Controls	Sources of Assurances	Gaps in Assurances	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Monthly Trend	Actions (Risk)	Action Lead	Target Date	Severity (Target)	Likelihood (Target)	Risk level (Target)
PR1 PR2 PR4	16	Failure to observe IPC policies and guidance	27/03/2023 CRR 05/04/2023	There is a significant and material risk of the transmission of infectious agents and outbreaks when IPC policies and guidance are not followed. This is most likely during times of extreme operational pressure (OPEL 4) when decisions are made by Gold Command using a risk based approach to lower some of the IPC standards to accommodate operational pressures. Staff are also like to not follow IPC guidance due to an insufficient workforce. This could result in harm to patients and staff, reputational damage and/or a material breach of CQC conditions of registration.	1. Staff training (both at induction and ongoing). 2. Risk-based IPC guidelines. 3. IPC and/or consultant microbiologist availalable 24/7 for additional guidance. 4. IPC and microbiology input in to Bronze and Silver Command structure. 5. Weekly hand hygiene and IPC audits through Tendable, with reviews at Care Group Quality Meetings.	None Identified	Trust Board Executive Committee Risk Commiteee Infection Prevention Control Strategic Group	Suboptimal compliance with Mandatory Training	Nurse, Chief	03/05/2023	5 Catastrophic Harm	4 Somewhat Likely	Significant	⟷	1. Improved completion of IPC mandatory training.	1. Care Groups	1. Monthly Updates	5 - Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR5	17	Impact of built environment on infection prevention and control	27/03/2023 CRR 05/04/2023	There is a significant and material risk of the transmission of infectious agents and outbreaks, due to current limitations in the built environment of the Trust. Key examples include: insufficient specialist and standard side rooms meaning patients with potential infections cannot be isolated, cramped bays which are difficult to clean and increase risk of infection transmission, inadequate ventilation leading to increased risk of transmission of certain pathogens and poor maintenance of the estate which can reduce the efficacy of cleaning. This could result in harm to patients and staff, reputational damage and/or a material breach of CQC conditions of registration.	1.Risk-based IPC guidelines, e.g. for prioritisation of side rooms. 2. Cleaning standards and training for domestic staff. 3. Use of portable air handling units on COVID-19 areas. 4. Ongoing backlog maintenance programme. 5. Proactive HPV decontamination programme. 6. Use of PPE. Staff training.	None Identified	Trust Board Executive Committee Risk Commiteee Infection Prevention Control Strategic Group	1. Lack of siderooms Trustwide 2. Lack of decant facility at Scarborough Hospital 3. Suboptimal Estate Clinical areas	Nurse, Chief	03/05/2023	5 Catastrophic Harm	4 Somewhat Likely	Significant	⟷	1. Both Emergency Departments have developed plans for identifying and housing potential HCID cases within their existing footprint. 2. The actions are captured in the wider IPC improvement plan 3. 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. 17/03/2023 Clarification on HCID rooms via the Trust ventilation. It was ascertained that rooms were not full HCID rooms and just specified to infectious containment rooms. Additional funding has been agreed to ensure as part of the Scarborough UEC full HEPPA filtration/ ventilation is in place for 11 rooms to increase capacity on site. This will increase significantly increase the capacity on site and across the Trust estate of infectious disease isolation rooms. 4. 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 associated IPC transmission risk.	1.Caroline Dunn -York Freya Oliver - Scarborough 2. Emma George 3. Colin Weatherill 4. Caroline Dunn -York Freya Oliver - Scarborough	1. York - June 2023 Scarborough - April 2024 2. May 2023 3. 4. York - June 2023 Scarborough - April 2024	5 Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR6	4	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.Utilisation of the NHS Digital Secure Boundary Service to ensure perimeter protection. 2.Full adoption of the Microsoft Defender product suite on end user devices and monitoring through the Microsoft Tool set. 3.Regular and timely patching in line with best practice guidelines. 4.Adopting where possible the Data Security and Protection Toolkit standards and principles. 5.Compliance to standards i.e. DSP toolkit encompassing key aspects of Cyber Security (Patching, AV management, Education and Training) 6.Trust wide information and sharing of the risk of cyber -attacks occurring and preventative measures to reduce the risk. 7.Joint DIS IG and Security Governance and Forums (Operational, Toolkit and ESP strategy)	None Identified	Board Executive Committee Risk Commiteee	None Identified	Chief Digital and Information Officer	03/05/2023	5 - Catastrophic Harm	4 - Somewhat Likely	Significant	⟷	1.Refresh our suit of Information Security Management Policies. 2.Creation of vetting process with especial focus on contract resource across the Trust with personal credentials issued for IT use. 3.Creation of a Vulnerability Management strategy. 4.Review and perform an idenpendant gap analysis of the Trust's proactive monitoring systems in line with ISO 27001 5.Review approach to staff training and awareness of cyber risks and create an engagemnet strategy. 6.Review the Trust approach to physical security and create a costed and prioritised action plan. 7.Conduct a full penetration test of the entire IT estate.	1. Sam Marshall 2. Sam Marshall 3. Sam Marshall 4. Sam Marshall 5. Rebecca Bradley 6. Sam Marshall 7. Sam Marshall	1. 30 June 2023 2. 30 April 2023 3. 30 June 2023 4. 30 June 2023 5. 30 June 2023 6. 30 June 2023 7. 30 June 2023	5 - Catastrophic Harm	3 - Possible	Significant
PR1 PR2 PR3 PR4	7	Sustained significant pressure in ED	17/10/2022	Risk to patient safety and workforce: 1. Overcrowding: linked to increased morbidity and mortality risk where the number of patients occupying the emergency department is beyond capacity for which the ED is designed and resourced to deliver at any one time. This can lead to delays to treatment for patients, for those requiring resus and those for the main department and thus reduced performance in quality standards. This is due to delayed transfers of care for patients requiring admission and from patients attending the department. In York it is also a result of building work reducing current capacity. This impacts on the ability to take handover of new patients from the ambulance service causing safety risks across the system. 2. Workforce: The above creates an environment that impacts on staff well-being and resilience causing additional risks to staff behaviours and performance and ultimately to patient safety. This affects both recruitment and retention.	Trust wide: 1. CIPHER cohorting of ambulance patients to provide resource to allow release of ambulances and care for patients on the corridor. 2. Clinically focused communication and escalation using the OPEL framework: A clear site-management process is in place with robust communication lines across all services. 3. Communication processes across the whole hospital site include: 2 hrly operational meetings, ED EPIC & NIC hrly huddles; focusing on the day's activity ('At a Glance' board), current status and looking at prediction of capacity and demand. Such processes help inform standard operating procedures and escalation. Links to System Control for support system wide including ambulance diversions. 4. Medical and Surgical processes to pull patients from the ED direct into specialty services, EAU and SAU open 24/7. EAU is open for direct ambulance access and this is being developed for SAU. 5. The High Intensity user Group is in place to ensure anticipatory care plans support decisions about optimal care and ensure rapid assessment is available when an unscheduled care episode occurs. This helps to minimise admissions, reduce length of stay if admission is necessary, and ensure transitions of care occur without delay. 6. HALO provided from YAS at times of surge/overflow requirements, who would provide monitoring, oversight and escalations to the EPIC/NIC. 7. Continued working with Vocare to stream additional patients into UTC.	None Identified	Trust Command process and structures. Urgent & Emergency Care Board Urgent and Emergency Care Programme CG1/2 Care Group Boards and sub committees Quality Improvement Group (System)	None Identified	Operating Officer, Chief	03/05/2023	5 Catastrophic Harm	4 Somewhat Likely	Significant	⟷	1.New ED build, with associated working model and patient pathways. 2. Integrated Urgent Care Model 3. Virtual Wards, 4.Discharge Framework 5. 7 day standards 6. Integrated Intermediate Care 7. Integrated models of care for Children and Young people	1. York - Jamie Todd 1. Scarborough - David Thomas 2. Gemma Ellison 3. Gemma Ellison 4. Gemma Ellison 5. Gemma Ellison 6. Gemma Ellison 7. Caroline Alexander	1. York June 2023 1. Scarborough June 2024 2. October 2023 3. October 2023 4. October 2023 5. October 2023 6. December 2023 7. September 2023	5 Catastrophic Harm	4 Somewhat Likely	Significant

BAF Ref	CRR ID	Title	Opened	Description	Current Mitigation	Gaps In Controls	Sources of Assurances	Gaps in Assurances	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Monthly Trend	Actions (Risk)	Action Lead	Target Date	Severity (Target)	Likelihood (Target)	Risk level (Target)
PR1 PR2 PR5 PR7	18	CQC Section 31 Notice Served on The Trust	27/03/2023 CRR 05/04/2023	There is a risk that the delivery of maternity services at both York and Scarborough hospital sites could be compromised if the conditions imposed by the CQC on the Trust registration as served in the Section 31 notice are not met. This could result in the services closing temporarily and the impact on local women and families in relation to reduced access, choice, confidence in and experience of maternity care would be significant. There would also be a resulting impact on the maternity workforce and the Trust in terms of morale, reputation and well-being.	Action plan in place to address concerns raised, and monitored for delivery through the monthly assurance reports and QRAG Regional Midwives supporting the required improvements • There is on-going weekly briefing and support provided through the PMAs and psychology support available for all staff •Additional programme management capacity has been funded to ensure the CQC Section 31 actions and SROs for each action are supported to deliver the improvement plans •Additional revenue and capital investment has been approved to support procurement of critical equipment, estate refurbishment and system upgrades and expansion of key maternity workforce MIA in place to support the required improvements	1. Substantive Director of Midwifery not in place. 2. Audits not currently providing assurnace that controls are mitigtaing the risks	1. Monthly assurance report to the Quality Committee and submitted to the CQC. 2.Audit schedule 3.InPhase action plan 4. Quality and Regulatory Assurannce Group (QRAG) monitoring of action plan delivery 5. Incident and complaints monitoring	None Identified	Chief Nurse	03/05/2023	5 Catastrophic Harm	4 Somewhat Likely	Significant		1. Improvement plan developed and submitted to the CQC on 3.12.23 2. Action plan delivery and update to Quality Committee monthly and submitted to CQC on 23rd of each month. 3. Establishment of task and finish groups to deliver required improvements revision of the Governance processes supported by NHSE and the MIA 4. Implementation of local audit programme 5. Weekly staff briefings 6. Psychology support for staff who require it business cases for workforce and environmental improvements 7. Recruitment of substantive Director of Midwifery and scrub nurse team 8. Establishment of project team	Sue Glendenning - Interim DOM	31-Oct-23	5 Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR5	14	Deterioration of reinforced autoclaved aerated concrete (RAAC) Pathology Roof Scarborough	04/03/2022 CRR 05/04/2023	Pathology roof and possibly intermediator floors are of an aerated construction and we have been advised that this construction method had a limited lifespan that has been exceeded and could be subject to failure. There is asbestos in the location also which prevents remedial work being undertaken. There has been a failure of this construction in public buildings. Due to the unknown status of RAAC, and the risk of roof collapsing, potential of death or serious injuries and risk of service closure. RAAC on corridor between North and South blocks has been found following a survey	The Trust has secured funding for the first phase of the plan to deal with the RAAC in the laboratory medicine building at SGH, which is aimed at removing staff from the first floor of the building. Paul Johnson is leading on this work for Mark with support from Ross Chamberlain. A short-form business case is being prepared for the remaining funding that will be needed in 2023-24 for RAAC eradication at SGH for submission to the Programme Board in June 2023. The Trust is funding the move of the internal occupant and RC is involved with this and there are monthly updates with the national team about RAAC in corridor areas also. Photographs and images are being taken to record deterioration. This is being mitigated by moving people away from the affected areas. There has been some movement in terms of national money and an update will be provided at the December meeting.	None Identified	There are already emergency plans within NHS/E to evacuate other properties within NHS should deterioration be identified The roofing is being monitored A meeting in early May with NHSEI to discuss funding plan in place to decant pathology services to new location. A full Trust site survey has been commissioned (Curtains) to see if there is any other locations of RAAC Trust wide. Portacabins have been delivered and are currently being fitted out. Occupation is expected in May 2023	None Identified	Finance, Director	03/05/2023	5 Catastrophic Harm	4 Somewhat Likely	Significant		1. A plan is in place to decant pathology services to new location. 2. A Plan is being developed in conjunction with NHS England to transfer remaining personnel to York and the building of a New Hot Lab at Scarborough. 3. A full Trust site survey has been commissioned (Curtains) to see if there is any other locations of RAAC Trust wide.	1. David Ogglesbury 2. David Ogglesbury 3. Mark Steed	1. End of April 2023 2. September 2023 3. June 2023	1- No Harm	1- Extremely Unlikely	1- Very Low
PR1 PR2 PR3 PR6	8	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	1. Awaiting feasibility study outcome.	Board Executive Committee Risk Commiteee	None Identified	Nurse, Chief	03/05/2023	4 Severe Harm	4 Somewhat Likely	Significant	⟷	1. Feasibility study plan is to be undertaken to identify the resourcing requirements.	1. Sue Glendenning	1. May 2023	3 - Moderate Harm	3 - Possible	Medium
PR1 PR2 PR3 PR4 PR5 PR7	9	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 8. Gynaecology 52+ waiting times 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	None Identified	Board Executive Committee Risk Commiteee	None Identified	Operating Officer, Chief	03/05/2023	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	1. Kim Hinton, monthly via Elective Recovery Board and Gemma Ellison, monthly via urgent & Emergency Care Board 2. Melanie Liley 3. Melanie Liley	1. Monthly 2. July 2023 3. July 2023	3 - Moderate Harm	3 - Possible	Medium
PR5 PR7	6	Failure to deliver our Annual Financial Plan	11/05/2022	There is a risk to delivery of our 23/24 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. 11. ICB task and finish groups (including the Trust) working on 23/24 planning.	None Identified	1. Monitoring of performance to plan through EC, DF&P and BOD. 2. External reporting to ICB and NHSE. 3. OAMs with Care Groups. 4. Detailed Financial review meetings with Care Group Finance Managers. 5. Confirmation from NHSE that H1 ERF will not be recovered. Confirmation that planning assumption for H2 is the same.	1. Operational pressures and CQC safety concerns routinley cause Care Groups to exceed budget envelopes.	Finance, Director	03/05/2023	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. 6. Engagement with the ICB and national teams to understand the movement in funding between 22/23 and 23/24 and the associated consequences at operational level.	1- 6 Finance Director	1-5 End of April 2023 6. End of June 2023	3 - Moderate Harm	3 - Possible	Medium

BAF Ref	CRR ID	Title	Opened	Description	Current Mitigation	Gaps In Controls	Sources of Assurances	Gaps in Assurances	Manager	Next Review Date	Severity (Current)	Likelihood (current)	Risk level (current)	Monthly Trend	Actions (Risk)	Action Lead	Target Date	Severity (Target)	Likelihood (Target)	Risk level (Target)
PR1 PR2 PR3 PR4	3	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 is further exacerbated during periods of industrial action. 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 and 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	1. Job Planning compliance 2. Full Erostering implementation	Board Executive Committee Risk Commiteee People and Culture Committee	None Identified	Workforce & Organisational Development, Director	03/05/2023	4 - Severe Harm	4 Somewhat Likely	Significant	⟷	1. Job Plan re-setting of expectations 2. Safer Care Investment Proposals to Board 3. Establishment review 4. Workforce planning 5.Re-present full e-rostering implementation business case (Once Nursing components provides benefit realisation)	1.Medical Director 2. Chief Nurse 3. Director Workforce & Organisational Development 4. Director Workforce & Organisational Development 5. Director Workforce & Organisational Development/Chief Nurse	1. Upon completion of 2023/24 Job Plans 2. Upon completion of 2023/24 Job Plans 3. May 2023 4. May 2023 5. 2023/24	4 - Severe Harm	3 - Possible	High
PR1 PR2 PR3	12	Patients With No Criteria to Reside	18/10/2022 CRR 16/01/2023	There is a risk of patient harm, deconditioning and poor patient experience due to an excessive number of patients whom have no Criteria to Reside occupying acute hospital beds. This results in restricted flow from Ed to AMU and downstream wards and leads directly to backlogs in ED and prevents timely ambulance handovers.	Daily monitoring of accuracy and completion of CTR codes by Patient Flow team. Daily tracking of non CTR patients (in both acute beds and local IPUs) on the patient tracker with comprehensive narrative of actions taken to progress discharge. -Daily escalation calls with partners to actively progress pathway 1-3 patients on daily basis. -Weekly Long Length of Stay (LLOS) reviews to ensure internal and external delays are escalated and treated. -System escalation calls as dictated by OPEL score. -System action plan with NY Place & York Place. -Bridlington Community Unit - 15+ residential Level care beds for patients with no CTR. -York Community Unit -19+ -Mulberry Ward Scarborough - 16 nursing level care beds (on site) for patients with no CTR. This facility cohorts non CTR patients so we can reduce the consultant cover for these medically fit patients. Re-location of BCU to WATERS Ward in Bridlington to expand capacity.	None Identified	Daily Patient Tracker Long Length of Stay reviews. Ward White Boards CTR dashboard (SIGNAL) Board QIG Urgent & Emergency Care Board Exec Committee Risk Committee DIFP Committee	No assurance that Local Authorities have firm plans to take non CTR patients out of the Acute and Community Bed Base.	Operating Officer, Chief	03/05/2023	4 Severe Harm	4 Somewhat Likely	Significant	⟷	1. Ongoing discussion with partner organisations via PLACE director to develop a comprehensive response and plan for decompressing non CTR patients off the acute and community sites, including KPIs 2. Ongoing dialogue with East Riding to increase the offer of D2A support 3.Revision of Truste Assessor Form (TAF) to make process more streamlined and digitised.	1. Jamie Todd / Shaun McKenna @ York and David Thomas / Sara Kelly @ Scarborough 2. David Thomas 3. Vicky Mulvana-Tuohy / Nik Coventry	1. Monthly via Urgent & Emergency Care Board 2. June 2023 3. June 2023	2 - Minor Harm	2 - Unlikely	Low
PR1 PR2 PR3 PR6	5	Major IT Failure	18/12/2020	There is a risk of the failure of the core technology estate (e.g. CPD, clinical or administrative 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.	None Identified	Board Risk Committee	None Identified	Chief Digital and Information Officer	03/05/2023	5 Catastrophic Harm	3 Possible	Significant	⟷	1 Secure Investment in infrastructure, storage, end user compute, networks and wifi to reduce immeadiate risks of out of support system failure. 2.Creation of a Vulnerability Management Strategy. 3. Creation and implementation of an IT Disater Recovery Plan. 4.Purchase of ITSM solution in line with the IT Service Management Strategy. 5. Implement tactical solutions to support IT operations including control, governance, major incident and problem management. Enhanced service management and operations including control, governance, major incident and problem management.	1. Luke Stockdale 2. Sam Marshall 3. Adrian Shakeshaft 4. Action Completed March 2023 5. Stuart Cassidy	1. Action completed for 2022/23 (9.2m invested) 2. 30 June 2023 3. 1 December 2023 4. Completed 5. 1 December 2023	5 Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR4	13	Fragility of Gastroenterology Service	21/09/2022 CRR 16/01/2023	There is a risk that the Gastroenterology service at Scarborough and York will continue to deteriorate due to workforce challenges. This will result in both routine and urgent referrals will not be able to be seen in outpatients for at least 2 years	Look at the feasibility of transferring all new elective patients without an appointment to other providers within the network. Tender for insourcing or outsourcing outpatient services. - Care Groups 1/2 working together to develop interim solutions Working Group has been established to develop and deliver a plan in order to manage the risk. Insoucing now in place. Agency Locum started and agreed 6 month contract Inclusion of GutCare has enabled new ways of working. Expanded the Endoscopy lists to include more units per lists, commenced a new Acute list every morning for 1 Hr which is helping with flow, helping to recover OP waiting lists seeing improvement in productivity Acute bleed rota (Monday-Friday) now in place.	None Identified	Exec Committee Risk Committee Care Group 1 & 2 Boards	None Identified	Operating Officer, Chief	03/05/2023	3 - Moderate Harm	5 - Very Likely	Significant	⟷	1. Working Group has been established to develop and deliver an action plan in order to manage the risk. 2. Agreed GutCare 1 day per week to include an ERCP and endoscopy list 3. Ongoing recruitment plans focusing on Speciality Doctor/ Associate Spec level Doctors	Jamie Todd and David Thomas 2. Jamie Todd 3. David Thomas	1. June 2023 2. 1 May 2023 3. Ongoing	3 - Moderate Harm	2 - Unlikely	Low
PR1 PR2 PR3 PR4	11	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.	None Identified	Care Group Board OAM Risk Committee DPF Committee	None Identified	Operating Officer, Chief	03/05/2023	5 Catastrophic Harm	3 - Possible	Significant	⟷	1. Continue to try to recruit to agency posts. 2. Continue to try to recruit substantive staff. 3. Deep Dive Review @DFP Committee	1. Karen Priestman 2. Karen Priestman 3. Karen Priestman / Melanie Liley	1. June 2023 2. June 2023 3. July 2023	5 Catastrophic Harm	2 - Unlikely	High
PR1 PR2 PR3 PR4	15	Risk of routine patients referred to Paediatric SLT having delayed assessment and intervention. Across all localities in York, Selby, Scarborough, Ryedale & Whitby	18/03/2021 CRR 05/04/2023	There is a risk that the children who have been referred to SaLT and are triaged as "Routine" will have a long wait for their initial assessment and any subsequent intervention. This is due to a shortfall in the SaLT workforce capacity to manage the significant backlog of patients who were delayed in being assessed and treated during the COVID period and the increased demand and complexity of referrals now coming to the service as a result of delayed assessment. This could result in a delayed diagnosis and poorer speech and life outcomes for those children, as well as a poor experience while waiting for their families.	All children triaged by Band 7 therapists. All children identified as urgent are seen within 2-8 weeks. - Opt in process is in place as follows: 1) at initial referral to be put on WL and 2) to book an appointment (if waiting over 18 weeks for routine assessment) to enable parental engagement and therefore reduction in WNB, highlighting safeguarding concerns quickly and reducing lost clinical time. -Case history proforma sent to parents prior to appointment led to increased capacity for assessment in f2f sessions which increased child engagement and focussed discussions with parents - Upstream focus in educating referrers using Care Aims Approach - significant transformation programme of work to consider a more effective delivery model for future with a focus on enablement rather than impairment; this has now enabled a more structured action plan to be proposed for 23-24 to address the waiting list and backlog.	None Identified	Board Exec Committee Care Group Board Risk Committee	None Identified	Chief Nurse	03/05/2023	3 Moderate Harm	5 Very Likely	Significant		1.Further discussion around current caseload:Total discharge option proposed by ICS Ethics Committee work 2. Waiting List Opt in Letter 3.New pathway: Universal offer 12 sessions (maximum) 4. Enquiry Line 5. SLT Website Offer 6.Business Case Investment in additional SaLT capacity to better meet need and support reduction in backlog and waiting times: 19.25 WTE across York and Scarborough/Whitby/Ryedale 7. Staff Survey-Wellbeing	1. Jenna Tucker 2. Jenna Tucker 3. Vicky Wright 4. Vicky Wright 5. Vicky Wright 6. Jenna Tucker 7. Vicky Wright	1.May/June 2023 2. May/June 2023 3. May 2023 4. Sept 2023 5. August 2023 6. May 2023 7. May 2023	3 Moderate Harm	2 - Unlikely	2- Very Low

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	CQC Update Report
Director Sponsor:	Heather McNair, Chief Nurse
Author:	Hazel McAtackney, Interim Head of Compliance and Assurance Emma Shippey, Head of Compliance and Assurance

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 Board of Directors with an updated position in relation to the action being taken to address the CQC regulatory conditions.

On the 23 March 2023 the Maternity action plan, in response to the section 31 warning notice, was submitted in line with CQC requirements. The next submission is due on 21 April 2023.

The CQC wrote to the Trust on 15 March 2023 to request further assurance regarding the section 31 for the Emergency Departments in relation to Mental Health Risk assessments. A response was sent by the Chief Nurse on 30 March 2023.

Recommendation:
For the Board of Directors 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**
Quality and Safety Assurance Committee	24 April 2023	*Meeting not held when papers were due.*

CQC Report
April 2023

1. Introduction and Background

Four inspections have taken place between 2019 and 2022 which have resulted in enforcement action. We received confirmation from the CQC that the Section 29A warning notices have been lifted.

An update on the following sections, which remain in place, is provided in this report:

- York and Scarborough Emergency Department – Mental Health Risk Assessments. (Jan 2020)
- 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

The Quality and Regulatory Assurance Group meets fortnightly. All Care Groups (not just the areas inspected) provide assurance on the CQC topics below.

Assurance Topic	Date	Assurance Topic	Date
Update MCA/DOLS	24.11.22	Workforce part 2 (split session)	02.03.23
Clinical Risk Assessments	08.12.22	IPC	16.03.23
Deteriorating Patients	22.12.22	Nutrition and hydration update	30.03.23
Catch up session to review deferred papers.	02.02.23	Staff education and training	13.04.23 *Deferred*
Workforce part 1 (split session)	16.02.23	Mental Capacity (returning assurance)	27.04.23

The Care Groups presented their assurance for Regulation 14 - Nutrition and Hydration at the QRAG meeting on 30 March 2023. Updates from the reports included:

Care Group 1 reported on the positive impact of the Patient Services Operatives in supporting the nutritional and hydration needs of patients. A recruitment event is taking place for Care Group 3 and if successful and all areas are fully established, the remaining candidates will be shared within Care Group 1.

Care Group 2 had a nutritional focus week with a nutrition information board competition which was won by Maple ward. The matron team and ward leaders have been present on wards at mealtimes talking about red trays and importance of accurate recording of intake.

Care Group 3 use a Nucleus dashboard but have noted anomalies that are still being addressed. These are primarily in relation to rates of completion of MUST score and risk assessments for patients who are admitted to a downstream surgical ward from the acute surgical admission area.

Care Groups 4 & 6 had the Digital Lead Nurse attend two time out days to talk about Nucleus and how the wards can improve compliance with assessments. It was noted that recording weight is impacting nucleus data as there is not a n/a option for recording weight when caring for patients at end of life.

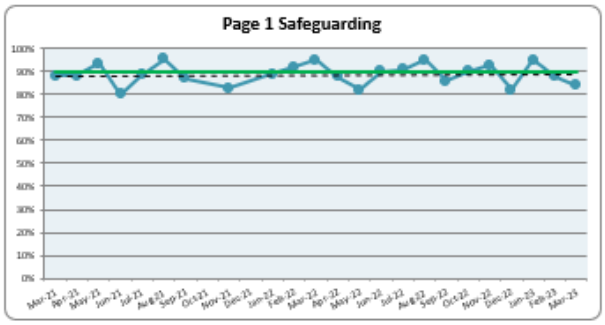
Care Group 5 have completed monthly fundamentals of care audits and although these have highlighted some good consistent practice they have also demonstrated some gaps in assurance. For neonates this have been around the documentation and recording of feeds, NG tube placement and pH gastric aspirate. These have been added to the documentation and the nurse educator has worked with the nursing staff to embed this.

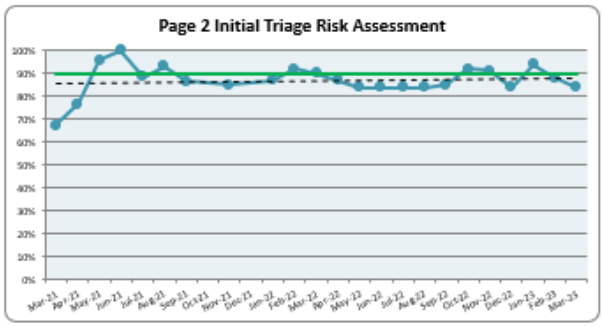
3. Section 31: York and Scarborough Emergency Departments, Mental Health Risk Assessments (January 2020)

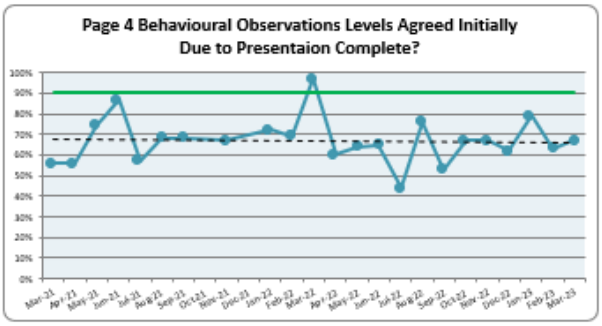
The CQC were not assured that patients who presented to the emergency departments with mental health needs were being assessed and cared for safely.

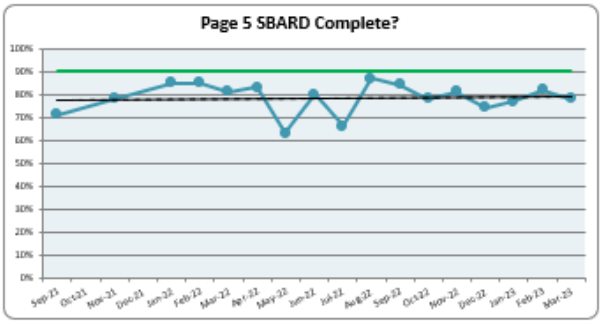
The CQC wrote to the Trust on 15 March 2023 to request further assurance regarding the section 31 for the Emergency Departments in relation to Mental Health Risk assessments. A response was sent by the Chief Nurse on 30 March 2023. Aside from acknowledging receipt of the information, no further correspondence has been received from the CQC. The results from the Mental Health Risk Assessment audits, with data from March 2023, can be seen below:

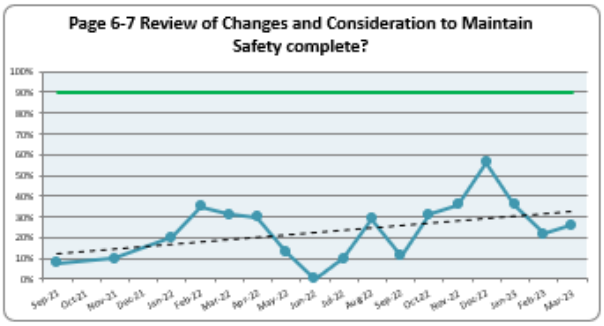
York Emergency Department



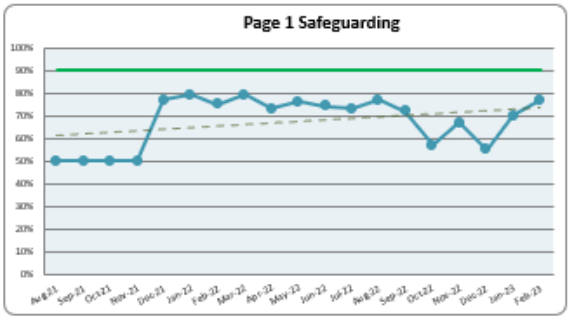


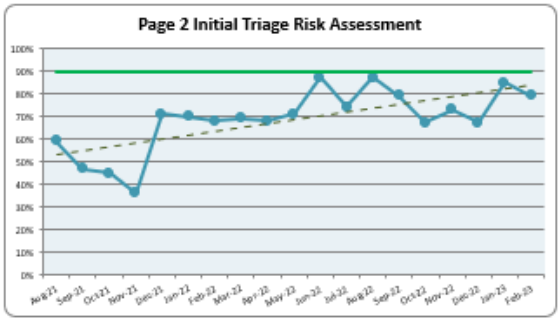


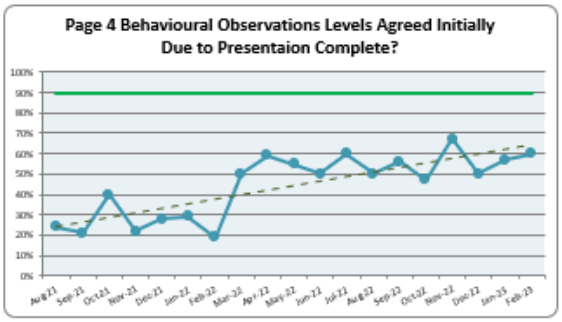


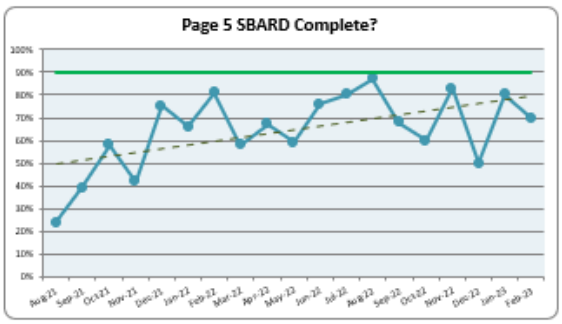


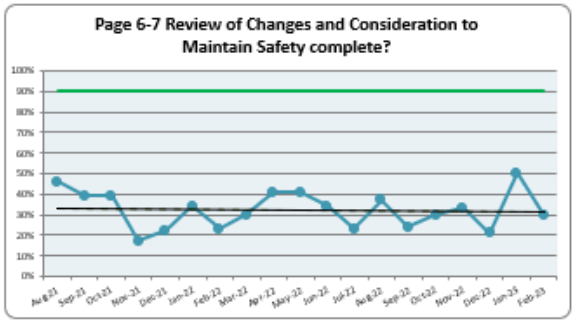
Scarborough Emergency Department











The Sister from the Emergency Department at York (Sarah Tugwell) reported that some mental health risk assessments were not completed for the sample of patients selected. However, if those which only had an incomplete back page are discounted, then 34 booklets were fully complete which is an improvement on the February 2023 results. The clinical educators continue to work with the team, the audit results are reported to staff and themes included in the daily safety brief.

The mental health assessment will be available on Nucleus in the coming months. The scope of the audit will therefore be reviewed with a focus on the quality of care delivered.

4. Section 31: Maternity and Midwifery services (November 2022)

Overview of Section 31 Action Plan Progress (InPhase)

Off track	1
At risk of exceeding timescale for delivery	21
On track	2
Complete	40

There are challenges in gaining updates from action leads in a timely manner. Delivery of some of the actions lacks assurance as not all workstreams are fully operational. The

Improvement Director is reviewing the assurance that can be provided in relation to delivery of the required improvements and this will inform the next steps.

On the 23 March 2023, the Trust submitted to the CQC:

- An updated copy of the InPhase action plan
- All reports written to provide assurance to senior leadership team / Trust Board to demonstrate compliance with conditions
- An update on training figures
- Maternity dashboard

The Head of Compliance and Assurance commenced in post in March 2023 and has worked with the Director of Midwifery in drafting the Maternity Services Section 31 CQC update report. The report for April 2023 has been circulated to the Quality and Safety Assurance Committee members prior to submission on 21 April 2023.

5. York Hospital Medicine Inspection (March 2022)

Section 29A (now expired)

CQC findings:

- Governance systems and processes failed to mitigate the risks identified in relation to nutrition and hydration, pressure area care and falls.
- Our inspection found that staff were not appropriately or consistently assessing and managing risk to patients. They did not always provide appropriate assessment and support to meet patients' nutrition and hydration needs; pressure area care and falls prevention.
- Patient risk assessments in these areas were not always completed contemporaneously and the care provided to mitigate risk was not always in line with the assessment.
- Staff did not always adhere to the requirements of the Mental Capacity Act.

While the CQC have lifted the condition of registration, we continue to monitor the action plan delivery.

Overview of Progress with the Section 29A Action Plan (InPhase)

Off track	1
At risk of exceeding timescale for delivery	0
On track	1
Complete	30

*Provision of bumpers and crashmats. These have been delivered at Scarborough in March, however there is a delay in the order for York. The Matron in ED is liaising with Procurement on a weekly basis to follow up on the order. The target date was originally 28 February 2023.
**The Visiting Policy is tabled for approval by the Senior Nurse Management Team on 28 April 2023.

CQC Inspection Report (Published June 2022)

Overview of Progress with the CQC Inspection Action Plan (InPhase)

Off track	0
At risk of exceeding timescale for delivery	0
On track	1*
Complete	24

*the action relates to the storage and location of medical records on wards. With the introduction of Nucleus, the volume of paper records needed is reducing. This action deadline has been changed to 30 June 2023 to allow time for Nucleus to become embedded across the Trust. In the meantime, to mitigate the risk of paper records not being stored securely the Information Governance team carry out regular walk round on ward areas giving immediate advice if needed.

Mental Capacity Act

The service must ensure that where a service user is 16 or over and is unable to give consent because they lack capacity to do so, care is given in accordance with the Mental Capacity Act 2005. (Regulation 11(3)).

Mental Capacity is the focus of the QRAG meeting on 27 April 2023. An update on the assurance provided from the Care Groups will be included in the May 2023 CQC update paper.

A system update to Tendable in February 2023 meant there was no information was reported. The March 2023 data is shown below:

Question	March 2023
Is there a capacity assessment completed within the notes?	94%
If yes, has this been completed fully including specifying the decision to be made?	96%
What was the decision stated on the form?	98%
Has a DOLS application been completed?	98%
If yes, is DOLS application documentation accurate and complete?	94%
Is a hospital passport or "what matters to me" document completed and available?	44%
If this document is available, is there evidence that care is being delivered as per this document?	100%

The Tendable audit results are all above 90% aside from the hospital passport question. Further assurance from the Safeguarding team will be provided in the May 2023 report.

Risk Assessments and Care Planning

The service must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users receiving the care or

treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b).

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 Nucleus data for March 2023 is shown below:

Assessment	January 2023	February 2023	March 2023
Patients with an up to date falls assessment	92%	93%	91%
Patients with an up to date bedrails assessment	92%	92%	93%
Patients with an up to date MUST assessment	72%	78%	79%
Patients with an up to date actual weight	79%	79%	80%
Patients with an up to date Purpose T	89%	92%	91%
Patients with up to date skin checks	76%	72%	78%
Patients with up to date documented hygiene care	93%	86%	92%
Patients with up to date rounding tasks (within 1 hour)	69%	74%	80%
Patients with at least 2 digital evaluations in last 24 hrs	71%	66%	48%

The Nucleus data in the table above will be presented at the next meetings of the Nutrition Steering Group, Falls Improvement Group and the Pressure Ulcer Improvement Group to triangulate with other data and inform improvement discussions.

The Chief Nursing Information Officer (Nicola Coventry) provided an update in regard to Nucleus data:

- As the current documentation was developed in silo, there are know significant areas of duplication and overlap, for example, there are >300 questions in the admission process. These can take from 30 to 90 minutes to complete. Nurses reporting having to stay behind at least once a week to complete documentation. These are under review.

The service must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1).

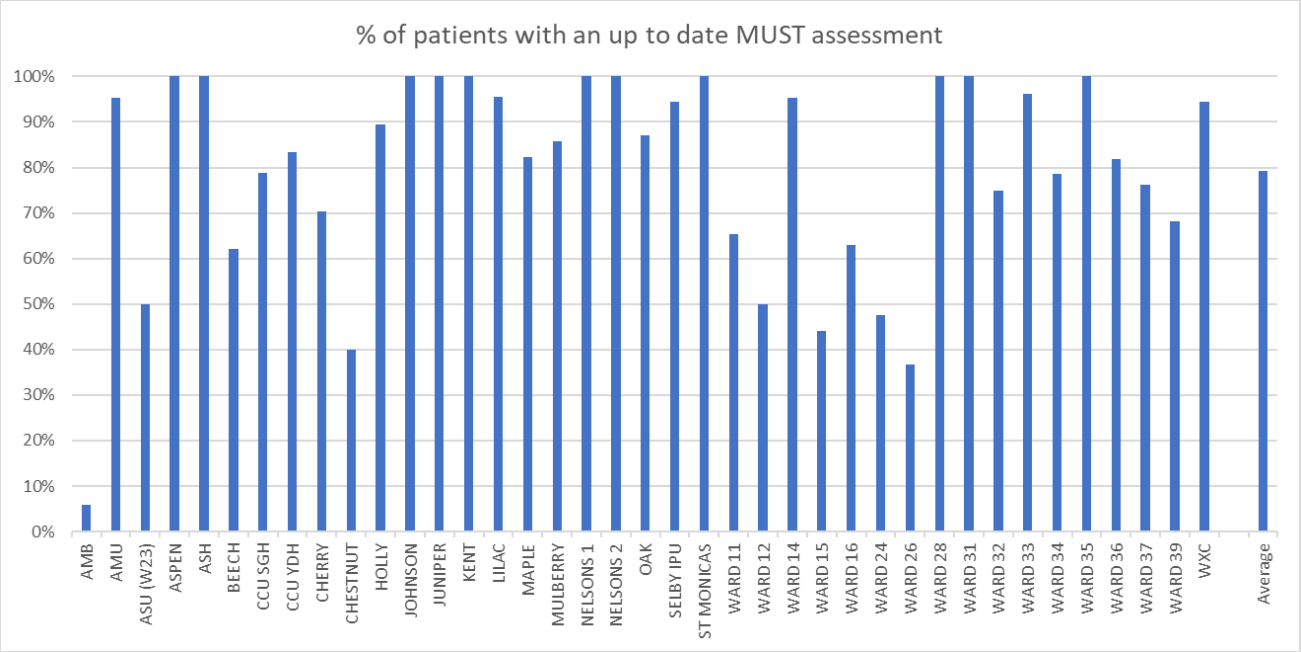
MUST Assessments

MUST assessments are now completed on the Nucleus system and performance can be tracked via the Signal dashboards.

The Nucleus dashboard is now live, and all ward managers and Matrons are reviewing this data monthly to focus improvements in completion of risk assessments and care planning. There has been improvement over the past few months with completing assessments in line with Trust policy and procedure. Additional work on MUST compliance is required as completion within 24 hours remains low.

In May 2023, the Nutritional Steering Group are holding a session to develop a plan for nutritional health covering the next 12 months. This will inform an improvement plan for the year with a focus on fluid management and nutritional needs.

The data for March can be seen below:



Should Do Action

There was one 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

One action was put in place to establish a subgroup with the aim to develop consistently high-quality accessible programmes in the trust. This action addresses the training and professional development elements of the requirement; however, it is not clear if the support, supervision, and appraisal. The training sub-group have been requested to further review this action.

6. York ED Inspection October 2022

Overview of Progress with the York ED Action Plan (InPhase)

Off track	1*
At risk of exceeding timescale for delivery	0
On track	0
Complete	24

*The action was for ED Clinical Educators to deliver bite-size medicines management fundamentals training to all registered ED staff**.** This deadline has been extended from 17 November 2022 to 31 January 2023 due to pressures within the department. A further revised deadline of 30 April 2023 was agreed at QPAs in March 2023.

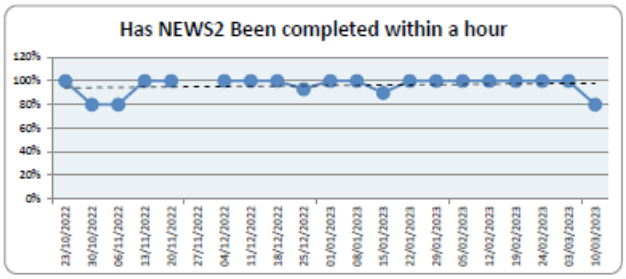
ED delays (including 12 Hour Stays)

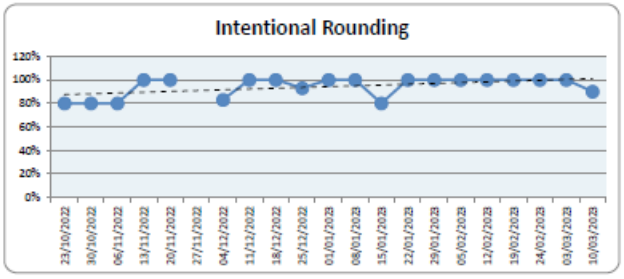
On a weekly basis the ED team undertake audits of key safety metrics for the 10 longest waits in both ED departments. The most recent audits are shown below.

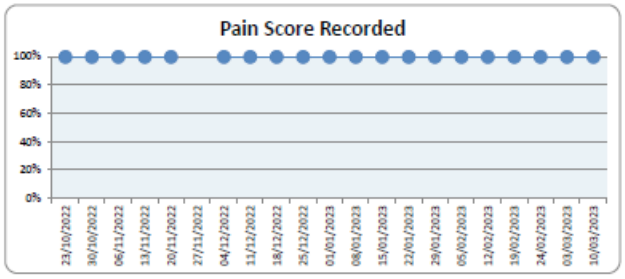
The ED are reviewing their action plans to ensure that the actions required are being implemented. Assurance of the action plan delivery will be overseen through the Care Group Quality and Safety meeting.

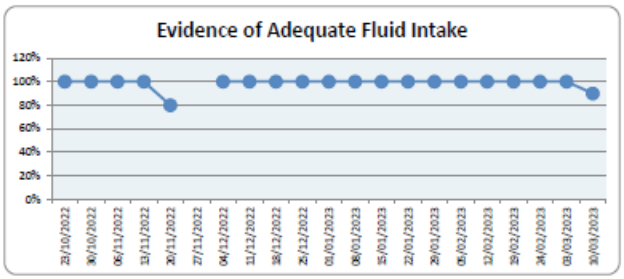
The audit results are shown below.

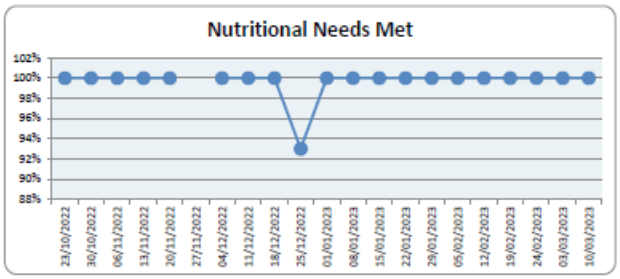
Scarborough Emergency Department +12 hour stay audit results.

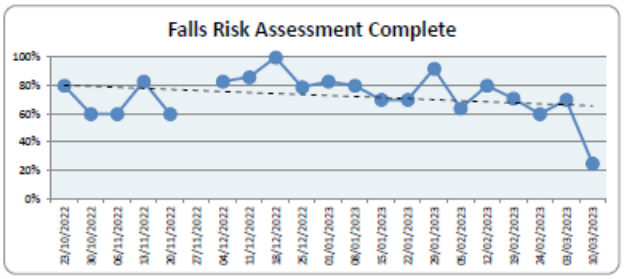


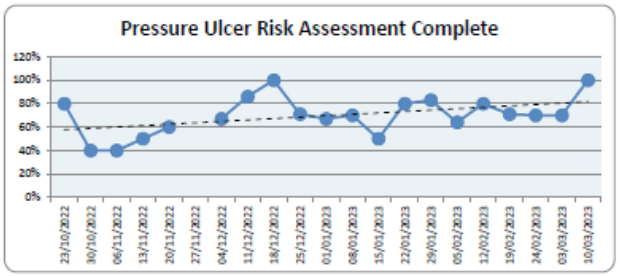


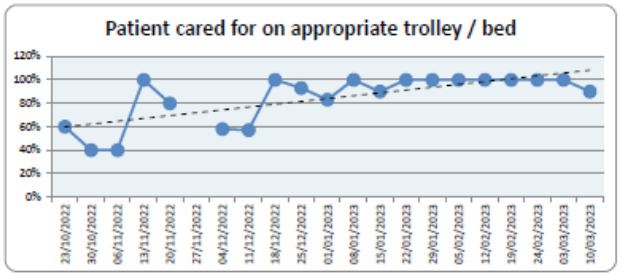


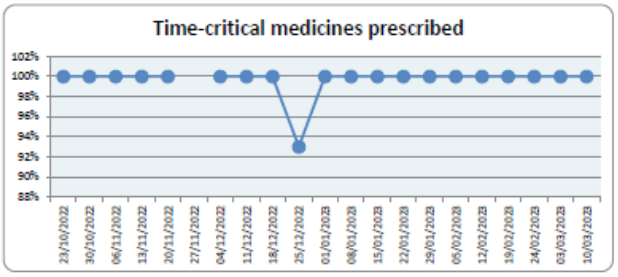


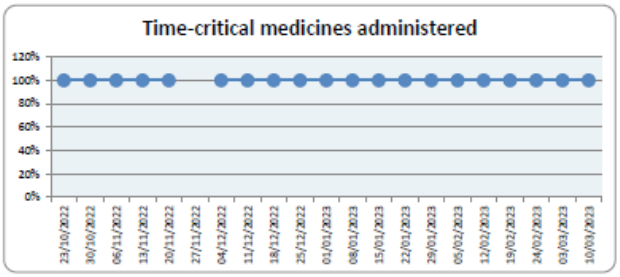


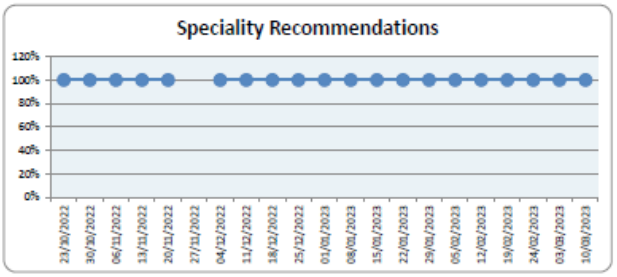


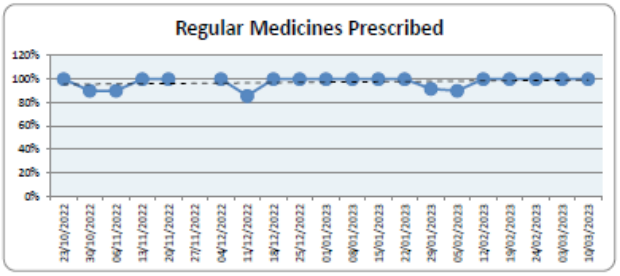

Pressure Ulcer Risk Assessment Complete

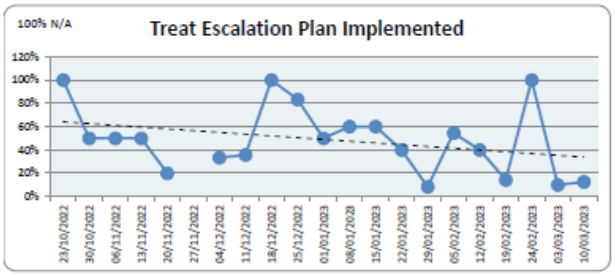

Patient cared for on appropriate trolley / bed

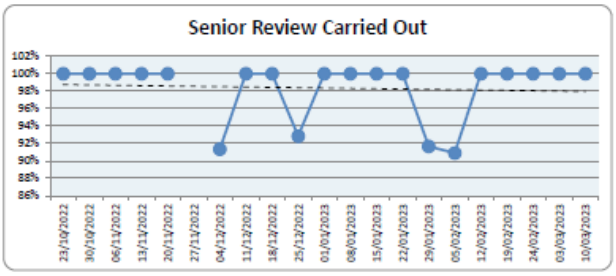

Time-critical medicines prescribed

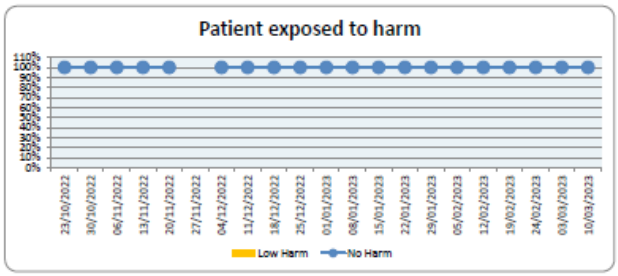

Time-critical medicines administered


Speciality Recommendations

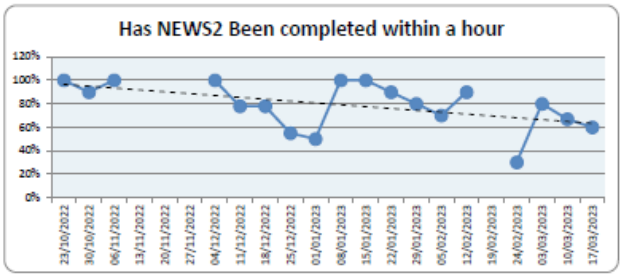

Regular Medicines Prescribed

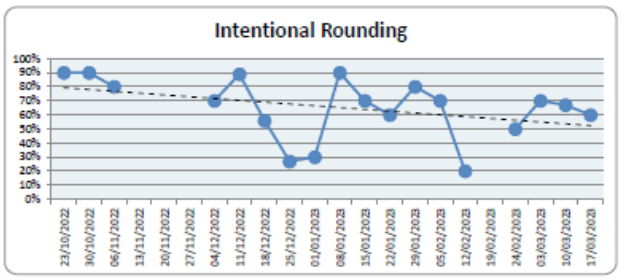

100% N/A
Treat Escalation Plan Implemented

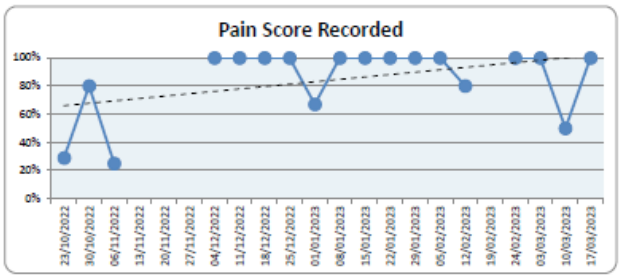

Senior Review Carried Out

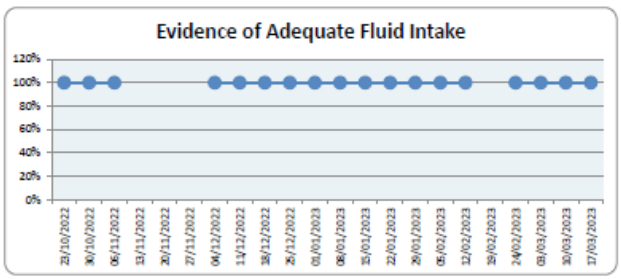

Patient exposed to harm
Low Harm
No Harm

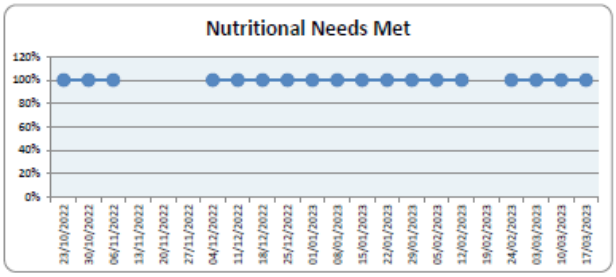
York Emergency Department +12 hour stay audit results.

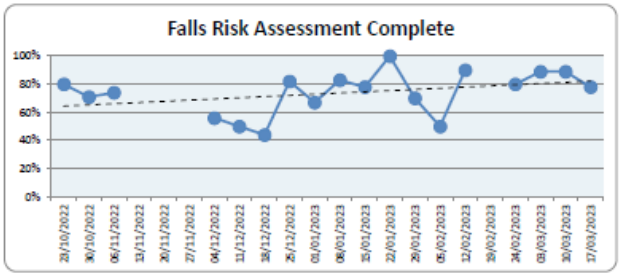


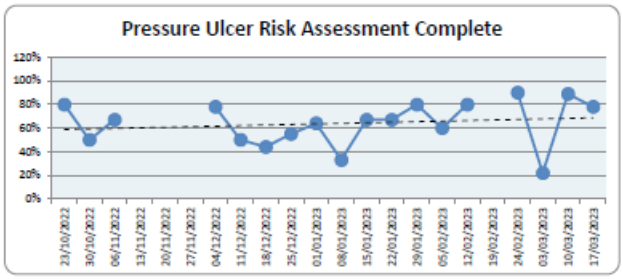


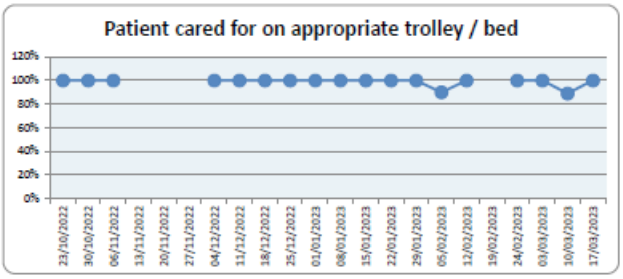


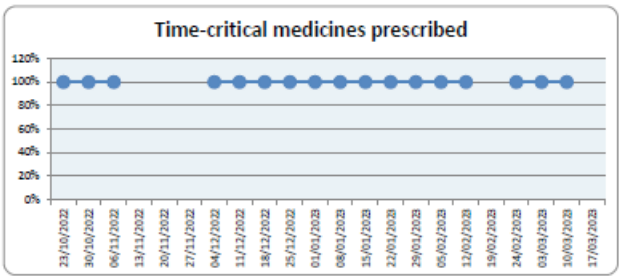


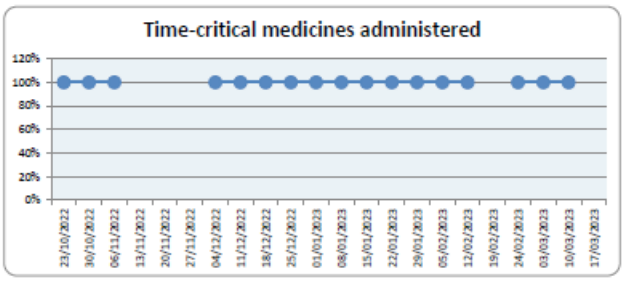


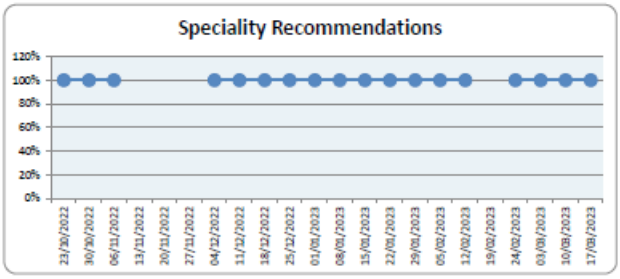


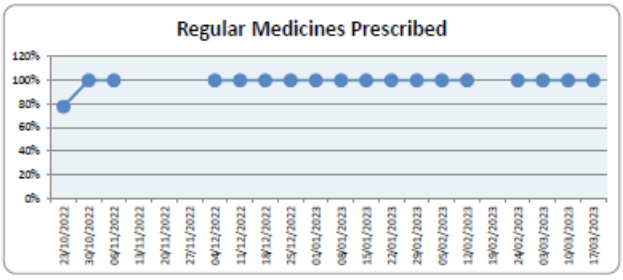


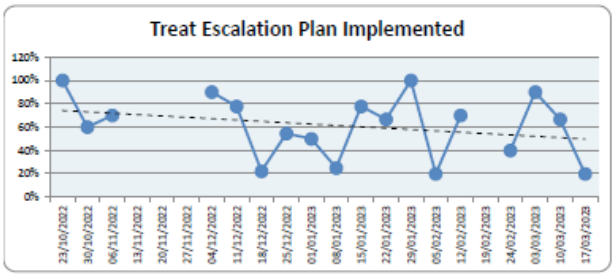


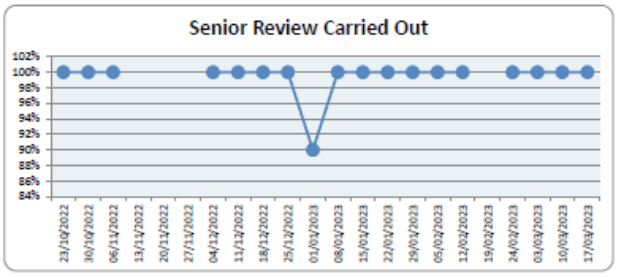


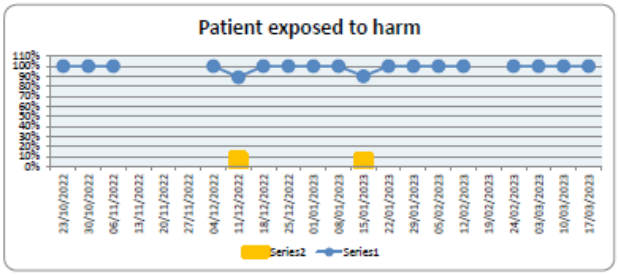












5 Recommendation

The Quality and Safety Assurance Committee is asked to consider the update within this report and the assurances for the delivery of key actions.

Date: 17 April 2023

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Perinatal Clinical Quality Surveillance Update
Director Sponsor:	Heather McNair Chief Nurse
Author:	Sue Glendenning, Interim Director of Midwifery Sarah Gallagher, Quality and Governance Lead, Care Group 5

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 outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document *'implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Trust Board of present and emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board; insight across the multidisciplinary, multi professional maternity services team. The information within the report will reflect actions in line with Ockenden and progress made in response to any identified concerns.

The maternity service continues to review and report all outcomes in relation to perinatal mortality and the external reporting criteria to HSIB (Healthcare Safety Investigation Branch), MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and PMRT (Perinatal Mortality Review Tool).

The service is currently supported by a Maternity Improvement Advisor as part of the NHSE Maternity Safety Support Programme (MSSP).

The maternity service has reported non-compliance with seven of the ten Safety Actions required by the NHS Resolution Maternity Incentive Scheme (MIS). Rapid work is being

undertaken across the multidisciplinary team to address this. Details of progress will be included in future reporting.

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

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History

Meeting	Date	Outcome/Recommendation
Quality and Safety Assurance Committee	24th April 2023	

1. Detail of Report and Assurance

1.1 Introduction

The Report of Donna Ockenden published on 30 March 2022, is the second and final report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an 'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust'. The final publication provided an additional 15 IEAs comprising ninety-two recommendations highlighting an urgency for essential change and improvement to maternity and neonatal services. Specific focus on listening to families is a key driver of both the interim and final reports, with Trusts expected to investigate, learn, and embed improvements to ensure the safety of women, babies, and families in their care.

Other key drivers for improvement and safety are, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality, MMBRACE and the perinatal mortality review tool, HSIB investigation and national reports, the Maternity Incentive Scheme and three-year delivery plan for maternity and neonatal services was published in March 2023 which identifies four key themes in supporting safer maternity and neonatal services.

The report below outlines the current trust position against the guidance and the current intelligence in relation to perinatal quality performance.

As part of the ongoing improvement work being undertaken within the care group Maternity services continue to be supported by the National and Regional Maternity Teams as part of the Maternity Safety Support Programme (MSSP).

1.2 Perinatal Surveillance Model

CQC Maternity Rating 2019	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Good	Requires Improvement	Good	Good	Good
Maternity Safety Support Programme		Yes				

	2023/2024											
	Jan	**Feb**	**Mar**	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Findings of review of all perinatal deaths using the real time data monitoring tool	4	0	0									
Findings of review of all cases eligible for referral to HSIB	0	1	0									
Report on the number of incidents logged graded as moderate or above	4	3	1									
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	71.8%	Trust Learning Hub not available										
Minimum safe staffing in maternity services to include. Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively												
Service user feedback	99%	-	-									
Staff feedback from frontline champion and walk abouts	1	1	1									
HSIB/NHSR/ CQC or other organisation with a concern or request	0	0	0									
Coroner reg 28 made directly to the Trust	0	0	0									
Progress in achievement of MIS 10												
Proportion of midwives responding with Agree or ‘strongly agree’ on whether they would recommend their trust as a place to work or receive treatment												Report Annually
Proportion of speciality trainees in Obstetrics and Gynaecology responding with ‘excellent’ or ‘good’ on how they would ratee the quality of clinical supervision out of hours												Report Annually

2. Current Perinatal Quality Intelligence

2.1 Moderate Harm Incidents reported March 2023

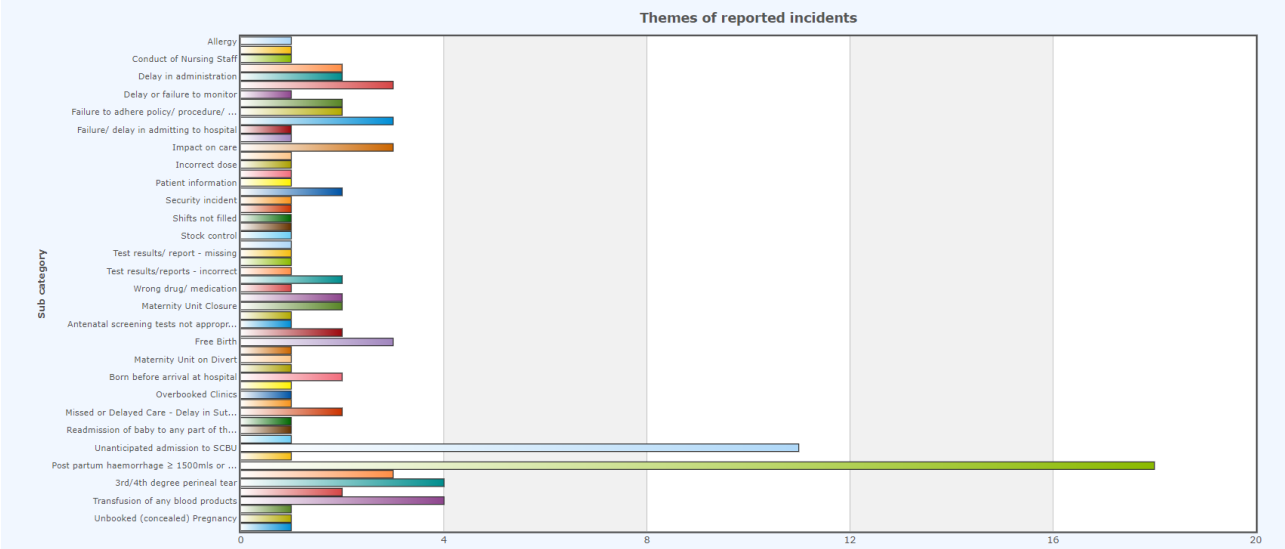
There has been a rise in the reporting of moderate harm incidents following the CQC inspection in 2022. The Ockenden report recommends that the categorisation of harm and the recommendation of harm levels should be considered from the perspective of the woman's experience and outcomes. All incidents where there is the potential for moderate harm to have occurred are reviewed at the weekly case review meeting attended by the MDT (including paediatricians) to ensure there is a rigorous review of the care pathways have been followed appropriately and that women and their families are offered support and a debrief should they want one. All women where there has been the potential for moderate harm are provided with a leaflet on discharge informing them that their care will be reviewed at the Maternity Case Review meeting and directing them to the Family and Friends Test Survey.

The following incident were highlighted as having the potential for moderate harm in March 2023, the incidents where the harm was downgraded to low/minor following MDT discussion and investigation are marked with an *.

Datix Number	Incident Category	Outcome/Learning/Actions
Postpartum Haemorrhage (PPH)/Major Obstetric Haemorrhage (MOH)		
WEB180097* WEB181619* WEB181280* WEB181645* WEB180017* WEB180920* WEB179898* WEB180100*	PPH>1.5 litre	The Maternity Services Data Set at December reports that the national average for PPH over 1.5 litres is 30/1000 births, the Trust average is 41/1000 births. 2.6% of births in March 2023 had a PPH of over 1.5 litres and there has been a reduction in this percentage over the last quarter (see maternity dashboard). Labour ward statistics demonstrate that of the PPH in March, three were following emergency caesarean section, two following elective caesarean section, three following spontaneous vaginal delivery, including one freebirth and one was a forceps delivery following an episiotomy. Perineal laceration and episiotomy increase the risk of PPH following delivery.
Arterial cord pH<7.1		
WEB 181026*	Low cord gas (below pH7.1 venous or below 1.05 arterial)	Baby born in poor condition, required basic resuscitation but was not admitted to the SCBU. The case was reviewed at the MDT maternity case review meeting which

		was attended by the fetal monitoring lead midwife. Following review, the decision was made that there minor/low harm caused to the baby but there was identified learning which will be included as part of the fetal monitoring training. Individual feedback for the staff involved was provided by the Clinical Director.
3rd and 4th degree tears		
WEB288343*	First baby, instrumental delivery, third degree tear	The Maternity Services Data Set at December reports that the national average for 3rd and 4th degree tears is 27/1000 births, the Trust average is 18/1000 births. The Trust refer women into the perineal tear clinic and offer a debrief. All 3rd and 4th degree tears are reviewed at the weekly Maternity Case Review
WEB180229*	Second baby, instrumental delivery as failure to progress, 3c tear	
WEB180098*	First baby, vaginal birth, 3b tear	
WEB180802*	Second baby, shoulder dystocia, 3b tear	
WEB181460*	First baby, vaginal birth, 3b tear	
Term admissions to the Special Care Baby Unit (SCBU)		
WEB181756*	Respiratory support	All term admissions to the special care baby unit (SCBU) are discussed at weekly Maternity Case Review attended by paediatricians. Of the eleven admission 8 were at the Scarborough site. These will be reviewed at ATAIN meetings in April for themes.
WEB181542*	Respiratory support and low blood sugars	
WEB181407*	Respiratory support	
WEB181162*	Respiratory support	
WEB180855*	Sepsis screening	
WEB180835*	Low blood sugars	
WEB180766	Respiratory support	
WEB180148*	Respiratory support	
WEB180080*	Respiratory support	
WEB179900*	Respiratory support	
WEB179834*	Respiratory support	
Other Moderate Harm Incidents		
WEB180010	Potential failure to identify the deteriorating patient	A Patient Safety Incident Report has been completed following MDT review and will be presented to the Trust Patient Safety Meeting in April 2023. The harm level was downgraded following presentation at this meeting
WEB180003	Bladder injury following emergency caesarean section	A Patient Safety Incident Report has been completed following MDT review and will be presented to the Trust Patient Safety Meeting in April 2023. The harm level was downgraded following presentation at this meeting

2.2 Current Open Incidents



All incidents are reported as described in the Incident Reporting (Datix) Guideline. The most reported incident is Postpartum Haemorrhage over 1.5 litres followed by unexpected admission to SCBU.

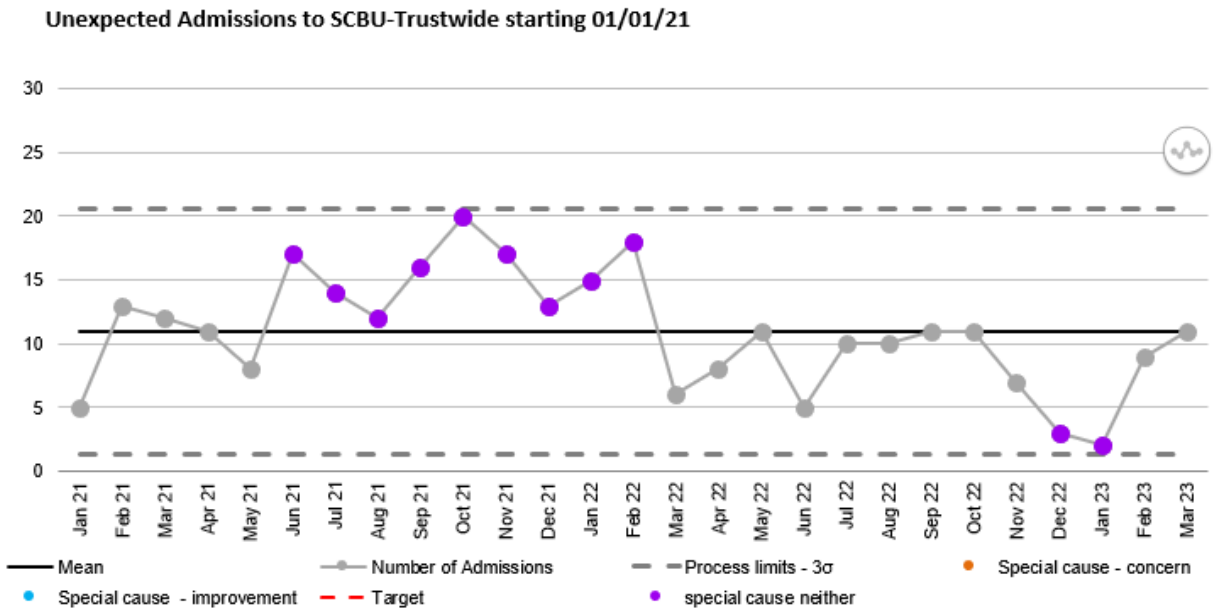
Unexpected admissions to SCBU

The national maternity and neonatal transformation programme has identified that over 20% of admissions of full-term babies (born at or over 37 weeks) to neonatal units could have been avoided and that there is the potential for harm to be caused when babies are separated from their mothers when it is safe for them to be kept together.

The Maternity Incentive Scheme, Safety Action 3: '*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?'* is an area of reported non-compliance for the Trust due to not having an embedded and robust review process in place with oversight from the obstetric and neonatal team as well as the opportunity for shared learning. This is a risk to the safety of babies and their families.

The transitional care pathway allows babies who need additional care after birth but do not require the level of support provided in SCBU to stay on the maternity wards with their mothers with support from neonatal nurses has been reopened on the York site, there is no pathway at the Scarborough site. This is a risk for the service and does not provide equitable care for women and babies.

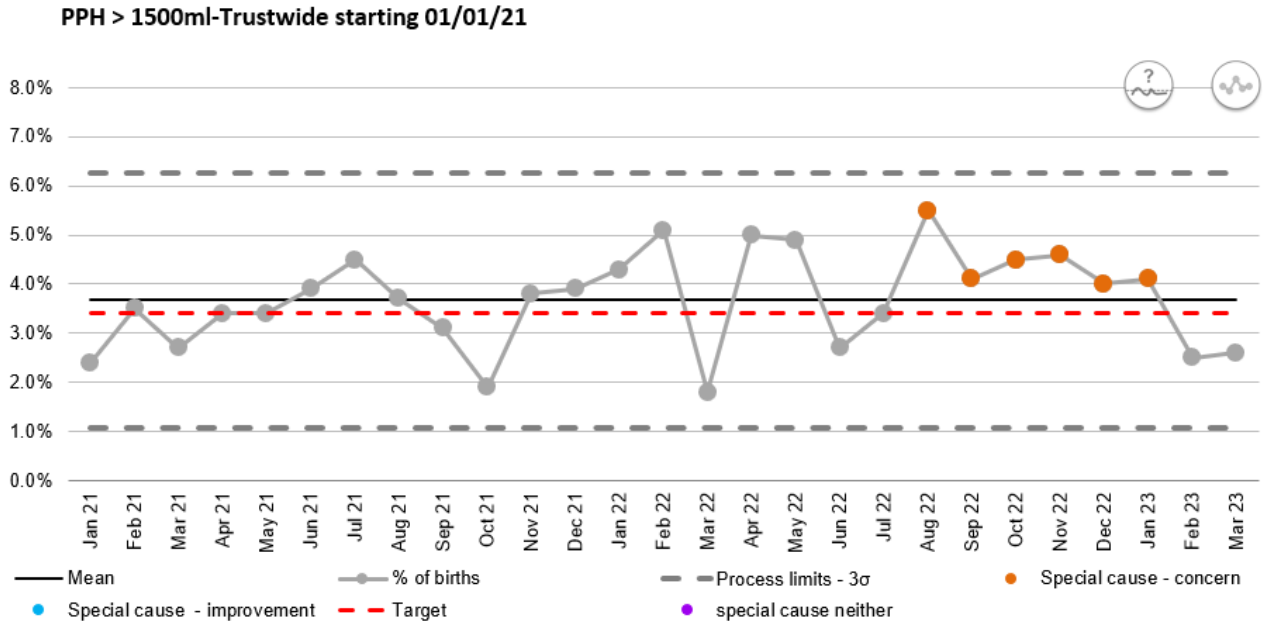
As mitigation and until these processes are embedded, the service reviews the number of admissions to SCBU as part of incident reporting and monitors the rate and any emerging themes or trend. The national ambition is for the rate to be below 5% of all births, the Trust is rate at the end of Q4 is 2.9% of births.



Postpartum Haemorrhage

The national Maternity Services Data Set for December reports that the national average for PPH over 1.5 litres is 30/1000 births, the Trust average is 41/1000 births.

In March 2023, 2.6% of births at the Trust had a PPH of over 1.5 litres and there has been a reduction in this percentage over the last quarter with no special cause variation noted on the SPC charts. The regional average within the LMNS (North Lincolnshire and Goole NHS FT, Hull University Teaching Hospitals and York and Scarborough NHS FT) is 3.6%.



2.3 Serious Incidents and HSIB Reports (Q4 2023)

Date Reported	Incident Details	Immediate Action Taken
11/01/2023	Postpartum haemorrhage following elective caesarean section. Total blood loss 3555mls SI declared. Under investigation.	Identified that the PPH proforma had not been complete, ensured they were available on the ward and in theatre Review and reflection of the case with the team involved
25/01/2023	Intrauterine stillbirth at 27+4 weeks. Hysterectomy following caesarean section SI declared. Under investigation.	Highlighted the requirement for a full set of observations to be undertaken in triage Review of the reduced fetal movement guidelines to ensure it reflects national guidance
12/02/2023	Baby transferred for therapeutic cooling to a tertiary unit to reduce the impact of HIE. Meets the criteria for HSIB investigation. Notification made.	Review of the case by the MDT, the review team concluded that this was an unavoidable admission and could not have been anticipated
13/02/2023	PPH following caesarean section that resulted in a hysterectomy. SI declared. Under investigation.	Rapid improvement work undertaken around the scoring of MEWS and understanding the barriers to recognition, calculation, and escalation of the deteriorating patient

2.4 HSIB Reports – implementation of recommendations and actions

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria, taken from Each Baby Counts and MBRRACE-UK. To meet the requirements of the 15 Immediate and Essential Actions (IEAs) from the Ockenden Report all incidents meeting this criterion are reported as SI's by the Trust however the investigations are undertaken by HSIB.

The requirement of Maternity Incentive Scheme, Safety Action 10 is : *Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification Scheme from 1 April 2021 to 5 December 2022.* The Trust is complaint with this action.

There are currently six active investigations being undertaken by HSIB and are highlighted below.

Reference and date	Criteria met	Emerging Learning	Immediate Action taken
MI-012762 01/08/2022	Maternal Death	Draft report received; five safety recommendations made Adherence to national guidance	Guideline updated to reflect RCOG guidance Audit to ensure all women with epilepsy are under consultant led care

		Communication between Trusts	
MI-017313 29/10/2022	41+0 weeks, intrapartum stillbirth	Draft report received. No emerging learning identified. No safety recommendations Investigation is exploring the systems and processes with maternity triage and care in the latent phase of labour	Benchmarking to be undertaken alongside the HSIB Assessment of risk during the maternity pathway, published March 2023 link
MI-017412 03/11/2022	Intrapartum stillbirth, breech presentation	Draft report received, one safety recommendation. The investigation explored birth preparation and education, information sharing in preparation for homebirth and complex births (breech)	Education sessions provided for all midwifery staff to improve documentation. Ongoing documentation audit to ensure compliance with NMC requirements and best practice
MI-017644 10/11/2022	HIE/Cooling	Draft report received, no safety recommendations. The investigation explored assessment of fetal growth, management of raised BP, oversight of induction of labour and intrapartum care.	There is now a daily consultant review and ward round of all women who attend the units for induction of labour.
MI-018270 26/11/2022	Early neonatal death	Awaiting report No emerging learning identified at this stage however the investigation is exploring, antenatal care, CTG interpretation, escalation and management, birth options and neonatal resuscitation	A neonatal resuscitation checklist and guide is under development to support staff during and following a neonatal resuscitation. This will be approved at the April Clinical Governance meeting and included on mandatory training and drop-in

			sessions held by the clinical skills midwives in May and June.
MI-022297 12/02/2023	HIE/Cooling	Investigation on going Areas to be explored are to be confirmed by HSIB.	Review of the case by the MDT, the review team concluded that this was an unavoidable admission and could not have been anticipated

2.5 Perinatal Mortality Review Tool Q4

All deaths of babies over 22 weeks gestation and all neonatal deaths for babies aged up to seven days are reviewed by the multidisciplinary team using the perinatal mortality tool. This is a national tool used in all hospitals across the UK developed by MMBRACE-UK, families are invited to be involved in the review process and receive a written summary of the care and the outcomes from the review.

The deadlines for completion of the reviews is a safety action required by the Maternity Incentive Scheme Safety Action 1: *Are you using the National Perinatal Mortality Review Tool to reduce perinatal deaths to the required standard?* All deaths must be notified to MMBRACE-UK within seven days and the initial review completed within one month. The tool must be completed by the multidisciplinary team within six months of the death to meet the MIS requirements. The Trust is compliant with this element of MIS.

CASES REPORTED						
Date of incident	**Reporting Criteria**	**Gestation**	**Details**	**Date to be/when discussed**	**Themes**	**Actions**
06.01.23	Neonatal Death	22+0	G9 P7+1 3 previous Lower Segment Caesarean Section Known placenta praevia and increta. Emergency caesarean performed due to antepartum haemorrhage. Total estimated blood loss of 7.1L and transfer to ICU. Baby sadly died shortly after birth.	21.04.23		
20.01.23	Unbooked Antenatal Stillbirth	24+0	Mother was unbooked and reports she didn't know she was pregnant and	21.04.23		

			delivered at home before any medical personnel arrived. Transferred to A+E and attended to by midwifery team when requested. Gestation was estimated by the Consultant Paed to be 24 weeks based on weight.			
25.01.23	Antenatal Stillbirth	27+4	Intrauterine death following a suspected concealed abruption 680ml estimated blood loss prior to delivery. Mother subsequently had a large postpartum haemorrhage, hysterectomy performed and transfer to ICU.	19.05.23		
CASES DISCUSSED AT PMRT MEETING						
19.09.22	Antenatal Stillbirth	37+0	Growth was noted to be tailing and there was fluid seen in bowel on ultrasound at 36+3. Referral was made to Fetal Medicine however baby sadly died prior to this appointment.	10.01.23	A plan to review the woman was made for 4 days later-after the weekend and Bank Holiday. A plan was to be agreed at this opportunity. This should have been	To ensure clear documentation of plans and thinking. Development of a SOP surrounding documentation and consent is an ongoing workstream.

					clearly documented as the intention. The risk allocation of this mother based on her history at booking was incorrect. This was an incidental finding that did not impact on the care of the woman or the baby.	Implementation of antenatal risk assessment tool in December at every appointment as safety netting. The use of the antenatal risk assessment is audited monthly with oversight from the Clinical Governance meeting.
19.09.22	Antenatal Stillbirth	38+6	At 38 weeks and 5 days, the mother self-referred with her first episode of reduced fetal movements. Staff were unable to hear the fetal heart on arrival and intrauterine death was confirmed via ultrasound scan. Mother was known polyhydramnios, but the fetal growth was plotting within normal range.	10.01.23	There is no evidence in the notes that this mother was asked about domestic abuse at booking. This was an incidental finding that did not impact on the care of the woman or the baby.	The introduction of Badgernet will make domestic violence and bereavement checklist completion mandatory.
28.09.22	Antenatal Stillbirth	35+6	Normal Symphysis Fundal Height (SFH) measurements antenatally. At 34+5	20.01.23	Lack of documentation within the	The introduction of Badgernet will make domestic violence completion mandatory.

			weeks, all well, reported good fetal movements. The SFH plots near 50th (minimal reduction in growth velocity) therefore a growth scan was requested. At 35+2 weeks the mother attended for ultrasound scan where sadly it was identified that the baby had died.		bereavement checklist. Not evident from the notes whether mother was asked about domestic violence. This was an incidental finding that did not impact on the care of the woman or the baby.	
29.10.22	Intrapartum Stillbirth	41+0	Mother attended in early labour, was assessed, and returned home to await events. Returned the following morning with increasing contractions, staff sadly unable to find fetal heartbeat. Intrauterine death confirmed on departmental ultrasound scan. Baby born by Emergency lower segment caesarean section 30/10/2022	17.02.23	Themes arising from the review mainly focus on reduced fetal movements not being acted upon.	Education sessions around documentation were provided for all midwifery staff in December 2023. Raising awareness of reduced fetal movements is included in the antennal risk assessment and is discussed with women at every contact. This audited monthly.

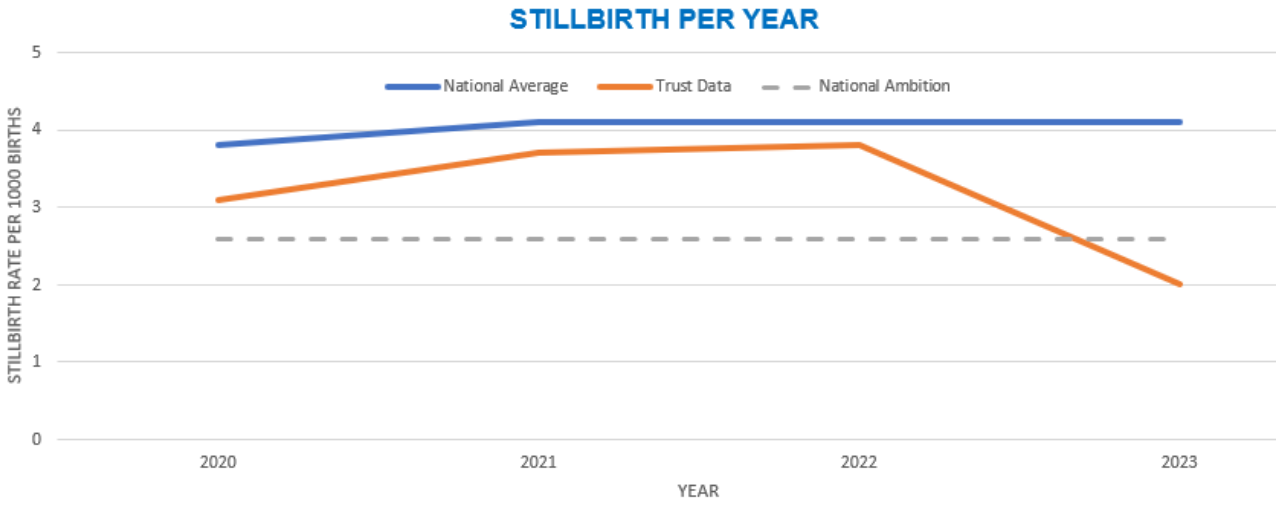
			due to failure to progress.			
03.11.22	Intrapartum Stillbirth	40+1	Baby was known to be breech and had short measuring femur. Mother was declining further care and obstetric input and opted for a home delivery against advice. Spontaneous rupture of membranes occurred at 01.00 at home, hospital not informed. Cord prolapses noted at 09.00 by the mother and triage called. Ambulance attended and transported to labour ward where the baby was confirmed to have died. Delivery by caesarean section.	17.02.23	This mother required transfer of her care but the time from decision to the transfer was too slow because there was a delay in the ambulance transfer due to ambulance not being able to access the property due to the location and weather conditions	The conclusion reached by the review team was that sadly this was unavoidable. Home birth assessment was complete, however, difficult to predict the conditions of the ground in advance.
26.11.23	Neonatal Death	40+4	Cat 2 trial of forceps due to pathological ctg. Baby born in poor condition with APGAR of 1/1 (HR <100). Inflation breaths and chest compressions commenced. 2222 paediatric emergency called. Required	24.03.23	This mother had an operative delivery but this was not carried out with appropriate urgency/grading This mother was induced but the type of fetal monitoring	Discussed at CTG case review with all involved for immediate learning and debrief Improved communication between the obstetric and paediatric teams to make it clear

			advanced resuscitation by paediatricians including intubation, drugs, umbilical artery catheter. No response - APGAR 0/5 0/10. Resuscitation stopped at 2021.		used during induction was not appropriate Recognition of hyperstimulation/ Tachysystole as indication for CTG. Reminder added into staff safety briefing.	when an emergency response it required

2.6 Stillbirth and Neonatal Deaths

A stillbirth is a baby born after 24 weeks gestation, which did not at any time breathe or show signs of life. In England, the government has an ambition to halve the number of neonatal mortality rate for babies born at a gestational age of 24 weeks or over, and to half the 2010 stillbirth rate by 2025.

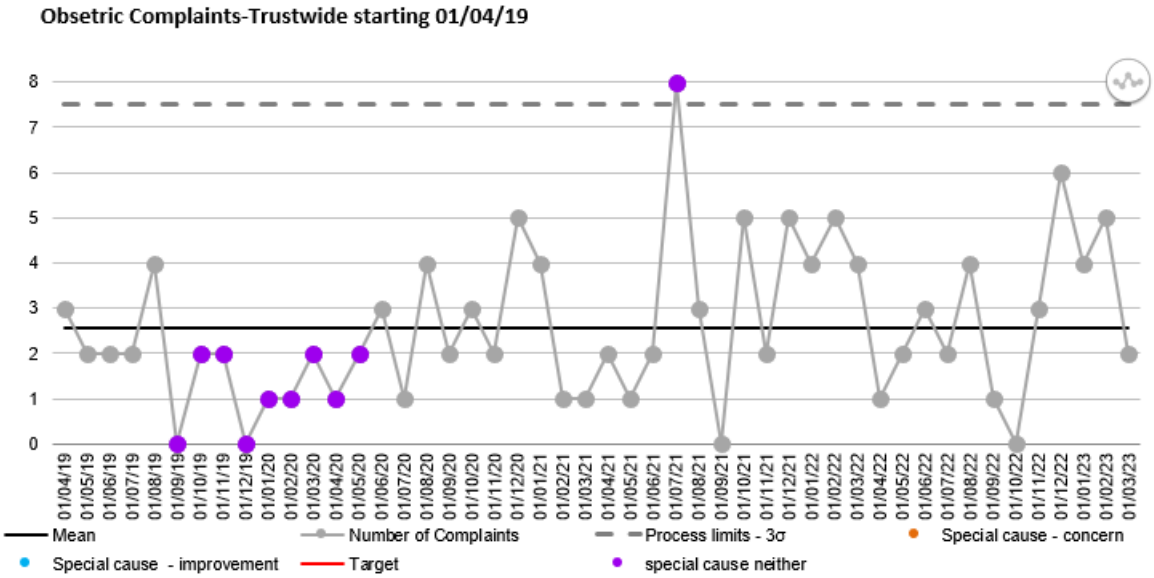
The stillbirth ambition in England is 2.6 stillbirths per 1000 births. In 2021, the rate was 4.1 stillbirths per 1000 births (ONS, March 2023). The current rate of stillbirth across both sites is 2 per 1000 births at the end of Q4, this has decreased from 3.8 per 1000 births in 2022. The Trust is committed to reducing the number of stillbirths in support of the national ambition.



2.7 Service User Feedback

Compliments and Complaints

There were eleven formal complaints (4 York, 6 Scarborough, 1 Bridlington) and thirteen concerns received in Q4 2023.



There has been decrease in the number of complaints in Q4 and the number in comparison to the number of births is low (11/949 births equates to 1.1%). Feedback from the people who use or visit our services is important to ensure that improvements are made. Work will be undertaken in April 2023 to ensure that the maternity complaints process aligns with PHSO NHS Complaints Standards, and we encourage women and their families to provide us with feedback and that this information is easy to access.

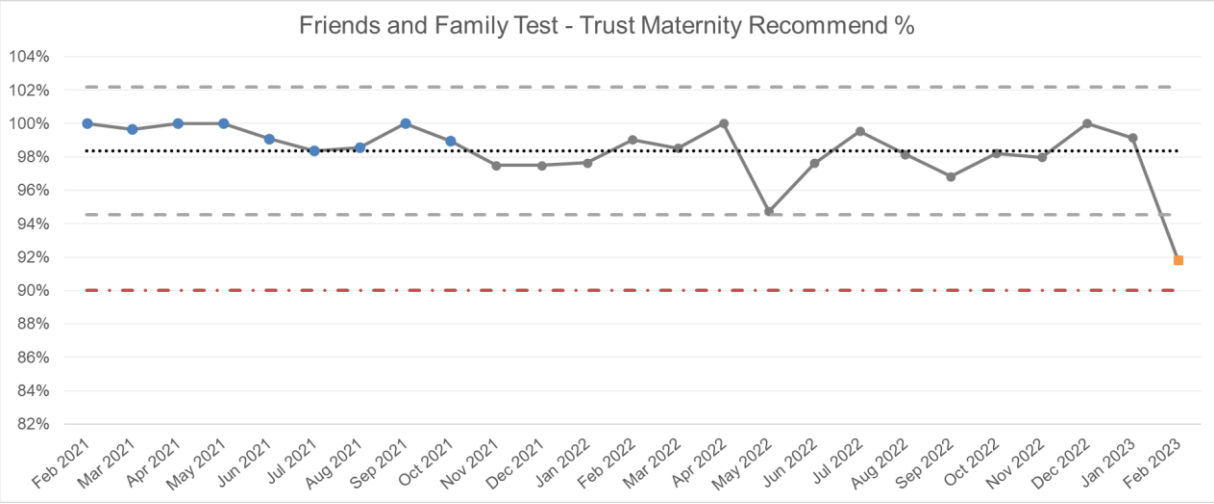
Examples of completed complaint responses and actions are below:

York complaint: the woman was spoken to in a way that caused distress during her antenatal appointment. The Deputy Head of Midwifery has contacted the woman to apologies and arrangements have been made about future care.

Scarborough complaint: the woman was concerned about her care on the antenatal ward following the birth of her baby. The Deputy Head of Midwifery has met with the woman to apologise, and a process is being developed to ensure that women at Scarborough who request a debrief receive one.

Themes from concerns are about the staffing levels, attitude of staff and communication with women and their families. The service recognises culture and communication is a common theme and in response will be providing nine half day workshops run by MedLed in May, June, and July focusing on culture, human factors and improving multidisciplinary working. It is anticipated that between 160 – two hundred members of staff will attend these sessions with a second wave planned for the autumn.

Family and Friends Test



There has been a decrease from 99% in January 2023 of women and families who would recommend the maternity services to families and friends to 92% in February 2023, however this remains above the 90% target. The numbers of responses, specifically at the York site was zero in January and February 2023 and only two in March, work needs to be undertaken to improve the level of feedback received.

3. Maternity Dashboard

The maternity dashboard highlights performance compared to both national and regional maternity service providers across the Local Maternity and Neonatal Services (LMNS) across a number of data points. The maternity dashboard will be reported by exception.

3.1 Performance Indicators

Maternity Dashboard - Activity Metrics

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of bookings	Mar 23	432	-			428	305	551
Bookings < 10 weeks	Mar 23	72%	95%			78%	68%	88%
Live births	Mar 23	345	-			350	280	419
Live births at term	Mar 23	314	-			323	262	385
Total births	Mar 23	344	-			351	284	418
Planned homebirths	Mar 23	0.0%	2.0%			0.7%	-0.3%	1.6%
1:1 care in labour	Mar 23	100%	100%			99%	97%	101%
Spontaneous vaginal birth	Mar 23	47%	57%			57%	48%	66%
Instrumental vaginal birth	Mar 23	13%	12%			11%	7%	16%
Elective caesarean section births	Mar 23	18.2%	13.0%			14.0%	8.7%	19.3%
Emergency caesarean section births	Mar 23	21.1%	17.0%			18.3%	8.3%	28.3%
3rd & 4th degree tear SVD	Mar 23	0.7%	3.0%			1.0%	-0.7%	2.7%
3rd & 4th degree tear instrumental	Mar 23	4.5%	6.0%			3.3%	-3.2%	9.8%
Induction of labour	Mar 23	38.1%	33.0%			37.2%	24.9%	49.4%
PPH >1500ml	Mar 23	2.6%	3.6%			3.6%	0.7%	6.4%
Stillbirths	Mar 23	0	-			1	-1	2
Antenatal stillbirth	Mar 23	0	-			1	-1	3
Intrapartum stillbirth	Mar 23	0	-			0	-1	1

Summary:

The number of births across both sites remains consistent across both sites however, the data indicated that there change in the way women are delivering across both sites with a decrease in vaginal birth and an increase in elective caesarean sections and inductions of labour.

The number of booking appointment < 10 weeks is consistently below the target of 95%, further work needs to be undertaken to understand if this is due to women presenting for booking appointments later or if is a data quality issue.

Decreased staffing in the community midwifery team has resulted in a limited service for women who want to birth at home over the last 12 months.

Comparison with the National Maternity Dashboard indicates that we are below the national average of 17% for elective caesarean sections and 22% for emergency caesarean sections. The national figures indicates that we are slightly above the average of 11% for instrumental deliveries and slightly below average for spontaneous vaginal deliveries of 49%.

Actions:

Increased number of elective caesarean sections and induction of labour can cause longer stays on the wards, increased theatre activity and bed blocking on the antenatal and postnatal wards. In response to this and to ensure good flow through the wards the service introduced Cervical Balloon catheters as an option for women whose labour is induced in March 2023. Initial feedback is that this has improved flow as some women can go home after it is fitted, and it reduces the time the induction process takes. This impact of this is monitored by the Ward managers with further improvement in patient flow and experience expected.

A business case has been written to increase the number of elective caesarean section theatre lists from half day to full day to manage the capacity.

Where women choose a homebirth and the community midwives are unable to support, local independent midwives are being utilised on a case-by-case basis.

Assurance:

The ward manager undertakes monthly audits to understand peak times for the maternity triage unit which informs safe staffing decisions for the next month.

There is a clinical assessment undertaken by a Consultant for all women who have their caesarean section either delayed or where they have to move site due to capacity to ensure that women are prioritised safely until the lists are increased.

All incidents of babies born before arrival at hospital and known free or unassisted births are reported and reviewed by the multidisciplinary team to identify any themes or learning.

3.2 Public Health Indicators

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Breastfeeding initiation	Mar 23	68%	75%	?		68%	61%	75%
Smoking at time of booking	Mar 23	9%	6%	F		11%	6%	16%
Smoking at 36 weeks	Mar 23	6%	6%	?		7%	3%	11%
Smoking at time of birth	Mar 23	10%	6%	F		11%	7%	16%
Carbon monoxide monitoring at booking	Mar 23	12%	85%	F	H	9%	5%	13%
Carbon monoxide monitoring at 36 weeks	Mar 23	17%	85%	F	L	41%	24%	59%
Current smokers referred to cessation	Mar 23	28%	85%	F	L	35%	9%	60%

Summary:

The data chart indicated that there is a consistent failure to meet the public health indicators for smoking cessation. These indicators are directly linked to Element 1 of the saving Babies Lives Care Bundle, Reducing Smoking in Pregnancy.

Actions:

The stillbirth working group is working to increase compliance with the SBLCBv2 with a specific workstream for all five elements of the care bundle. The services have access to the Trust smoking cessation team who regularly visit the antenatal and postnatal wards and have arranged drop-in sessions on the wards to support women and their families.

Assurance:

The SPC charts indicate there was a rapid increase in compliance in August 2021 and then a rapid decrease in December 2022. This directly correlates with the digital midwife manually checking all records and ensuring data was inputted on the electronic patient record. Carbon monoxide (Element 1) is routinely being completed at 36 weeks and there are monitors available in the community, the area of non-compliance is recording results in the electronic records. The introduction of Badgernet in the community and antenatal services in March 2023 will result in women's records being held in one place which will see improvement in compliance.

The risk of having patient records in more that one format and stored in more than one location is on the Obstetric Risk Register.

4. Training Compliance

The Learning Hub system is used at the Trust for recording training information. There have been disruptions to the system since 8 February 2023. This has meant it has not been possible to enter the fetal monitoring training attendance data onto the Learning Hub. Training compliance information can therefore not be produced. It is hoped that that training figures will be available for May 2023.

Face to face fetal monitoring training was delivered on the 9 and 27 March 2023 and training is planned for the 17 and 20 April 2023.

The continued disruption to Learning Hub will be mitigated in April 2023 by the manual collation of crude training figures in order to provide a level of assurance.

5. Staffing

5.1 Midwifery Staffing

Community Staffing

Adverts for Community Midwives remain on NHS Jobs due to ongoing vacancies and have recently appointed a full-time experienced midwife from a local Trust. This means that weekly bank shifts are advertised, and visits are reduced and prioritised ensuring day 1 visits by a midwife. We have recently rotated a midwife from labour ward to community and are asking for additional volunteers. Both Band 7 leads work clinical on escalation with support from the interim matron as needed. We are working with the Recruitment and Retention midwives on a plan for the newly qualified midwives joining us in the autumn and how they can work supported in the community setting.

Following a staff feedback session held by the Associate Director of Midwifery in March 2023, we are aware that many midwives are not happy to work in community due to high caseloads, increasing complexities and antenatal complications, safeguarding matters, and increased perinatal mental health issues, with limited to no time to support such high-risk women/birthing individuals. On calls for escalation and homebirth also do not appeal

to most midwives. The reduction in pay due to less unsociable hours is also a contributory factor.

The service recruited a community Matron who started in post in April 2023 and the plan is to fully evaluate midwifery working patterns, booking clinics in line with the implementation of Badgernet will support lean working with a view to introducing midwifery led antenatal education classes once more and improvements in working hours/patterns alongside a long day model will be considered.

The Homebirth service remains active, working with independent midwives locally on a case-by-case basis as per need. We are in consultation with Scarborough midwives to address on calls so that community teams are not utilised for unit escalation, thus ensuring a more robust homebirth service cross site. The department have agreed funding for a Homebirth Team and a paper will be presented to Trust Board in May that will outline both Continuity of Care plan and Homebirth Team plan. A phased implementation will take place over the next 12 to 18 months.

International Midwives

The service has recruited six International Recruitment midwives. At present only one is fully included in the numbers and working clinically as they have completed their supernumerary period and have their pin. Three have recently passed their practical exams in March and are now awaiting their NMC pins to come through. Once their NMC pins come through they can then commence their supernumerary time on Labour Ward.

Maternity Support Workers

Maternity Support Worker/Healthcare Care Assistant, the application process has now closed for the Level 4 training to support Band 2s to progress to Band 3s and received 18 applications across the service. Training is planned for September 23, February 24, and May 24. We also have been given further funding to help with their training. The department is also advertising for Maternity Support Worker's. The impact is we will be able to meet the 90:10 split as outlined in the Birthrate + report. However, it will still mean we have vacancy as not at 90% for registered staff.

Newly Qualified Midwives

The Recruitment and Retention Midwives held some very successful open days at both sites in March and advertising for newly Qualified/Preceptorship Midwives for September and October in take. Preceptorship days are held once a month and all 15 are still in post that joined the department last year. We have three more Newly Qualified Midwives joining us at York at the end of April

Maternity Services are also recruiting to a Practice Development Midwife and Clinical Skills Midwife at Scarborough, additional hours in the screening team and a diabetes Midwife, a new funded post. The Recruitment and Retention Midwives funding has been extended until March 2024 to support ongoing recruitment.

Resignations

There have been two resignations in this reporting period at York, a Band 6 Midwife and Health Care Assistant. Themes will be shared following exit interviews. This increases vacancy in both staff pools so additional bank shifts for the short term whilst we continue to recruit. Maternity leave and short- and long-term sickness percentages remain consistent

across all areas, we have seen no improvements or reductions in either. Work related stress related absence appears to be increasing.

5.2 Medical Staffing

There are currently four medical vacancies at Scarborough (one Consultant, two Registrars and one SHO). The Consultant vacancy is out to advert and being covered by a locum as are the Registrar vacancies and the SHO contract has been extended.

At York, there is vacancies for one Consultant and one Registrar due to sickness, this is being mitigated by the on-call system and locum cover.

Daily absence monitoring of staffing levels is completed at both sites and there is a clear escalation process for surges in absence.

5.3 Scrub and Recovery Roles

A dedicated Maternity Theatre Manager started in post in February 2023, a new position to oversee the running of maternity theatres to support the standardisation of practice in line with National Guidelines.

Recruitment for twenty-seven WTE Theatre Scrub Practitioners has been approved by the Trust Board and shifts for scrub theatre staff are available on the bank. A continuous advert for band 5 Theatre Practitioners / ODP's in Maternity was published on Trac on the 12 April 2023 with four applications received in 24 hours. A recruitment update will be provided in the May submission along with a detail of the current and planned fill rate for scrub shifts. The team will work with eRoster to create the rota to allow better oversight of vacant shifts.

It is anticipated that recruitment of the twenty-seven WTE Theatre Scrub Practitioners could take up to 24 months. International recruitment is being considered to fill these vacant posts as the Trust will shortly be recruiting in India.

Additional bank shifts are offered for various roles to include NIPE, Discharge Midwife, Telephone Triage and Scrub Shifts, these all contribute to the safety of the department and allow some flexibility to support with the scrub practitioner role. The Department is looking at overall fill rate of these shifts and any bank shifts for Scrub Practitioners from Care Group 3 and will update on this next month. During this period of recruitment, the maternity department continues to undertake a daily risk assessment via the staffing huddle and ongoing escalation.

6. Maternity Voices Partnership

Work is ongoing to establish links with community groups and organisations to raise awareness of the MVP's. The York MVP Chair will be invited to both the clinical governance and Maternity Transformation Boards following review of both meetings and invited to attend the Equality Delivery System (EDS) scoring event grading event in March

as a stakeholder. Funding has been requested via both the LMNS and NHSR to support the role of the MVP's.

The EDS Maternity scoring event was completed in March with colleagues from maternity, the equality, diversity and inclusion lead and a range of stakeholders. The session focused on a key question 'In this changing context, are maternity staff equipped with skills and knowledge to provide high quality care for our diverse community'. From feedback received and evidence presented future work will focus on aligning the work with maternity transformation, partnership working across the Trust and ongoing engagement with diverse voices and services alongside the MVP. The Trust offers a range of Equality Diversion and Inclusion training which has been shared with staff however it has been identified that maternity specific training is important and is currently being explored.

The Perinatal care for trans and non-binary people maternity guideline has been adapted with permissions from Brighton and East Sussex for use within the LMNS by the Transformation Lead Midwife and Equity and Equality lead at the LMNS and is currently being reviewed within the governance process. Work is ongoing to co-produce a patient information leaflet and embed the new guideline across the LMNS.

The first '15 moments' visit is taking place in April. The Department have identified a range of networks from the EDS scoring event who represent diverse voices, communication, and dissemination of information about the MVP. A new monthly meeting with the York MVP Chair, Transformation Lead Midwife and Associate Director of Midwifery has been established.

7. Safety Champions

Patient Safety Walkabouts continue with the Chief Nurse and Non-Executive Director (NED) across both York and Scarborough sites as part of the Mat Neo Safety Programme and representing as Board Champions. In addition, the Corporate Patient Safety Team undertake patient safety walkabouts and the department are looking to consolidate feedback and learning from these walkabouts into a single improvement plan that will be shared via the MAT Neo Safety Action Log. The MAT Neo Maternity Safety Champions Meetings have been refreshed with new Terms of Reference and agenda and the next meeting is planned for the 25th of April, the focus of the meetings going forward will be implementation of the learning from the Walkabouts at the request of the NED.

Where possible local action is implemented immediately and following the walkabout on the 31st of March at Scarborough with the Chief Nurse and NED the following was actioned.

1) The 'scores on the doors' board outside of labour ward was unfortunately out of date by the 13th of March, this was addressed by the Matron with the Ward Manager and Labour Ward Coordinators and moving forward will be updated daily as this is the first impression you have on arrival to the labour ward. The ward clerk immediately addressed the issue on the day.
2) The clinical governance board on Hawthorn was out of date from December, this was addressed with the Ward Manager to ensure that the Board is kept up to date with the data, a month in arrears to ensure the data accurately reflects the ward's goals and risks.

8. Maternity Incentive Scheme (MIS) year 4 Progress Update

Safety Action	information	Update	Rag
Action 1	PMRT	Compliant with the requirement	
Action 2	Maternity Dataset	Compliant with the requirement	
Action 3	ATAIN	Transitional care has been introduced in York and there are plans for Scarborough. ATAIN meetings need embedding on both sites	
Action 4	Clinical workforce planning	The neonatal workforce is being reviewed	
Action 5	Midwifery workforce planning	We are not able to evidence that all women receive 100% 1:1 care or the supernumerary status of the Labour Ward Coordinator	
Action 6	Saving babies lives	Badgernet will support evidencing compliance with the public health indicators	
Action 7	Service user feedback MVP	Work is ongoing to establish links with community groups and organisations to raise awareness of the MVP's	
Action 8	MDT training	Training trajectories have been developed to ensure there is a plan in place to improve compliance	
Action 9	Safety champions	The MAT Neo Maternity Safety Champions Meetings have been refreshed with new Terms of Reference and agenda and the next meeting is planned for the 25th of April	
Action 10	NHS resolution	Compliant with the requirement	

Non-compliance with all 10 Safety Actions is a risk to patient safety and could cause reputational damage. Areas of non-compliance have been added to the Obstetric Risk Register.

As part of the maternity transformation programme, a specific workstream has been dedicated to the Maternity Incentive Scheme, this will meet on 17 and 18th of April to benchmark current progress and identify areas for improvement.

The service will be complaint with all 10 Safety Actions by March 2024.

9. Ockenden Immediate and Essential Actions

The table below shows the RAG rated position for compliance with the seven IEA's following the assurance visits that took place in June 2022 and the current update at the end of Q4 2022/23

Ockenden Interim report Immediate & Essential Action	Position following regional assurance/ support visit 23/6/2022			YSTHFT Recommendations	LMNS ongoing assurance of Trust action plan			YSTHFT Ongoing Actions
	Met	Partial	Not	23rd June 2022	Met	Partial	Not	Q4 2023
1: Enhanced Safety	4	3	0	The triumvirate meet but this is not currently minuted . There is a plan to further establish this process which the trust should consider implementing to strengthen compliance with this element. Clear evidence of development of action plan as MDT which is then shared widely within the trust at local and board level. Key concerns reported were – embedding twice daily consultant ward rounds embedding of antenatal risk assessments; informed consent and improving coproduction .				The Senior Triumvirate from January 2023 continue to meet weekly – meetings produce brief action notes and an agenda. Embedding twice daily consultant ward rounds, a continued focus and some improvement. April relaunch of Ockenden Audits. Triangulation of incidents and complaints, claims needs to be strengthened. Complaints have become a focus to ensure timely completion and understanding themes, DHoM leading. Benchmarking to the NHS complaint Standard.
2: Listening to Women & Families	2	2	0	Some staff were aware that there is a maternity NED. The organisation should consider how the profile of the NED can be raised in maternity post pandemic. This would strengthen the relationships with MVP and staff and support the ward to board reporting The trust should consider inviting those with lived experiences to initiate development of guidelines, information resources, service design rather than comment on completed trust documents.				Agenda reviewed for Safety Champions to commence April 2023. NED walkabouts with feedback to DoM and AdoM MVP to be invited to Governance Meetings in 2023 – now Chairs in post for York and Scarborough the service will progress to invite the Chairs to these meetings. Maternity Patient Experience Survey – Action Plan requires embedding and further work – with DHoM leading on complaints this will become higher profile
3: Staff training & working together	2	4	0	The trust should consider a variation of clinical skills and drills in different areas, and should also consider baby abduction drills in all areas. When forward planning for training the trust should consider review of workplace culture with a specific focus needs to be on supportive and collaborative leadership style at all levels in maternity services				Abduction Drills will continue with further of embedding of learning Invitations received for second Cohort Culture - postponed until October to enable maternity team to establish and permanent DoM to be in post. Progression with MEACC training . Training compliance included as part of the PCQS Report presented monthly to the Quality Committee. The DoM and Clinical Director attend. Recognised challenges currently with Learning Hub, and local mitigations need to be established. Advert for Practice Development Midwife . Conversations ongoing within Trust regarding headroom and time required TNA.
4: Managing complex pregnancies	1	2	3	Plans are in progress within the LMNS to fully implement the maternal medicine service. Further work with the LMNS to identify and define how they will work within this pathway is required to give an oversight				

Ockenden Interim report mediate & Essential Actions	regional assurance/ support visit {DATE OF VISIT}			YSTHFT Recommendations	LMNS ongoing assurance of Trust action plan			YSTHFT Ongoing Actions
	Met	Partial	Not	23rd June 2022	Met	Partial	Not	Q4 2023
isk assessment throughou pregnancy	0	3	0	The trust articulated manual audits of paper notes of antenatal risk assessments, which demonstrated increasing compliance. However the service are keen to further enhance audit to ensure that data and therefore actions are meaningful within a QI methodology.				More work required, ongoing focus working across the MDT . New audit too developed January 2023 and for further review regarding auditable standard. Mapping Exercise to be undertaken in gaps in risk assessment.
Monitoring fetal wellbeing	1	3	0	It is evident that there is an established training programme in place with good compliance The trust has clear plans to develop the programme further, including device training Feedback and Lessons Learned from incidents are disseminated by the leads				Fetal Monitoring Lead working with the MDT to improve compliance particu with the medical workforce. Clinical Director and Director of Midwifery atte Quality Committee to update monthly via the PCQS.
7: Informed consent	2	1	3	Website reviewed on day of visit, relatively easy to navigate and can be translated into different languages but limited information available for service users. The service should consider inviting the MVP to review the website and its content and coproduce materials which will fulfil this criteria .				Increased collaboration with the MVP and will be asking to support with this piece of work. Opportunities to engage with women and families through the complaints process. Benchmarking against the CQC implementation of the MCA 2005 in matern services has started, this will feed into the work around informed consent.
Workforce / Guidelines	2	1	2	The trust currently utilise a 'step down' approach for supporting transitional care. There are guidelines in place and these are audited as part of SBLv2. The trust should consider how to develop this service to ensure it supports all women with babies requiring transitional care, and how they utilise incidents, complaints and concerns to support development of the service It would be helpful if the trust could demonstrate how they plan to meet the ask with the RCM leadership manifesto by sharing their action plan in respect to this				Transitional Care in York opened formally opened in October 2022, unfortun closed in December due to neonatal nurse staffing. Reopened the week of th February 2023.. Scarborough pathways need to be reviewed. Workforce Paper presented to Executive Committee March. Interim Director of Midwifery with confirmed plan for substantive post

The Associate Director of Midwifery is leading on this workstream and will provide monthly updates via this report. There is current work supported by the project lead on mapping the 15 Immediate and Essential Actions.

10. Recommendations

The Trust Board is asked to.

i) Receive and discuss the report
ii) Note the current level of assurance and identified gaps in assurance
iii) Recognise the significance of this report for the Maternity Service and that further detailed work is required to ensure full compliance
iv) Note the associated risks involved

END.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Maternity Workforce Review Paper
Director Sponsor:	Heather McNair, Chief Nurse
Author:	Sarah Ayre, Associate Director of Midwifery / 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 Standards
☒ Quality and Safety	☒ Workforce
☐ Elective Recovery	☒ Safety Standards
☐ Acute Flow	☒ Financial
	☐ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlight:

This report is presented six monthly to support the assessment of progress in meeting the criteria of NHS Resolution Maternity Incentive Scheme (MIS) safety action five.

The Maternity Department's priority is to provide outstanding care and safety for all women, birthing individuals, and their babies, alongside being the best place to work. The midwifery and maternity workforce requirements to deliver this are clearly defined through national guidelines which support the Trust in assessing compliance against safer services workforce and transformation programmes.

These are outlined in Better Births (2016), Safer Maternity Care (2016), the NHS Long Term Plan (2019), the Ockenden Reports of December 2020 and March 2022, Saving Babies Lives Care Bundle version 3 anticipated in 2023 and the Maternity Incentive Scheme Year 5 ten safety actions, to be published in 2023. The maternity service is also awaiting the publication of the NHSE national Single Maternity Plan 2023 and the findings from the Ockenden Report further to the investigation into failings in maternity care in Nottingham.

An updated Continuity of Carer plan for 23/24 is in development and will be completed by May 2023. This plan anticipates requirement for additional investment in both the registered and unregistered workforce. This will enable the development of a dedicated WREN Team (Women Requiring Enhanced Nurturing) and will provide continuity of care for women and birthing individuals considered most at risk as identified through the latest MBRRACE Report[1].

The report outlines the workforce development plans which support the maternity service in addressing the current deficit in midwifery staffing cross site against both safe core and integrated staffing requirement as identified through the Birthrate Plus® (BR+) recommendations, as well as developing the specialist, dedicated roles supporting governance, speciality service development and improvement work.

The monthly escalations on staffing red flags and the impact of staffing on diverts and closures through the maternity Perinatal Clinical Quality Surveillance (PCQS) Report are also reviewed alongside the workforce assessment as an indicator of service pressures related to staffing and ability to manage demand and acuity within current workforce and staffing levels.

The report also notes the recent investments in midwifery workforce confirmed in quarter three & 4 2022-23 for the dedicated home birth team, the 24/7 telephone triage service, the 24/7 triage service at Scarborough, a Specialist Digital Midwife Lead, a permanent Director of Midwifery and scrub practitioners for Obstetric theatres cross site.

Recommendation:

The Board of Directors are asked to receive this report for information and assurance.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

Meeting	Date	Outcome/Recommendation
Executive Committee	5th April 2023	Agreed funding as per CQC Recommendation

[1] MBRRACE-UK Saving Lives Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20

Midwifery Workforce Oversight March 2023

1. Introduction and Background

This report outlines the current midwifery workforce establishment and profile as of February 2023 and considers the current risks to core service stability alongside the future requirements for further service and safety improvements.

The key priority for the Trust Board is to enable the maternity service to provide a robust future workforce which can sustainably deliver safe and personalised care to all our women, birthing individuals, and families in line with all national safety guidelines and best practice. Our aim is to provide outstanding care for all women, birthing individuals, and their babies, whilst being the best place to work. The Safety of Maternity Services in England, July 2021 highlights the importance of achieving the right staffing levels in maternity to ensure safe care. Sub-optimal staffing levels have been an on-going critical theme in Care Quality Commission (CQC) maternity services inspections nationally described as inadequate since the investigation into failings at Morecambe Bay (Kirkup Report, 2015).

2. National priorities

The following national priorities provide the key drivers for expansion and development of the maternity workforce to deliver safe and high-quality care for our local women and birthing individuals.

2.1 Continuity of Carer

In July 2021, a Maternity Strategy was shared with the Trust Board and the Local Maternity and Neonatal System (LMNS) to demonstrate the maternity service level commitment for continuity of carer to be default model of care offered to all women by March 2023, as set out in NHS England 2021/22 priorities and operational planning guidance published March 2021.

In April 2022, in recognition of acute midwifery staffing shortages nationally, the target date was extended to March 2024. Trusts were asked to assess whether their services could support existing continuity of carer provision; the decision was made by the Head of Midwifery to pause continuity of carer at this time until baseline safe staffing levels could be achieved. In July 2022 a revised plan, in conjunction with the LMNS, was submitted to NHSEI detailing the Trust's updated plans for implementation.

Continuity of Carer as of February 2023 remains paused within York and Scarborough Maternity Services. The plan submitted in July 2022 will be revised again in line with the priority work on equality and equity across the LMNS and will be ready for consideration by the Executive Committee in May 2023. It is anticipated that this will require additional workforce investment, and the first phase of continuity team funding is highlighted in Table 3, page 9. The risk of failing to meet the required targets is captured on the Maternity Risk Register as highlighted in appendix 1.

2.2 NG4 Safe midwifery staffing for maternity settings, NICE (February 2015)

> NICE recommend that commissioners, Trust Boards and senior management ensure women, babies and their families receive the midwifery care they need, including care from specialist and consultant midwives, in all maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units) settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services). This should be regardless of the time of the day or the day of the week.

In line with NICE recommendation NG4, in 2021 the service undertook a systematic process to calculate the midwifery staffing establishment utilising the Birthrate Plus® (BR+) toolkit. This is a nationally recognised workforce planning and decision-making system for assessing the needs of women and birthing individuals for midwifery care throughout pregnancy, labour, and the postnatal period, both in hospital and community settings. The methodology used in the tool has been in constant use in the UK since 1988 and calculates the required number of midwives to meet the needs of women, birthing individuals, and babies in relation to defined standards and models of care, whilst incorporating local workforce planning factors.

In January 2022, the findings from the BR+ report was shared with Trust Board alongside the Workforce Review paper. The BR+ report provided an analysis of the numbers of staff required to deliver safe maternity care based on the acuity of the women receiving care in 2019. This report was received and acknowledged by the Trust Board.

This BR+ report has informed this current workforce overview for 2023/2024, however of important consideration are the significant changes and additional requirements of the service since 2019. BR+ recognises that not all the clinical work in maternity services needs to be undertaken by midwives and that by enriching the skill mix to include maternity support workers (MSWs), midwifery time and expertise can be better focused and targeted. A recommendation to repeat the BR+ audit is made within this report.

2.3 Maternity Incentive Scheme – 10 Safety Actions

In July 2021 and February 2023, the Trust declared non-compliance with NHS Resolution's Maternity Incentive Scheme (MIS). One of the safety actions not achieved was around the midwifery workforce element as we were unable to demonstrate that 100% of women received 1-2-1 care in labour or that 100% of the time the labour ward coordinator was supernumerary. This element currently remains a significant risk for compliance with year 5 cross site. Recent investment has been secured for an additional Band 7 on shift at night and weekends cross site, through implementing a 24/7 Triage service. We also have funding to support a clinical out of hours escalation model which will help support reduction and closure of this risk and ensure compliance for this safety action. Both roles are planned to be established by July 2023.

2.4 Ockenden – 15 immediate essential actions (IEA)

The final report of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust published a further 15 IEAs in March 2022, see appendix 2. IEA 1 specifically discusses workforce planning and sustainability whilst IEA 2 outlines how all Trusts must maintain safe maternity staffing through a clear escalation and mitigation policy alongside ensuring there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. The IEAs support and inform the workforce investment requested within this paper.

3. Considerations

This workforce paper outlines the current registered and non-registered staffing position cross site and the requirements of our clinical and specialist midwifery roles as per Table 4 on page 10, to ensure the service can meet the aim of providing outstanding care for our women and birthing individuals, whilst being the best place to work alongside the requirement to meet each of the national priorities of providing safer maternity care. The Trust is currently also unable to fulfil several national requirements that demonstrate a safe service due to workforce challenges. The main ones include:

1. Offering continuity of carer to all eligible women by March 2024
2. Meeting the requirements of the MIS 10 safety actions – year 4 submission reported non-compliance for seven of the ten safety actions
3. Ockenden compliance for workforce

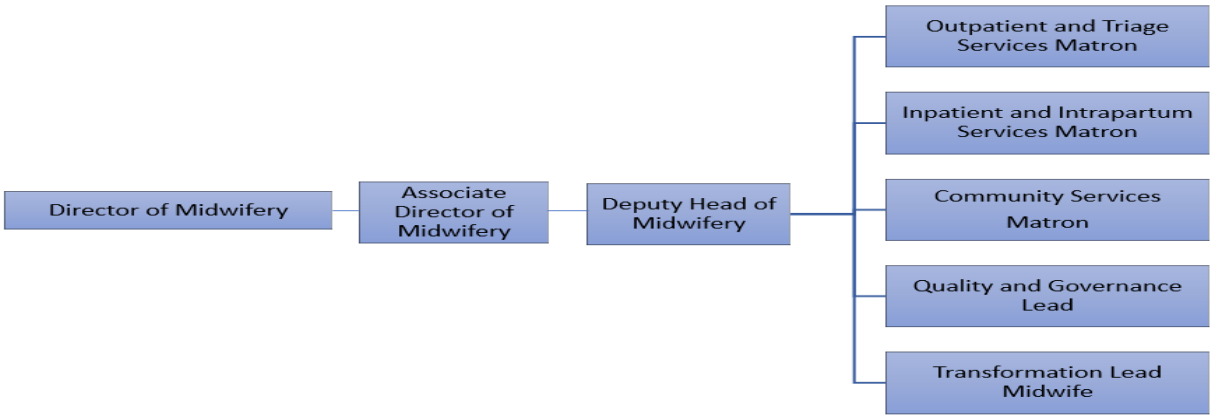
The risks associated to this are capture on the Maternity Risk register, as per appendix 1.

4. Current Position

The Associate Director of Midwifery is undertaking a review of the midwifery workforce to include a review of budgets, staffing establishments, roles and responsibilities and the required additional roles needed to ensure compliance with MIS, Ockenden and the wider national transformation program including equity, diversity and digital. This paper concludes the first phase of this review.

The Ockendon reports in December 2020 and March 2022 and Safer Maternity Care Progress Report 2021 each highlight that strong multi-disciplinary leadership teams are needed across maternity services to improve safety, and this has been a focus for recruitment for both medical and midwifery staffing since Summer 2021. The obstetric medical Consultant team has expanded through additional investment and recruitment by an additional five Consultants to ensure Scarborough maternity service is sustainable and can co-ordinate medical rotas and clinical lead roles across both sites. A new model of O&G medical clinical leadership is being considered from June 2023 to enable further dedicated clinical leadership resource for maternity transformation and clinical governance. The midwifery senior leadership team is outlined in figure 1, the department is recruiting to a substantive Director of Midwifery, currently this is a seconded position, all other roles are permanently recruited to.

Figure 1. Midwifery Senior Leadership Organogram, March 23



4.1 Workforce

Operational pressures due to midwifery vacancy, sickness absence, secondments and maternity leave all continue to contribute to the significant challenges in ensuring overall staff experience as demonstrated through the staff survey responses, alongside the orientation experience of the newly registered midwives and international midwives. The service accommodates an increased number of midwifery students on placement from York, Leeds, and Hull Universities. The focus on the retention of midwives in post is of significant concern nationally with a shortage of around four thousand midwives. NHSEI in recognition of this have funded 2.0 wte Recruitment and Retention Band 7 posts for maternity services at York and Scarborough, until March 2025. The two midwives in these posts have relocated to the area and work at both sites supporting recruitment and retention strategies and have been instrumental in reducing the midwifery vacancy by 50% in 6 months. The themes from exit interviews over the last 6 months have been relocation or promotions.

4.2 International Midwives

The Maternity Department are fully recruited into our supported placement of six internationally recruited midwives as of March 2023 who will be practicing and in the budgeted establishments by June 2023.

4.3 Upcoming Recruitment

Open day events were held for final year student midwives in view of opening our recruiting in May for September intake; York on Saturday 11th March and Scarborough Saturday 25th March 2023.

The Recruitment and Retention Leads are also in attendance at many regional and national events, working to increase our profile and attract staff to the Trust. In the last 6 months they have attended:

- NEY Regional Event on Shared Learning
- Return to Midwifery NHS Event
- NEY International Midwives Event
- NEY Shared Learning on IR Midwives
- Northeast & Yorkshire and Northwest - Unit based Retention midwives Forum
- LMNS Retention & Support Midwives Meeting
- Legacy Midwives Meeting
- North of England Regional Event - Workforce & Stay Conversations
- Retention: Solutions for Today and Tomorrow
- Local Careers events at York based sixth forms/Universities**.**

4.4 Midwifery vacancy

Total cross site midwifery vacancy as of February 2023 is 9.07 whole time equivalents (wte) as demonstrated in table 1, page 7, alongside maternity leave of 8 wte. Long-term sickness absence of approximately 2.2 wte and secondments totaling 2.0 wte also figure significantly in the unavailability of registered staff. Long term sickness absence and maternity leave have remained consistent for the last 4 months and the largest vacancy sits within York Community. Overall, this means we average a 20 wte midwifery shortfall in our cross-site rosters.

Table 1 Cross Site Midwifery Vacancy Breakdown as of March 2023

B6's	Budget	Substantive in post (incldluing new starters on the way)	Substantive vacancy	On Mat Leave	On Secondment	Available for roster	Roster Vacancy	Notes
Triage	4.61	7.69	-3.08	0.40		7.29	-2.68	Triage tel budget to come
Labour Ward & Theatre	27.39	29.65	-2.26	3.20		26.45	0.94	
Ward	24.64	25.19	-0.55	2.40	0.80	21.99	2.65	
ANC	4.92	5.32	-0.40	2.00		3.32	1.60	
	61.56	67.85	-6.29	8.00	0.80	59.05	2.51	
							2.69	Triage tel budget to come
							5.20	Hospital Vacancy
Community	29.3	26.63	2.67	0	1.2	25.43	3.87	Community Vacancy

	B7	B6	B3	B2	
Managers	4.00	0.00	0.00	0.00	**4.00**
Triage	3.23	4.61	5.15	0.00	**12.99**
Labour Ward & Theatre	5.15	27.39	1.86	6.91	**41.31**
Ward		24.64	8.06	2.80	**35.50**
ANC	0.00	4.92	2.40	0.00	**7.32**
Total	12.38	61.56	17.47	9.71	**101.12**
Triage tel		2.69			

4.5 Support Worker vacancy

Band 3 Maternity support workers (MSWs) are an integral part of the maternity workforce and are instrumental in supporting midwives and the wider maternity teams, mothers, birthing individuals and their babies through pregnancy, labour and during the postnatal period. BR+ recognises that not all the clinical work in maternity services requires to be undertaken by midwives and that by enriching skill mix to include MSWs, midwifery time and expertise can be better focused and targeted. BR+ suggests factoring in up to 10% of midwifery hours to be provided by appropriately educated and competent Band 3 MSWs and this is our current model.

In March 2018, the Secretary of State for Health and Social Care announced a package of measures aimed at professionalising the maternity support worker role. Health Education England has led this important piece of work and developed the Maternity Support Worker Competency, Education and Career Development Framework. Full implementation of framework and associated apprenticeship standards provides assurance that MSWs are appropriately educated and competent. However, within the current workforce cross site, the roles, responsibilities, and job titles of MSWs vary widely. Having secured funding from NHSEI for support with embedding the MSW framework over the coming year, the maternity department are looking to support all band two healthcare support workers employed in maternity to progress to band three in line with the framework, whilst recruiting into the current six wte vacancies.

The long-term plan will be to consider a 20:80 unregistered / registered workforce split as it is nationally reported a decrease of 45% UCAS applications for midwifery in 2022 and a growing vacancy of over 3700 wte midwives nationally.

It is noted the MSW vacancy is higher at York than Scarborough, as demonstrated in table 2 below, and our Recruitment and Retention Leads have plans to explore reasons for this via staff engagement sessions.

Table 2 Cross Site MSW Vacancy as of March 2023

	Budget	Vacancy	Percentage
York	**30.59**	**6.67**	**21.80%**
Scarb	**15.66**	**-0.14**	**-0.89%**

4.6 Future aspirational roles

Consideration is requested for the investment into future roles in line with, but not limited to, the requirements of Ockenden for the development of maternity services to further support safe, quality, sustainable and transformational care for all women and birthing individuals. In brief this includes a Consultant Midwife, Lead Midwife for Education and Pastoral Care and Midwives qualified in Advanced Clinical Practice, dependent on job specifications and skills these roles range from band seven to band 8b as per agenda for change and are included within table 4 on page 10 as aspirational roles. It also includes the development of a resolute team for women requiring enhanced nurturing (WREN).

- ### Consultant Midwife

  The Royal College of Midwives' (RCM) Strengthening midwifery leadership: a manifesto for better maternity care (2019) acknowledges that a vital part of delivering safe quality care is strong, effective midwifery leadership, focused on getting the best out of every member of staff. Consultant midwives are experienced and acknowledged clinical experts in their field. They lead, support, coach, mentor, inspire and empower their midwifery colleagues. They are leaders with both the responsibility and the ability to evaluate, develop and improve the provision of maternity services. For 23/24 we have a Transformation Lead Midwife in post for 12 months funded by the LMNS, as the portfolio for this role develops, it is possible to see similarities with that of a consultant midwife and our aspiration is to continue this role and develop the post as a Consultant Midwife for Public Health. This will help support the work of the WREN team and address the current risk to women and birthing individuals due to inequalities in healthcare.

- ### Advanced Clinical Skills Midwife

  In November 2022 HEE published the Advanced Clinical Practice in Midwifery Capabilities Framework which enables organisations to put in place new midwifery roles, helping them better meet the needs of those who use their maternity services. The framework has been produced in line with recommendations made by analysis conducted by HEE and it draws from and builds upon excellent examples of good practice from across the midwifery system nationally. Advanced clinical practitioners can play a key role in maternity services that deliver safer, more personalised care for all women and birthing individuals, helping to improve outcomes and reduces inequalities. The aim is for a whole time equivalent Advanced Clinical Skills Midwife for each site who will support complex pregnancies, enhance obstetric care, and lead the way in improving and developing standards of practice for all midwives whilst improving the safety and quality of care.

- ### WREN team

  In 2016-18, 2,235,159 women gave birth in the UK of which 547 died during or up to a year after pregnancy from causes associated with their pregnancy. All (90%) of the women who died had multiple problems such as a mental or physical health diagnosis, older age, domestic abuse, living in a deprived area, or unemployment. More than half of the women who died were overweight or obese. Outcomes for women were not equal, with significant differences in mortality rates between women from different areas and women of different ages. For instance, women living in the most deprived areas were almost three times more likely to die than those who lived in the most affluent areas. Maternal death rates were almost four times higher for women from Black ethnic backgrounds and almost two times higher for women from Asian ethnic backgrounds, compared to white women.

Our aim is to create a resolute team in line with the national Continuity of Carer targets, to provide specialised care to women and birthing individuals that fall into these groups to help improve outcomes.

5. Required Investment

Investment into training, recruitment and retention alongside staff wellbeing is crucial to ensure a safe and engaged workforce for the future. Funding for additional workforce, immediate asks and aspirational roles are requested for the next three years and highlighted in table 3 below.

Table 3 Midwifery Workforce Funding Request

	23/24	24/25	25/26	TOTAL
Additional recurrent budget required for existing specialist roles and increase in hours	£319,869	£133,062	£110,657	£ 563,587
Immediate additional funded roles	£88,525	£122,876	£0	£211,401
Aspirational additional funded roles	£0	£758,159	£0	£758,159
Total	£408,394	£1,014,097	£110,657	£1,533,148

Table 4, page 10 demonstrates the current Leadership and Specialist Midwifery roles funded and the additional immediate ask for funding some of these roles with more hours implemented from 2023 through to 2026.

Table 4 Midwifery Workforce established and requested funding 2023-2026

Leadership and specialist roles as of April 2023	Band	Current Substantive Budget	Additional WTE Required	Additional Recurrent Budget required 23/24	Additional Recurrent Budget required 24/25	Additional Recurrent Budget required 25/26	Total Investment required over next 3 years
Director of Midwifery	8d	1.00					£0
Associate Director of Midwifery	8c	1.00					£0
Deputy Head of Midwifery	8b	1.00					£0
Matron – Inpatient/Intrapartum Services	8a	1.00					£0
Matron – Outpatient Services	8a	1.00					£0
Matron – Community Services	8a	1.00					£0
Quality & Governance Lead for CG5	8a	1.00	0.10	£6,144	£0	£0	£6,144
Patient Safety Lead	7	1.45	0.55	£30,431	£0	£0	£30,431
Lead midwife for screening services	7	1.60					£0
Support Midwife for screening services	6	0.40					£0
Scanning	7	1.20					£0
Lead midwife for fetal monitoring	7	0.80					£0
Perinatal Mental Health Lead Midwife	7	1.00					£0
Perinatal Mental Health Support Midwife	6	0.80					£0
Practice Development Midwife YH & SGH	7	1.60	1.40	£77,460	£0	£0	£77,460
Digital Lead Midwife – (External funding now ceased, funding agreed March 23)	7	0.00	1.00	£0	£0	£0	£0
Lead Midwife for Diabetes	7	0.60	0.40	£22,131	£0	£0	£22,131
Infant Feeding Coordinator Midwife YH	7	0.60	0.50	£27,664	£0	£0	£27,664
Infant Feeding Coordinator Midwife SGH	7	0.40	0.50	£27,664	£0	£0	£27,664
Bereavement Lead Midwife (Externally funded for 1 year to 31.03.24)	7	0.60	0.40	£0	£22,131	£0	£22,131
Bereavement Support Midwife	6	0.80					£0
Professional Midwifery Advocates (this role is provided but not in budget)	6	0.00	2.00	£89,343	£0	£0	£89,343
Midwifery Practice Learning Facilitator (Externally funded for 1 year to 30.09.23)	7	0.00	0.80	£22,131	£22,131	£0	£44,263
Maternal medicine specialist midwife (Externally funded for 1 year to 14.01.24)	7	0.00	0.80	£9,221	£35,041	£0	£44,263
Better Births Midwife (Externally funded for 1 year to 18.02.24)	8a	0.00	1.00	£7,680	£53,758	£0	£61,438
Recruitment and Retention Lead Midwife YH (Externally funded for 3 years to 31.03.25)	7	0.00	1.00	£0	£0	£55,328	£55,328
Recruitment and Retention Lead Midwife SGH (Externally funded for 3 years to 31.03.25)	7	0.00	1.00	£0	£0	£55,328	£55,328
Total			**11.45**	**£319,869**	**£133,062**	**£110,657**	**£563,587**
Immediate asks							
Education and Workforce Lead Midwife (funding requested through MIS for 1st year)	8a	0.00	1.00	£0	£61,438	£0	£61,438
Project Lead Midwife – MIS and Ockenden (funding requested through MIS for 1st year)	8a	0.00	1.00	£0	£61,438	£0	£61,438
Safeguarding Lead Midwife YH	7	0.00	0.80	£44,263	£0	£0	£44,263
Safeguarding Lead Midwife SGH	7	0.00	0.80	£44,263	£0	£0	£44,263
Total			**3.60**	**£88,525**	**£122,876**	**£0**	**£211,401**
Aspirational roles for 24/25							
Consultant Midwife	8b	0.00	1.00	£0	£71,323	£0	£71,323
Advanced Clinical Skills Midwife – advanced practitioner	8a	0.00	1.00	£0	£61,438	£0	£61,438
WREN Team (Equality and Diversity Team) - both sites (funding requested through COC for 1st year for 2.00 WTE B4's)	6	0.00	14.00	£0	£625,398	£0	£625,398
Total			**16.00**	**£0**	**£758,159**	**£0**	**£758,159**
Grand Total		**18.85**	**31.05**	**£408,394**	**£1,014,097**	**£110,657**	**£1,533,148**

6. Risks

There are several midwifery staffing related risks currently on the Maternity Risk Register and are highlighted in appendix 1.

There is an urgent requirement to provide theatre practitioners to scrub in Obstetric Theatres, highlighted In Staffing of Obstetric Theatres - A Consensus Statement' (2008). The Current position at the Trust is that Midwives are still expected to perform this role. Care Group 5 are working with Care Group 3 as part of the Maternity theatres Oversight Group to strengthen the governance around the day to day running of Obstetric Theatres alongside the development of an appropriate workforce model and recruitment has commenced.

There are risks that the Trust will be unable to deliver key work streams within the Maternity Transformation Programme, due to a lack of available workforce and a risk for failing to provide choice of place of birth to women and birthing individuals as per Better Births (2016).

The CQC issued the Trust with a Section 31 for Maternity Services in November 2022 which has placed a refreshed emphasis on midwifery workforce challenges, this is also captured on the Trust Risk register.

7. Summary

It is recognised that the current workforce requirements to embed models of care that ensure quality, safe, personalised, and inclusive care have changed significantly from the workforce costings provided in the initial BR+ report received in April 2020.

Recruiting into midwifery posts is proving challenging due to national and regional factors; attracting staff to the Trust whilst under a section 31 is difficult and so ensuring culture change is key, as per the recent feedback received at the Ockenden Assurance visit in June 2022 and the Regional Midwifery Office's staff engagement sessions in February 2023, alongside the most recent staff survey results. Although not in the public domain, all staff are aware of the Section 31 and regionally we are aware this is discussed.

Further significant investment in workforce is required as highlighted in table 4 on page 10 over the next three financial years to ensure a midwifery workforce able to meet the regional and national priorities to provide safe care across our city, rural and costal demographics, whilst working towards the completion and end of the CQC Section 31. As a Maternity Service we aim to strive for improved staff experience supporting recruitment and retention strategies in line with the NHS People Plan, which outlines behaviours and actions that staff can expect from NHS leaders and colleagues, to improve the experience of working in the NHS for everyone.

8. Next Steps

- Investment required as per Table 4 on page 10 to ensure the safe delivery of care and understanding of decisions made against this. This has been incorporated into the maternity investment implications prioritised by Care Group Board for consideration by Executive Committee in their Trust financial planning in the first week of April 2023.

- A Birthrate Plus® (BR+) audit to be commissioned to provide an up-to-date recommendation based on 2022 data. The fee to commission a whole scale review is approximately £9,800 +VAT.
- Associate Director of Midwifery to continue the workforce review and planning with the Senior triumvirate and Finance Manager in line with the development of the Maternity Strategy for 2024-2028, alongside national priorities as published this year.
- Establishment of a dedicated workforce programme of work under the Maternity Improvement (Transformation) programme which will provide assurance to both the MIS compliance reporting and assurance to the Trust Maternity Transformation Steering Committee.
- This report to be shared with all maternity staff, the LMNS and local commissioners.

Date: 27th March 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Guardian of Safe Working Hours 2022-2023 Q4 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:

- The £15,000 national funding provided to "enhance junior doctor rest facilities" has been spent. Details are contained within the report (item 2.1).
- Staffing and training issues highlighted via exception reports and Junior Doctor Forum (JDF) have led to improvements for FY1 Doctors in Care Group 3 (York).
- A more structured, transparent, co-ordinated approach to managing leave requests is necessary across the organisation (item 2.4.1).
- Updates to the exception reporting software implemented to improve response times.
- Information on external locum work for Q4 unavailable at time of submitting report.

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

No ☒ Yes ☐

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

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

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

Board report: Guardian of Safe Working Hours 2022-2023 Q4 report

1. Introduction and background

This is the 2022/2023 Q4 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 January 2023 to 31st March 2023 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 can 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 Employment, 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*

Two Guardian fines were levied in Q4.

In January 2023, 1 fine was levied against Care Group 1. A doctor on Elderly Medicine placement at York Hospital worked a 14-hour shift, 1 hour over the maximum shift length. The doctor reported a very busy weekend shift during which "the whole team was overwhelmed with the number of unwell patients, reviews and weekend jobs."
The total Guardian fine for this breach of safe working hours was £119.25 split as per the TCS as follows: £44.72 to the trainee and £74.53 to the Guardian. However, in this instance the doctor portion of the fine was less than the amount that would have been paid for a usual overtime claim, so the doctor element was uplifted from £44.72 to £45.74 to compensate.

In March 2023, 1 fine was levied against Care Group 5. A doctor on a Paediatrics placement at Scarborough Hospital worked a 13.25-hour shift meaning a breach of 0.25 hours in total. The report indicates handover overran due to the large volume of patients in the department.
The total Guardian fine for this breach of safe working hours was £21.77. This was split as per the TCS as follows: £8.16 to the trainee and £13.61 to the Guardian. However, in this instance the doctor portion of the fine was less than the amount that would have been paid for a usual overtime claim, so the doctor element was uplifted from £8.16 to £9.65 to compensate.

Junior doctors voted to spend the fines on providing food at Junior Doctor Forum meetings.

The current balance from fines received is £856.24. 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 on 1 January 2023		**£869.09**
(+) Guardian fine	+£74.53	£943.62
(+) Guardian fine	+£13.61	£957.23
(-) JDF meeting catering 29-03-2023	*-£100.99*	£856.24
Closing balance on 31 March 2023		**£856.24**

The Guardian cost centre also held the remaining £15,000 government funding for improving Junior Doctor wellbeing. The process of determining what to spend the money on was led by Dr Hester Baverstock, President of the York Doctors Mess Committee. The details are contained in the table below. Items where VAT can be reclaimed are presented with tax excluded.

Item	Cost	VAT
Coffee machine	£7,650	Excluded
3-year extended warranty for coffee machine	£2,775	Excluded
Installation of coffee machine	£1,000	Excluded
IT equipment: 2 x PC / mouse / Keyboard (£904) 4 x large monitors with webcam (£672) 2 x software (£750) 4 x headset (£103) 2 x cisco phones (£330)	£2,759	Excluded
Coffee table	£396	Included
Total	**£14,580**	

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 originate from Foundation Year 1 (FY1) doctors and relate to overtime and missed breaks.

No reports were submitted as an “immediate safety concern” in Q4.

Most reports came from doctors working in Care Groups 1 and 3 – eighteen and twenty-one respectively.

56% (10) of those from Care Group 1 came from doctors working in Elderly Medicine, although two pertained to out-of-hours shifts during which multiple wards are covered.

Six of the remaining reports were from a single ward; five for overtime and one for missed breaks. On all occasions the reporter expressed the ward was understaffed.

71% (15) of reports from Care Group 3 pertain to shifts covering Urology, including both ascribed to Anaesthetics due to cross cover and rota design.

Of the fifteen, four were for missed educational opportunities – on three occasions doctors in postgraduate training were too busy to attend mandatory teaching. The reports correspond to items raised at the Junior Doctor Forum. The Care Group has responded with an array of actions including an improved departmental induction, a consultant led FY1 departmental training programme and the recruitment of Locally Employed Doctors, the first of whom has been allocated to Urology. Further improvements to staffing levels are in place from August changeover and the situation is being kept under review.

2.2.1 Exception reporting tools

At the end of March, Health Medics Optima (HMO), the online system used by doctors to exception report, was improved to allow doctors and their supervisors to be messaged directly from the system itself. HMO now issues automatic reminders to supervisors to review reports and to doctors to accept report outcomes. In Q4, 49% of exception reports were reviewed within 7 days; we expect automatic reminders to improve this.

2.3 *Summary of rota gaps and locum usage*

External locum requests are reported on by Medacs Healthcare. Data for Q4 has been requested but not yet received.

Internal locums (bank) are managed via the Patchwork application. Data for Q4 is included in Appendix 2.

5,046 shifts were requested compared to 4,984 in Q3. The majority were requested as a result of vacancy (50.8%) and ‘service requirement’ (30.3%). Only 10.5% of shifts requested were for consultant grade doctors.

2.4 *Junior Doctors' Forum*

The improvement in attendance by junior doctors has been maintained since the recruitment of representatives, although uptake is still predominantly in York. The agenda is drawn up by the Vice-Chair (Foundation Year 1 Doctor) in conjunction with the representatives – although all juniors across the Trust are invited to contribute. The Vice-Chair leads the meetings. This approach has enabled the forum, and its activities, to be led by the junior doctor body.

2.4.1 Management of leave request and queries from doctors

A recurrent and persistent problem surrounds the ability for doctors to get leave approved. This includes applications for study leave to attend essential training. The root causes are multifactorial – high turnover in medical deployment, the loss of an on-site medical deployment team affecting communication and development of relationships with doctors, rota gaps limiting the number of doctors able to take leave at any given time and low uptake of locum shifts due to burnout and rates of pay.

Two main problems impact applications for leave. Firstly, delays in getting a response from the Medical Deployment Team and secondly, that requests are declined without all avenues being explored to facilitate their absence. Individuals do not know who, or how, to escalate the decision.

It is important to note that whilst the deployment team is aware of the medical staffing level within a department, there are other members of the team (e.g., Advanced Care Practitioners) whose presence may allow for the leave to be granted. It is therefore important to adopt a more collaborative approach.

The creation of a flow chart making it clear who is responsible for each stage of the pathway, the escalation process before a leave request is declined, how decisions can be appealed and expected timescales has been recommended.

Better systems, coordination and communication between doctors, medical deployment / employment teams and senior operational care group staff would lead to increased satisfaction.

2.4.2 Junior Education Forum (JEF)

Whilst issues around education and training remain welcome and valid topics for discussion at the Junior Doctor Forum, the Director of Medical Education (DME) has introduced a separate forum to discuss any problems or concerns in these areas. The JEF was launched in March. The DME attends both fora so links between the two will remain strong.

2.4.3 Junior Doctor Case Presentation Competition

Throughout February and March, with the final held on 31 March, the Guardian worked with the Medical Education Team to administer the 7th Annual Junior Doctor Case Presentation Competition.

Doctors at the Trust are invited to submit abstracts relating to interesting or unusual cases with finalists presenting the case to a panel of judges and wider audience. This valuable opportunity for shared learning also provides doctors with useful experience in abstract writing skills, face-to-face presentations and a welcome boost to their education and training portfolios. The overall winners this year were:

Dr Mohamed Balousha and Dr Muhammad S Effendi (Scarborough) for "*Multimodality approach for management of Infected Abdominal Pannus (escutcheon) in a Morbidly Obese Patient*" and Dr Smrity (York) for "*An unusual case of muscle weakness*".

3. Summary

The national funding for junior doctor wellbeing was successfully utilised.

We have once again demonstrated the positive impact exception reporting has on workforce planning and service design by implementing an array of improvements in surgery (York). This should improve staff morale and in turn patient care.

Satisfaction with processes related to rostering and leave applications continues to be low. This is an area of ongoing concern that requires attention.

Date: 06 04 2023

Appendix 1: Exception reporting data for 2022-2023 (Q4)

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions open**
CG1			
Cardiology	1	1	
Diabetes and Endocrinology	1	1	
Elderly/rehab medicine	10	6	4
Emergency Medicine	1	1	
Renal Medicine	1	1	
Respiratory	4	3	1
CG2			
Acute Internal Medicine	1	1	
Respiratory	1	1	
CG3			
Anaesthetics	2	2	
Surgery: Colorectal	3	3	
Surgery: Upper GI	3	3	
Surgery: Vascular	2	2	
Urology	11	11	
CG4			
CG5			
Obstetrics & Gynaecology	4	3	1
Paediatrics	5	2	3
CG6			
Ophthalmology	1	1	
Total	**51**	**42**	**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	51	72%	38	75%
F2	9	13%	5	10%
CT1-2 / IM1-2/ ST1-2	3	4%	6	12%
IMT3/ ST3+	8	11%	2	4%
Total	**71**	**100%**	**51**	**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	56	79%	28	55%
Late finish & early start	0	0%	1	2%
Missed breaks	4	6%	3	6%
Late finish and missed breaks	7	10%	7	14%
Difference in working pattern	0	0%	3	6%
Missed breaks & Difference in working pattern	0	0%	1	2%
Inadequate supervision	1	1%	0	0%
Inadequate clinical exposure	0	0%	1	2%
Inadequate supervision & unable to achieve breaks	1	1%	0	0%
Unable to attend scheduled teaching/training	2	3%	3	6%
Teaching cancelled	0	0%	4	8%
Total	**71**	**100%**	**51**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	13	7	10	8
FY2	2	1	2	0
CT1-2/ST1-2	1	0	5	0
IMT3/ST3+	1	0	0	1
Total	**17**	**8**	**17**	**9**

49% addressed within 7 days (63% 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	182	158	1,853	1,572
Acute Medicine YH	637	335	6,345	3,150
Ambulatory Care SGH	1	0	6	0
Cardiology YH	1	0	8	0
Cellular Pathology (SHYPS Network)	8	8	40	40
Community In Patient Units	24	22	184	169
Elderly Medicine SGH	25	22	225	196
Elderly Medicine YH	102	93	977	895
Emergency Department SGH	491	377	4,843	3,743
Emergency Department YH	823	722	7,604	6,722
ENT YH	59	58	742	729
General Medicine SGH	751	594	6,767	5,341
General Medicine YH	187	94	1,622	801
General Surgery SGH	58	44	737	562
General Surgery YH Consultants	9	9	139	139
General Surgery YH Juniors	215	141	2,366	1,544
Home First Unit (HFU) SGH	204	169	1,954	1,677
Maxillo Facial YH	68	66	785	767
Obstetrics & Gynaecology SGH	142	136	1,680	1,620
Obstetrics & Gynaecology YH	114	95	987	815
Occupational Health YH	8	7	64	56
Oncology YH	32	21	237	163
Ophthalmology SGH	5	5	46	46
Ophthalmology YH	24	24	226	226
Paediatrics SGH	210	197	2,462	2,338
Paediatrics YH	191	176	1,806	1,668
Radiology YH	40	40	97	97
Respiratory YH	31	31	256	256
Theatres, Anaesthetics and Critical Care SGH Consultants	78	78	1,176	1,176
Theatres, Anaesthetics and Critical Care SGH Juniors	80	80	856	856
Theatres, Anaesthetics and Critical Care YH Consultants	2	2	6	6
Theatres, Anaesthetics and Critical Care YH Juniors	23	19	239	187
Trauma & Orthopaedics SGH	40	36	499	474
Trauma & Orthopaedics YH	181	134	1,960	1,486
Total	**5,046**	**3,993**	**49,787**	**39,515**

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**
Anaesthetic ICU different base cover	30	30	496	496
Anaesthetic Juniors & SAS	100	96	1,055	1,003
Anaesthetics General different base 24 hr on-call gap	8	8	191	191
Anaesthetics General different base Mon-Fri on-call gap	16	16	230	230
Anaesthetics General same base Mon-Fri on-call gap	3	3	42	42
Anaesthetics ST3+/Specialty Doctor/SAS	4	4	28	28
Consultant*	385	374	3,020	2,913
Consultant WE/Bank Holiday/Discharge*	119	113	1,419	1,362
CT/GPStR/ST1-2	2,175	1,765	21,624	17,638
FY1	255	149	2,260	1,323
FY2	492	206	4,783	1,911
On-call consultant*	27	27	410	406
On-call ST1+/SD	27	23	352	278
ST3+	978	795	9,806	7,969
ST4+	382	341	3,483	3,147
T&O ST3+/Specialty Doctor/SAS	45	43	590	579
Total	**5,046**	**3,993**	**49,787**	**39,515**

Table 7: Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual Leave	75	74	768	755
Bank Holiday	4	4	41	42
Bed Pressure	26	15	259	142
Compassionate Leave	6	1	76	13
COVID-19 (Additional demand)	8	7	48	44
COVID-19 (Staff sickness/isolation cover)	30	9	323	103
Extra Clinic	20	17	137	122
Extra Weekend Support	5	3	41	23
Induction	14	12	148	122
Maternity Leave	18	12	187	138
On-call cover	142	140	1,591	1,566
Paternity Leave	13	13	180	181
Service Requirement	1,531	1,196	14,490	11,187
Sick Leave	433	258	4,274	2,612
Sickness - Long Term	57	45	590	483
Sickness - Short Term	56	36	564	365
Special Leave	21	18	245	211
Vacancy	2,565	2,117	25,600	21,246
Winter Pressure	22	16	228	164
Total	**5,046**	**3,993**	**49,787**	**39,515**

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Chief Operating Officer's Report
Director Sponsor:	Melanie Liley, Chief Operating Officer
Author:	Andrew Hurren, Operational Planning and Performance Manager 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 Standards
☐ Quality and Safety	☐ Workforce
☒ Elective Recovery	☐ Safety Standards
☒ Acute Flow	☐ Financial
	☒ Performance Targets
	☐ DIS Service Standards
	☐ Integrated Care System

Summary of Report and Key Points to highlights

The Trust is reporting an improved end of March position for 78-week RTT waiters of 192 compared to the trajectory of 397 and revised forecast of 243. This progress is monitored on a weekly basis by the Chief Executive and national team. Whilst the Trust remains off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 162 against a target of 121 for March, this is an improved position and represents a reduction of 53 patients compared to the end of February 2023 position. The Trust will be required to report against the asks in the recent national letter on Cancer backlogs.

The Trust has submitted the final iteration of the activity and performance plan. The level of activity identified to date equates to circa 104.5% of 2019/20 activity levels. This level of activity contributes to the overall target of achieving 109% of 2019/20 activity that has been requested of the ICB.

Recommendation:

That the Board of Directors note the report and associated actions.

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 and associated actions.

3. Current Position/Issues

At the time of writing the report, the COVID-19 inpatient numbers have increased across the Trust to 143 from 115 on the 8th of March.

The Trust is managing industrial action for the British Medical Association Junior Doctor strike on the 11th to 15th of April.

4. Board Assurance Framework: PR 3 - Failure to deliver constitutional/regulatory performance and waiting time targets

4.1 Board Priorities: Acute Flow

Advise (1): Time lost to ambulance handover delays and handovers >60 minutes remains above target with 27% of ambulances having a handover time of over 60 minutes against the <10% target.

Advise (2): The total number of patients waiting over 12 hours in ED increased (20% against target of <8%), with those waiting more than 12 hours after a Decision to Admit also increasing (1,070 against zero target, February 2023: 901).

The Urgent and Emergency Care Programme key objective to address these priorities are:

To deliver high quality, safe, Urgent and Emergency Care (UEC), for our communities, with our partners, delivered in the right place, at the right time, appropriate to our patient's needs.

Recruitment to the Programme team has progressed and the two Programme Managers, Deputy Programme Manager and two Project Managers start in April. The programme team will be working across the four priority programmes for the organisation. UEC, Elective Recovery, Maternity and People and Culture. The Programme metrics have been revised for April in line with national standards and workstream metrics developed which will be part of a new internal UEC dashboard. The milestone plan has been developed in line with planning submissions on the ECS trajectory showing key delivery points in the summer and October ahead of winter. Additionally, work has continued with the QI team to explore joint working opportunities and avoidance of duplication whilst progressing shared approaches.

Each workstream has continued to be developed with key updates as below:

4.1.1 Urgent Care: Formal confirmation on the procurement and contracting process is awaited from the ICB. Additionally, stakeholder workshops have commenced with clinical teams and partners including YAS, Totally and Nimbus and across all Places; York, Selby,

& Scarborough. The due diligence process has been commenced to review risks and opportunities for the Trust in preparation for a detailed Board paper.

4.1.2 Children and Young people Integrated Care and Assessment: Conversation has progressed to include North Yorkshire GPs to identify the opportunities to work together to provide integrated urgent care models for Children and Young People. The York work on understanding behaviours and population has been summarised and although the CAT hub is not currently funded beyond March other integrated models of care are being explored. A public health summit is being scheduled for June 2023 which will bring together all system partners to discuss and agree the next steps for integrated care.

4.1.3 Virtual Ward: The focus of the March UEC Programme Board was Virtual Wards. An agreement was made for a single virtual hospital approach for the organisation with explicit focus on delivery of care for patients that would otherwise be treated in hospital. A commitment was made to identify several pathways that will provide a critical mass of patients to sustain a virtual ward model of care. Some surgical specialties may have very small numbers of patients but will still be able to access the infrastructure. Diagnostics, Acute Medicine, Respiratory and Paediatrics pathways will be further developed with a plan to test some specific diagnostic pathways before the summer. The national requirement is to have the full plan in place by December 2023.

4.1.4 SDEC: The ECIST missed opportunity audit has taken place looking at the criteria to admit in York EAU. The findings report will be received in April, initial feedback identified opportunities to create more direct access to SDEC (already in the programme plan). SDEC has now been confirmed as one of three priority areas for the Collaborative of Acute Providers; we will work as part of the ICS group to explore all opportunities and share learning.

4.1.5 Discharge: The ECIST criteria to admit audit has taken place in York (Scarborough in April) which has provided useful context to further develop the Discharge framework/Internal Professional Standards. The ECIST Clinical Lead and Improvement Manager will continue to work with the organisation to develop and embed this approach. Further internal stakeholders have also been involved including CGDs, Deputy Chief AHP and Head of Site Operations.

4.1.6 7-day standards: The Internal audit completed on standards 2 and 8 requires recommendations to be agreed; a meeting is scheduled with CGDs in early April to link this to the development of the Discharge Framework/Internal Professional Standards. Standard 5 assessment continues with information from the Radiology Information System to clarify compliance with the standard.

4.1.7 Access to post hospital care: Initial system conversations have taken place with additional resource brought into the York Place team to explore opportunities in this pathway. The next steps in April are to agree timescales and outcomes on this workstream.

The system plan continues to be developed with partners covering all three areas of pre-hospital, in hospital and transfer of care. A monthly partnership session has been established to support further development and delivery of the plan for both York and North Yorkshire Places.

4.1.8 CIPHER for ambulance cohorting in ED's and PTS discharge contract in place since December 2022 funded by NY and York place. The contract with CIPHER for ambulance clinical handover at Scarborough and York ED's has now been extended to March 24 with

confirmed ongoing system funding. The Trust is working with VCS services to support discharge of patients.

4.2 Board Priorities: Elective Recovery

Advise (1): Whilst remaining a challenged position, March 2023 has seen an improvement on a range of elective and cancer performance metrics in comparison to February 2023.

Assure (1): Reduction seen in elective RTT long waiters over 78 weeks; Trust achieved 192 at the end of March 2023, this included ten patients that the Trust transferred to Harrogate & District FT in January but have not been treated. This position was below the trajectory that the Trust submitted to NHSE for the end of March (397) and the revised forecast of 243.

Assure (2): Patients waiting 63 days or more on the Cancer PTL has fallen from 219 to 162.

Assure (3): There were zero 104-week RTT waits at the end of March 2023.

2022/23 Operational Guidance Requirement	Feb-23	Mar-23	
Eliminate 104 week RTT waits	0	0 ⇔	National target - 0
Reduce 78 week RTT waits to zero	414	192 ▼	Trajectory 397 by end March 2023
Return the number of people waiting for longer than 62 days to the level in February 2020	219	162 ▼	National ask - max of 121 at end of March 2023

4.2.1 Elective Programme

The 2023/24 Elective Programme has now been agreed, please see Appendix 1 for a detailed overview of the programme.

4.2.2.1 RTT position

The Trust has continued to see improvements in the long wait position in March, with the number of 78-week RTT patients reduced to 193 (February: 414). The 192 included ten patients that the Trust transferred to Harrogate and District FT but are not yet treated and are to be declared in our figures. The Trust significantly over delivered on the trajectory of 397 and revised forecast of 243 submitted to NHSE for the end of March 2023 and has declared an intention as part of the Tier 1 regime to deliver zero 78-week RTT waiters by the end of June 2023.

There were zero 104-week RTT waits at the end of March 2023.

The national ask for 2023/24 is to eliminate RTT waits of over 65 weeks by the end of March 2024, at the end of March 2023 the Trust had 1,034 patients waiting over 65 weeks. A trajectory to deliver zero has been submitted as part of the 2023/24 planning round with

Care Groups working to weekly forecast positions to deliver the target. The weekly RTT performance meeting monitors and challenges performance against the trajectory.

The Trust has seen improvement in the total RTT waiting list position, reducing to 49,717 at the end of March 2023. A sustainable RTT waiting list for the Trust is around 26,000 open clocks. The activity plan for 2023/24 has been modelled against the RTT waiting list and is forecasted to deliver a 3% reduction by March 2024. Further capacity would be required to deliver significant improvement in waiting times.

4.2.2.2 Cancer Position

The Trust remains under Tier 1 for the Cancer 62-day backlog. The Trust remained off trajectory to meet the target 121 for the end of March 2023, with 162 patients waiting over 63 days at the end of March. This does however represent a significant improvement on the end of January position (335).

The Cancer performance figures for February showed significant improvement in the 28-day Faster Diagnosis standard (69% compared to 57% in January) and 62-day wait for first treatment (from urgent GP referral) position (60% compared to 54% in January).

The refreshed weekly Cancer PTL meeting is now established with increased focus on breach avoidance in addition to backlog clearance.

The 2023/24 cancer priorities have been developed and are aligned to the national asks and cancer alliance plan and funding allocations. This includes the delivery of 80% of lower GI referrals with an accompanying FIT result. The new pathway was implemented with support from primary care and cancer alliance on the 27 February 2023.

4.2.2.3 Diagnostic Position

Diagnostic performance data for March showed an improvement, up to 58.5% from 55.3% at the end of March for patients waiting less than 6 weeks. Improvements are noted in the following imaging modalities:

- Non-Obstetric Ultrasound up 8%, significant decrease in backlog position. Most patients now seen within 4 weeks however some speciality areas (Head and Neck and Paediatrics) still have long waits.
- MRI up 5% with reduction in backlog position because of increased mobile scanner capacity (funded by national monies) which commenced at the start of February. Fast Track Turnaround times continue to decrease for MRI (average turnaround of 17 days)
- CT has increased by 13% with significant reduction in backlog position.

4.2.2.4 Clinical Risk

As a result of the increased validation and focus on the PTL and CPD worklists it has been identified that patients have had their referral to treat (RTT) Clocks Stopped and Patients not treated.

Within CPD there were three processes which promoted patients to notify for consultant review:

1. For clinical review on discharge/defer during COVID-19 March 2020
2. For clinical review on discharge/defer for consultant sickness November 2022

3. For clinical review if patient had no activity at 15 weeks September 2019 – 9 December 2022

When clinicians selected the Follow up option, in conjunction with FUPB or PIFU; whilst it created a worklist item for the admin team to rebook the patients, it also initiated stopping the RTT clock and putting the patient onto an 'Active Monitoring' status.

This has resulted in a cohort of patients who have had their clocks stopped and as a result of this and the worklist items not being actioned by the admin teams, no action was taken and patients were not booked. Because no activity was booked or the patient was not added to FUPB or PIFU the referral was closed via the 'autoclose' process.

The Trust has therefore closed patient referrals without actioning them, so patients who were accepted for an appointment have not been seen.

Two significant risks have been identified:

- Potential patient harm because of delays experienced.
- Potential reputational risk as we may need to open very long wait RTT clocks**.**

A paper has been discussed at Elective Programme Board and submitted to the Trust Quality and Safety meeting to outline the proposed way forward which includes a task and finish group to provide assurance that the immediate issue is resolved or mitigated, to agree a process clinical assess/review patient cohorts to identify next steps for patients and assess the degree of any harm and to ensure any technical, process or personal changes are made and learning shared across all teams.

This task and finish group is in the process of being established and will meet fortnightly.

There is a continued risk with the ongoing validation and work to reduce the open worklist items (over 1 million items) that further issues will be identified. A review of how this work could be expedited is ongoing.

4.2.3 NHSE Intensive Support Team and EY consultancy support

The Intensive Support Team (IST) and EY Consultancy continue to provide support to the Trust. The teams are working to support the Trust on a range of issues including governance, speciality recovery planning, skills and development of the teams and data to support operational teams.

The IST workstreams progress is illustrated in the graphic below:

Workstream	Action	Status
Governance	Critical review and refresh of governance	Completed
	Implementation of WERM	Completed
	Review of clinical harm process	Ongoing – reviewing SOP and guidance from other Trusts
	Development of recovery action plans	Action plan template approved at ERB and H&N commenced
Training	Launch of mandatory RTT training	Completed for initial cohort Paused extended cohort for review
	Back to basics workshop	Scheduled 040423 with all operational managers
KPI's and Reporting	Review of operational reports	Completed
	Development of elective KPI's	Ongoing - 13 KPI's agreed and elective dashboard being developed
	Implement clock stop audit	Process agreed and completed for initial cohort (H&N)
Diagnostics	Develop operational reports and PTL	Not yet commenced
OP pathway booking process	Process mapping of booking process	Information shared – table top review ongoing
Maximising capacity	Demand and capacity	Tool agreed and commenced in H&N

The progress against the EY Consultancy workstreams is detailed below:

Governance

- Development of the elective governance book – completed and to be approved by Elective Programme Board on 25th of April.
- Develop report outlining the findings and recommendations for executive oversight, draft completed and session with Executive Directors scheduled.

Informatics

- Audit of current elective recovery related report available on SIGNAL and complete interviews with users – completed
- Develop report of summary findings and recommendations – completed and draft report submitted. Discussion with business intelligence team scheduled.

Imaging

- Development of dashboard and insights – in progress, draft report completed for validation.

Histopathology

- Review of high-level histopathology service to identify opportunities for performance improvement – in progress and validating findings with stakeholders.

4.2.4. Delivery of the 2022/23 Activity Plan

The Trust experienced industrial action during March, which affected some outpatients and surgery despite this the Trust delivered above plan elective activity across inpatient points of delivery.

March 2023 Activity

Point of Delivery	Planned	Actual	% Plan	% 19-20 outturn
Advice & Guidance	3,865	3,151	82%	143%
Outpatient 1st	18,470	15,326	83%	130%
Outpatient FU	31,192	38,590	124%	122%
Day Case	6,439	7,559	117%	153%
Ordinary Elective	499	592	119%	131%
Non-Elective	6,715	5,943	89%	116%

The reported data does not include the additional activity at the Ramsay elective hub, which will be included within the final Elective Recovery submissions.

5. Operational Plan 2023/24

The national NHS 2023/24 priorities and operational planning guidance has set three core tasks:

- Recover our core services and productivity.
- Make progress in the key ambitions in the NHS Long Term Plan.
- Continue transforming the NHS for the future.

The headline ambitions for the recovery are:

1. Improve ambulance response and ED waiting times (with a revised 76% Emergency Care target)
2. Reduce elective long waits (eliminate 65 weeks by end of March 2024) and cancer backlogs (continue to reduce the number of patients over 62 days on cancer pathways) and improve performance against the core diagnostic standards.
3. Make it easier for people to access primary care services, particularly GP services.
4. Reduce outpatient follow up activity to 75% of 2019/20 levels.

The operational planning priorities remain in line with the ‘Delivery plan for tackling the COVID-19 backlog of elective care’ published in February 2022. The financial planning guidance introduces an expanded variable element for elective care to incentivise electives and 1st outpatient appointments and procedures.

The guidance reinforces system working as part of the transformation of the NHS, with a focus on maturing collaboratives and place-based partnerships and the development of a Joint Forward Plan.

5.1 Current position

- The final iteration of the plan has been submitted.
- The Trust has attended two confirm and challenge meetings covering Workforce, Patient Safety, Activity, Performance and Finance.
- The level of activity in the plan equates to circa 104.5% of 19-20 activity levels. This level of activity contributes to the overall target of achieving 109% of 2019-20 activity that has been requested of the ICB.
- In terms of performance the Trust has modelled and submitted trajectories that will achieve the delivery of zero RTT 65 waiters, the required reduction for cancer 63 plus day waiters, Cancer FDS and Emergency Care targets by the end of March 2024**.**

Recommendation

That the Board of Directors note the report and associated actions.

Date: 13th April 2023

Minutes

Digital, Performance & Finance Assurance Committee
21 March 2023

99-22/23 / Attendance: Lynne Mellor (LM – Chair), Denise McConnell (DM), Jim Dillon (JD), Andrew Bertram (AB), Melanie Liley (ML), Mike Taylor (MT), James Hawkins (JH), Luke Stockdale (LS), Nik Coventry (NC), Mark Steed (MD), Malcolm Veigas (MV), Catherine Thompson – observing)

Apologies for Absence: Penny Gilyard (PG)

LM welcomed Catherine Thompson (Governor) to the Committee.

100-22/23 / Declarations of Interests

There were no changes to the declarations of interests.

101-22/23 / Minutes of the meeting held on 14 February

The minutes of the last meeting held on 14 February were approved as a correct record.

102-22/23 / Matters arising from the minutes

Action 106 – 239 devices were identified as having not touched the network for 90+ days and 6 were returned following communication with users for clarity. There is further work to do on the culture of multiple device usage and whether more docking stations are required. Action agreed as closed.

Action 109 – the Committee said assurance was needed around timelines of opportunity and plans to maximise these. The action was closed on the basis that an overall Nucleus workplan come back to the Committee (considering AHP's and clinicians), noting the challenge that we do not fully know the Nucleus potential yet.

Action 116 – the Trust has c.3500 devices over 4 years old and LS said he was working with the wider capital team to introduce an annual rolling programme to maximise IT equipment. The Trust also noted investment from EPR Technical Readiness funding, and the action was closed.

Action 124 – JH confirmed that this was taken as an action and will be prioritised through the normal process. The Committee was assured that it was in the work plan and the action was closed.

Action 126 - LM confirmed this was raised to the Board and can be closed following Mike Taylor checking if the item was discussed at the Executive Committee

Action 129 – this is scheduled for Board in March and the action was closed.

Action 54 – there are plans to progress this once resourcing challenges are fixed. The action was closed.

Action 110 – MS said there is work to better categorise minor, medium and major works in a more structured way, and that the team is committed to closing all open jobs – there are c.400 in total and approximately 50% have been completed. Additional capacity has been brought in to support this including temporary internal appointment of a Minor Works Supervisor. A 3-year contract with Micad has just been signed and subject to business case approval, there may be a request for a team of in-house tradespeople to respond to jobs faster. Action agreed closed following MS update.

Action 137 – ML and JH are working on these priorities and the action was closed.

Action 138 – action closed as it is included in the planning round.

Action 139 – LS gave assurance that manual checks are now being undertaken as lessons learned. Holistic partnership work will include a substantive review of disaster recovery. Action closed.

Action 140 – deadline extended to October.

Action 141 – action closed.

Action 143 – to be reported back to Committee in April.

Action 125 – action closed as update was received via the COO report.

Action 134 – ML confirmed that Karen Priestman and Mark Quinn will attend the Committee in June.

Action 136 – date TBC but expected to be either July or August.

Action 117 – to be combined with action 109.

103-22/23 / Escalated Items

The escalated items discussed included the need for the support of a paperlite strategy, and the Quality and Safety committee to review the current RTT position – a summary is included in the Chair's Briefing.

104-22/23 / 2022/23 Forecast Outturn compared to Draft 2023/24 Financial Plan

This was discussed as part of the Finance update and AB said a full discussion would be held at the next Board session. The plan is still being finalised, but he said he expected it to project a £39.7m deficit - £29m as underlying position and £11m of CQC-related costs, including nursing investment.

105-22/23 / Trust Priorities Report – Digital, Finance and Performance, to include:

Digital and Information Report Update
(to incl. digital strategy update / information governance / cyber security)

Service desk calls have peaked due to the nhs.net migration but staff are coping with this. There was an increase in information governance incidents around inappropriate access to records and SARs have also increased. The reason is unknown, JH said work is underway to investigate why requests have increased.

DM noted the risk to delivering statutory responsibilities (P29) and asked if we are meeting targets. JH said historically we have not met these and that help was requested from care groups, but work and staffing pressures have impacted this. LM noted the increase in the number of cyber incidents and LS gave assurance that this was immediately flagged and mitigated.

EPR Update

NC shared a presentation on EPR. The Committee noted that we have received funding from the frontline digitisation programme, which is focused on a consistent digitisation level across all Trusts.

The Trust noted that this project will completely replace paper records to ensure that only digital records are used. The Committee discussed the need for the Trust to support the move to paperless by starting to endorse a paper-light strategy now, and the Board should support. JH also advised the Committee that there is significant tension within the ICS regarding EPR utilisation and agreed to update as required.

Action: Board to review and discuss the current 'paper-light strategy' and lead the way on e.g. the process, system, culture change needed for adoption of a paper-light strategy across the Trust.

Operational Performance (Trust Operational Performance to national standards, Recovery Plans and Chief Operating Officer Report)

Covid numbers remain a challenge with 134 patients testing positive at time of writing. Flu is not currently being considered an issue.

The junior doctor industrial action meant that over 1200 patient appointments were cancelled as well as over 150 elective patients. 50 of these collectively were 78-week waiters. The team are trying to reappoint where they can, but this is a challenge and the Committee noted that this is a national picture.

Our national Urgent and Emergency Care (UEC) recovery plan has now been analysed in detail and ML said she was comfortable that the five national areas of focus are covered within the seven key priority streams. These will be predominantly addressed through our discharge framework and work is being done around integrating urgent and intermediate care as well as work across the system and via virtual wards.

ML asked the Committee to note that we are working with PLACE teams around urgent care and the ICS is currently considering their contractual arrangements around integrated urgent care. The Trust is being considered as a key provider, but this has not come via formal route yet. We are also still waiting on confirmation of discharge funds – the key elements of which are funding for Bridlington and York care units and CIPHER support for ambulance handover work. The work with CIPHER has resulted in significant service provision improvement that has overtaken YAS as a whole. This is crucial evidence for discharge funding. There are two key metrics that UEC planning is focused around – achieving 76% for ECS and reducing ambulance handover numbers.

Elective care now has a more robust governance framework and there has been positive feedback from the IST and Ernst Young (EY) teams.

We continue to declare 0 104-week waits, which is being monitored weekly. The Trust originally submitted a trajectory of 397, which was then reviewed to 243 and we are now forecasting a position of 198. This is a significant improvement despite the recent industrial action and ML asked the Committee to note the fantastic work that teams have done to maintain these improvements.

Cancer performance continues to be monitored via the Tier 1 regime. Whilst we remain off trajectory for our current and end of March position (219 against a 121 target at time of writing), this has now reduced to 191, marking a continued improvement. This currently performance is the best recorded since monitoring started in February 2021. This has been recognised by the national Tier 1 team and we have moved from the bottom 10 into the bottom 30 Trusts. This is a significant improvement and part of the work we have done has moved us as an ICS into a position as equal first nationally for cancer performance.

We are not where we need to be in terms of diagnostic positions but there has been a significant improvement –currently at 55.3% versus 47.5% in January. This is discussed via the Tier 1 regime and support is sought where needed.

Activity around follow-up appointments needs further work. We have declared that we will not achieve the 75% improvements target and the Committee noted that anything over 75% of 19/20 outturn is outside the block payment for follow-ups. ML said we are working with Karen Stone (Medical Director) around improving clinical engagement and this will be a significant piece of work.

JD asked how the Trust will focus efforts and ML said key pieces of work have been set out that will be strictly adhered to along with being more directive with operational teams around what is required from them. Weekly Elective Recovery Meetings (WERM) are being held by specialties with a focus on patient level detail and the next piece of work will be around outpatients. Extra finance has also been secured (c.£1.5m) to help with this and ML said that clinicians have been supportive.

There was a discussion about RTT levels and ML said that the need for further work with primary care colleagues has been recognised, in part around referral behaviours and patterns. The Committee noted that the patient tracking team was established in 2017 against a lower RTT figure (c.26k), so the team may need further capacity to handle the increased numbers.

MT said the clinical impact of the rising RTT should be escalated to the Quality & Safety Assurance Committee for assurance and evidence of mitigations.

LM said it would be helpful to see key milestones, deliverables and plan to gain assurance that the plans are sustainable beyond the central and EY interventions (noting that EY contract ends at the end of March). Given the Committee's two primary objectives (acute flow and elective backlog), LM added that it might be beneficial to summarise and share what achievements have been made against these two priorities since set in the last year and share Trust progress with the Communications team to thank teams for their efforts.

Action: Quality Committee to review current and forecast RTT position re patient risk

Finance Update
(to incl. Income & Expenditure position / Efficiency Programme update / Cash & Capital)

At of end of February, we are reporting a £2.2m deficit and we have been successful in securing CT scanner funding (£1.4m). There is some reliance on the recovery actions that each care group has taken to balance our position at the end of the year.
AB gave updates on two risks that were raised at private Board. Firstly, the heat pump system will not be delivered before year end, but we will have a vesting certificate to prove ownership by the end of March. This was purchased by Vital Energi and AB said that they have been incredibly supportive to work with, adding that this is no longer a concern. The risk around the lease for the Community Stadium is rapidly reducing. The council have agreed the various easements requested, the revised designs have been accepted and the lease is currently with Trust lawyers. AB said he expected the lease to be signed next week. AB gave an update on one additional risk – the mechanical engineering contractor for the UEC build on SGH site went into administration. However, IHP have selected another partner to pick up this work where it was left, and AB added that this is an IHP risk rather than ours. The only impact for us will be the timeline interruption.

106-22/23 / Mandatory Reporting Scorecard

This was received for information and there was no further discussion required.

107-22/23 / YTHFM Update – to include:

YTHFM Q3 Business Assurance Report

MV said the KPIs remain as they were in terms of sickness absence. There is now a Workforce Planning Group that reviews end-to-end processes for managing Trust staff and we are looking at using 'Smartsheet' (software for collaboration and work management) for operational managers. MV added that the Trust will achieve the CIP target, over-recovering by £18k.

There was a discussion about sickness trends and MV said that Smartsheets would be able to show pattern analysis in more detail. We are currently doing all we can for musculo-skeletal (MSK) and Seasonal Affective Disorder (SAD), and we are close to having 0 staff over 12 months long-term sickness absence – reduced from 47 to c.11. The Healthcare Cash Plan will launch soon, which will offer healthcare incentives to band 1 and 2 staff to encourage proactive self-care. JD asked if Return to Work interviews were happening consistently and MV said yes, adding that there is empathetic skills training being held for supervisors.

There was a discussion about ventilation review and emergency remedial work, and LM asked for a progress update. MS advised that a number of ventilation plants at Bridlington (BDH) have been identified as significantly sub-standard due to backlog maintenance over a number of years. Lessons learned include a more strategic approach to backlog maintenance and in terms of remedial work, one unit is being replaced with a new system and the remainder are being refurbished. There is also a fact-finding process being run across trade staff, supervisors and senior management within estates to understand how things got to this point.

The Committee sought assurance around the CAFM system and why it has taken so long to implement its phased deployment. The Committee asked for a programme report of the system deployment including deployment of RFID i.e., asset tagging, to gain assurance

that benefits were being realised and DIS were being engaged as necessary. MS said the 3-year Micad contract will commence on 01 April, giving stability, with a focus on planned maintenance and soft facilities management services, with the former being piloted at Malton Hospital. JH asked if beds being moved out of bays would trigger maintenance and said that he and MS should link in around EPR strategy as this will include bed management systems.

Action: MS to provide update on ventilation replacement/refurbishment including supplier timescales

Action: MS to provide an update on the CAFM system deployment including for example assurance on benefits for patients/staff

Sustainability Update

JM said a lot of work has been done in the last quarter. There was a delay on YH site as the subcontractors supplying the heat pump system went into administration. Our main contractors managed to secure the system and some of the employees from the subcontractors and this is now underway albeit delayed. Work at BDH site was delayed due to bad weather but it is now moving at pace and the main contractors are confident that they will complete on time.

A new grant application was made in February having been previously unsuccessful in the last quarter due to the project being oversubscribed and a delay in our grant application (£8m). The new application is for £3m around the York local authority's devolution deal, and we have also submitted one for just under £1m in the hopes that if the former is unsuccessful, there will still be a chance of receiving the latter.

The Committee noted that the YH shuttle bus had not achieved the desired level of patronage and as such the contract will terminate at the end of April. The money earmarked for this will hopefully be used more widely to offer free public transport to staff for accessing YH and SGH sites. This is planned to commence in June and communications around it will follow. LM asked if there was anything planned for smaller sites and JM said there would be promotion for active travel but as more staff are based at YH and SGH, these were the main focus.

108-22/23 / Executive Performance Assurance Meeting (EPAM) minutes

These were received for information and there was no further discussion required.

109-22/23 Risk Management Update – Corporate Risk Register (CRR)

MT said that action owners and target dates are now documented against each risk for each Committee so this will help to provide assurance.

110-22/23 / Items to escalate to Board and/or other Committees

LM confirmed that these would be included within the Chair's brief for Board of Directors but noted the two main ones as follows:

- Board to review and discuss the current ‘paper-light strategy’ and lead the way on e.g., the process, system, culture change needed for adoption of a paper-light strategy across the Trust.

- Quality Committee to review current and forecast RTT position re patient risk

111-22/23 / Items to escalate for BAF and CRR consideration

The Committee discussed risk throughout the meeting and the Chair during the meeting checked with Committee members that there was nothing specific to escalate on this occasion.

112-22/23 / Summary of actions agreed

LM agreed to review this with RH outside of the meeting.

113-22/23 / Any other business

LM asked that thanks were passed on to all of the teams noting the continued pressure, added to the busy time of setting plans for the year ahead. There was no additional business to discuss.

114-22/23 / Time and Date of next meeting

The next meeting will be held on 18 April at 9am-11:30am.

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Lynne Mellor	Date: 18 April 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
The Committee welcomed the Governor Paul Johnson to the Committee as the current DPF Governor observer. *The Committee thanked the Digital, Finance and Performance teams for all their contributions over the last fiscal, and all those wider teams involved in delivering for the benefit of patients, staff and the wider community.*			
Digital			
i)	- The Committee discussed the Digital KPIs. It sought further assurance on the Huntelight Foetal Monitoring system issue: it was assured the immediate risk was mitigated and there is no immediate risk to patients. However, it did ask for a report back on the resolution of support for the system which is currently not 24x7x365. (Only, Mon-Fri). The Committee also discussed the wider issue of systems like this which are part of the 'Shadow IT' which the Trust runs, which often DIS are unaware of until there is an issue. It was agreed that DIS working with Procurement and the Trust Business would provide assurance in due course, that a Shadow IT policy, process and any necessary training is put in place to mitigate the risk of future system support issues. The Committee agreed this would be flagged to the Quality and Safety Committee given potential risks of the Huntelight Foetal Monitoring system SLA and the wider issue of Shadow IT. - The Committee welcomed the configuring of Medical IoT device vulnerability software. - The Committee noted the risk on FOIs and the risks including not meeting statutory responsibilities. It requested, for assurance, an update on the planned policy submission for the next meeting. - The Committee reviewed the current plans for EPR Technical Readiness investment, for assurance it requested an update on key risks and the top-level investment delivery plan. The Committee also asked for assurance to have a ESP closure report re expenditure v delivery v benefits for the Trust/patients/Staff over the last 12 months.	BOARD/ QUALITY & SAFETY COMMITTEE	INFORMATION
Performance			
i)	- The Committee noted the Trust is continuing to see a fluctuating number of Covid patients presenting at the Trust with numbers at time of reporting at 143 moving to 122 as of the Committee Day. - The Committee noted that the Trust is still not meeting targets for ambulance handover (27% against a target of 10%) and the total number of patients waiting in ED over 12 hours (20% against a target of 8%).	BOARD	INFORMATION

	- The Committee noted the progress of the UEC Recovery Plan in 5 key areas embedded within the Acute Flow programme, and still requested for assurance, visibility of key deliverable milestones with benefits for patients for both Acute and Elective programmes (i.e., plans beyond current external help). For example, how is the Trust planning to meet re Virtual Ward, a national ask is that a full plan is needed by December 2023.		
ii)	- For Elective Backlogs: The Committee was pleased to note post the meeting that the RTT position has been reported as zero on 104 week waits, thus meeting the national target. The 78 week waits position had a planned trajectory of 397; in March it reduced to 198, with an improved final outturn for the year of 193 (the Committee was assured the Trust is on track to meet the intended Tier 1 regime plan of zero by the end of June 2023). The Committee still expressed concern over the overall total RTT waiting list position which is unsustainably high at 49k – a sustainable model is 26k. The Committee sought more assurance re plans to address. - Cancer position – remains under the Tier 1 regime for the Cancer 62-day backlog, as it remains off trajectory, with 162 patients waiting. Current performance whilst still off target is the best recorded since Feb 21. - The Committee discussed the clinical risk associated with patients having their referral to treat clocks stopped and patients not treated. The Committee asked for an update on progress from the task and finish group given the potential patient harm. The Committee noted that this has been flagged also to the Quality and Safety Committee. - The Committee welcomed the new programme structure from the Intensive and EY team and assurance that this governance will be mirrored across the Acute/UEC programmes.	BOARD	INFORMATION
Finance			
i)	- The Committee welcomed the news that the Trust had delivered its annual financial plan for 2022/3. The Committee noted that the CIP over-delivered by £1.1M against a target of £32.4m (however over £10M was non recurrent, the ask from the committee is for the business next fiscal and beyond, to support more recurrent efficiency initiatives) - The Committee discussed in detail the draft annual financial plan for the fiscal 23/4. The Trust facing challenges to reach a balanced budget i.e., can the forecast deficit be reduced further as the March Board approved the submission of a deficit plan of £33.7M (following a further £6M reduction in spend given ICB ask i.e., was £39.7m).	BOARD	INFORMATION
YTHFT			
i)	- The Committee noted in the absence of the EPAM minutes there were not items to escalate. It did note that the current MD had left the Trust and a new MD had been appointed.	BOARD	INFORMATION
Governance			
BAF/Corporate	- The Committee discussed the risk paper and reviewed each relevant risk in more detail during and following the discussion.	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		The Committee was pleased that Cyber issues were presented to the Board in March. LLP cyber desktop discussed.	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		Deficit issue resolution for 2022/23 as the Trust delivered its annual financial plan. However,	Draft plans to be approved, and monitoring/control of the deficit risk.

			Trust draft forecast for next year is concerning with risk of significant deficit.	

Report to:	Board of Directors
Date of Meeting:	26 April 2023
Subject:	Sustainability/Net Zero & Climate Change Assurance Report
Director Sponsor:	Andrew Bertram, Finance Director
Author:	Jane Money, Head of Sustainability

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 Trust Board's approved Green Plan, published on the Trust website, incorporates the mission statement "***The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to actively encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services, its premises, its patients and visitors, and its partners in line with NHS targets***."

- The key focus of the Sustainability Team in the last quarter has been the following:

    - Delivering the Bridlington and York building carbon reduction plans with target completion date of 31st March 2023 for the external Public Sector Decarbonisation Scheme (PSDS) grant funding. The fit out of solar panels has been hampered by windy and snowy weather at Bridlington but is still on track for the 31st March 2023. The vast majority grant aided work at York is also concluding but unavoidable delays have been caused by the heat pump

supply company being shut down by administrators which has led to the need to rely on a vesting certification process to allow most of the remaining grant to be drawn down. Discussions are on-going with Salix, the grant managing agent, to agree the final figures but it is anticipated that currently £60k is at risk. A significant amount of work has been undertaken and Appendix 1 shows photographs of the works.

- Discussions were also held with Vital Energi about submissions of Expressions of Interest (EoI) for the North Yorkshire Net Zero Fund for Scarborough Hospital and two were made in time for the deadline in early February. One EoI was for £2.9m for replacement lighting with LEDs, Building Energy Management System upgrade and optimisation and solar electric canopy over electric vehicle car charging points. The £0.8m submission was for just the Building Energy Management System upgrade and optimisation. The selection process leading to grant submissions is due to be advised at the end of March and the outcome will not be known until December 2023, with works undertaken in 2024/25 for the successful applications.
- Continuing work with the NHSE/I Living Labs Innovation programme project through discussions with our internal service leads to move this to the implementation stage.
- The presentation of a business case that has resulted in the termination of the existing York Hospital Shuttle Bus (HSB) service at the end of March 2023 as it has not achieved sufficient patronage to cover its costs. Instead investment has been approved for the provision of opportunities to support staff more widely to make lower carbon choices on their commute (and visit) arrangements which will commence in June 2023.
- Maintaining progress on providing monitoring information to NHSE/I in relation to delivering the NHS net zero carbon agenda and keeping up to date on recent guidance around net zero estate management.
- Work has been undertaken to compile the 2021/22 Trust Carbon Footprint through support from the Internal Audit Work Programme as a temporary measure (in the absence of a permanent Sustainability Team member) which is anticipated to be completed by 31st March 2023.

- In February, the Trust was advised that the grant application for PSDS3b funding was unsuccessful due to the total applications considerably exceeding the funding available, and the process of the allocation of funding on a 'first come first served' basis for a scheme that has become heavily oversubscribed. PSDS3c grant opportunities are anticipated to be released in the Autumn 2023.

- A new job description for a Net Zero Carbon Data Analyst (to replace the vacant Environmental Awareness Officer role due to an ever increasing need for carbon reporting and analysis of projects) was submitted for job evaluation and banding at the start of January and it is anticipated that recruitment will start in April 2023.

- The Energy Manager left the Trust in December 2022, and a recruitment process has resulted in a job offer which has been accepted, subject to the satisfactory conclusion of the HR checks. It is anticipated this will be completed shortly with a view to a potential start in late April/ early May 2023.

- The Sustainable Development Group held its quarterly meeting in February when the leads highlighted progress in relation to the delivery strands of the Trust Green Plan (see section 3.7 for more detail).

- The Sustainable Development Group also discussed a new draft Sustainable Procurement Policy which was endorsed by the group for submission to the Executive Committee for approval (see Appendix 2).

- Also in the last couple of weeks NHSE have published a NHS Net Zero Building Standard for all new buildings and major refurbishments and extensions which will be subject to HM Treasury business case approval process. These will be reviewed and integrated into the refresh of the Trust Estates Strategy over the coming months.

Recommendation:
It is recommended that the Board note:

- The continuing focus and progress of the works to deliver the completion of the Public Sector Decarbonisation Scheme at York and Bridlington Hospitals, and the wait for the determination of the recent application for funding at Scarborough Hospital,
- The continuing progress by the Sustainable Development Group on a variety of carbon reducing measures being developed across the whole Trust,
- The challenges of limited resources to progress and support the wider sustainability programme within the context of a growing agenda, and
- The arrangements being put in place to cope with the current vacancy of the Environmental Awareness Officer (temporary support from Internal Audit Team and a revised role of Net Zero Carbon Data Analyst for advertising in April 2023).

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

Meeting	Date	Outcome/Recommendation

Sustainability /Net Zero & Climate Change Assurance Report

1. Introduction and Background

1.1 This report has been written with the aim of updating the Digital Performance and Finance Assurance Committee and the LLP Management Group, of York and Scarborough Teaching Hospitals NHS FT ('the Trust') and the YTHFM LLP ('YTHFM') of the progress made to provide assurance on the commitment to deliver a Net Zero Carbon NHS.

1.2 The Trust's Board-approved Green Plan incorporates the mission statement "*The York and Scarborough Teaching Hospitals NHS Foundation Trust strives to actively encourage, promote and achieve zero carbon emissions in all that it does, through its staff, its services, its premises, its patients and visitors, and its partners in line with NHS targets"*.

1.3 Since the last report, the Sustainable Development Group has held its quarterly meeting and some new guidance has been issued introducing an NHS Net Zero Building Standard for new buildings and major refurbishments.

1.4 Work continues to deliver the Public Sector Decarbonisation Scheme (PSDS) grant-aided projects at York and Bridlington hospitals, with further significant progress at both sites to introduce low carbon air source heating systems alongside a number of other carbon saving measures and also solar panels at Bridlington.

2. Considerations

2.1 The NHS Standard Contract Service Condition 18 requires plans to be drawn up to meet the NHS net zero targets including:

- Taking all reasonable steps to deliver the NHS net zero targets,
- Providing an annual summary on progress and publish data,
- Transitioning fleet and quickly as possible to zero emission vehicles,
- Phasing out fossil fuels as main source of heating,
- Promoting sustainable travel choices for staff,
- Installing EV charging for fleet,
- Adapting premises to reduce risks associated with climate change and severe weather, and
- Reducing waste and water through best practice and new innovations.

2.2 The latest publication relating to delivering a greener NHS from NHS England is a NHS Net Zero Building Standard (22 February 2022) that provides technical guidance to support the development of sustainable, resilient, and energy efficient buildings that meet the needs of patients now and in the future. The Standard will apply to all investments in new buildings and upgrades to existing facilities that are subject to HM Treasury business case approval process and are at pre-strategic outline business case approval stage from 1 October 2023 onwards. There are six documents in total setting out the standard requirements, various compliance, monitoring and reporting tools and these will need to be reviewed and integrated into the refresh of the Trust Estates Strategy and the work going forwards requiring HM Treasury business case approval.

3. Current Position/Issues

3.1 The key focus of the Sustainability Team in recent months has continued to be the following:

- Supporting the development of building decarbonisation plans as a priority, which is required to achieve 80% carbon reduction by 2032 and net zero 2040 from a 1990 baseline. This work has accelerated through the achievement of external Public Sector Decarbonisation Scheme (PSDS) grant funding for projects at York and Bridlington Hospitals. The work at Bridlington Hospital has seen significant progress on site during the last quarter with solar panels fitted to the roofs of the building, electrical connections within the roof voids and a mini solar farm under construction at the boiler house end of the site. Some of this work has been hampered by windy and snowing weather but the team remain optimistic about the completion of the install by 31st March 2023 with commissioning completed after this date. The new heat pump system has also been delivered and is currently being installed with Northern Powergrid (the electricity Distribution Network Operator) works to site planned in for 18th March. The Combined Heat and Power Plant has now been disconnected to make way for the connection of the solar panels. At York the insulation, new windows and wall cladding works to the exterior of the main ward block which began in July 2022 is now drawing to a close along with the electrical and pipe works in preparation for the heat pump system. Steel platforms are now due to be delivered to site on week commencing 20th March and will be craned onto the roofs in the 2 weeks which follow. Unfortunately, the company supplying the heat pump system was closed-down by administrators in February and the system will now not be available for delivery to site by 31st March 2023. Vital Energi the main contractor has managed to buy all the equipment required and are in the process of providing vesting certification so that the grant can still be obtained for the equipment. Discussions are on-going with Salix (the grant managing agent) about the arrangements for the works which will be undertaken after 31st March. It is estimated that approximately £60k may be lost from the grant. Appendix 1 includes photographs of the work to date.
- Work has also continued on finalising the contracts for which signing has been delayed at York due to the delayed completion arrangement on the works.
- The last report to this committee advised that an £8 million grant application was made for PSDS3b funding on 12th October 2022 for a potential project at Scarborough Hospital, but due to the first-come first-served system, our application was unsuccessful alongside a number of other submissions made ahead of this Trust, in a heavily oversubscribed process. PSDS3c scheme for grant applications is to be released in Autumn 2023.
- In January the York and North Yorkshire Net Zero Fund was announced as part of York and North Yorkshire local authorities Devolution deal and Expressions of Interest (EoI) were invited from public sector organisations by 6th February 2023. Discussions were held internally and with Vital Energi and two EoIs were submitted. Expression of interest 1 (EOI 1) for £2.8863 million for Scarborough Hospital Building and Transport Decarbonisation Scheme consisting of replacement lighting with LEDs, Building Energy Management System upgrade and optimisation and solar electric canopy over electric vehicle car charging points. Expression of interest 2 (EOI 2) (a subset of EOI 1 (in case EOI 1 is rejected)) for £ 791.5k for just the Scarborough Hospital

Building Decarbonisation (BEMS) Building Energy Management System upgrade and optimisation [this is a sub- part of EOI 1) but is the part that offers the greatest carbon saving for the amount of grant requested. Applications will be assessed and prioritised in March 2023, with applicants notified by the end of the March 2023. However, funding cannot be issued until a Combined Authority for York and North Yorkshire has been established. It is anticipated that funding agreements will be issued in December 2023 for works which must be completed by March 2025.

- Discussions have continued with the NHSE/I Living Labs Innovation programme leader and consideration is being given to a proposal to treat and re-use single use disposable curtains. Further information has been requested before the next meeting can be held. It is anticipated that a further meeting with our internal service leads will lead to a decision whether the Trust and YTHFM would like to move forward with this trial to the implementation stage.
- A business case was discussed at the Trust's Executive Committee, which included a review of the costs and benefits of the existing York Hospital Shuttle Bus (HSB) service and considered further opportunities to support staff more widely to make lower carbon choices on their commute (and visits). The report made it clear that whilst the service has operated now for 4 years, it has not attracted the level of patronage to warrant a continuation of this service. Communications are on-going about the alternative options available to service users. The business case also set out some details for arrangements to support staff more widely to access public transport and this will be launched in June. Options are also under consideration for the connection York Hospital to the stadium area where the Trust has healthcare services running.
- Maintaining progress on providing monitoring information to NHSE/I in relation to delivering the NHS net zero carbon agenda and keeping up to date on recent guidance around net zero estate management continues to be a key part of the sustainability Team's work.

3.2 YTHFM's failure to recruit a suitable replacement candidate for the Environmental Awareness Officer resulted in a shortfall in resources. Twenty days' support from the Internal Audit Work Programme started at the beginning of December, as a temporary measure, to update and compile and analyse the findings of the 2021/22 Trust Carbon Footprint. This data compilation is anticipated to be completed by 31st March. Subsequent days are to be funded by the current sustainability team vacancy until a suitable permanent arrangement can be put in place.

3.3 A new job description was submitted for job evaluation and banding at the beginning of January for a Net Zero Carbon Data Analyst designed to replace the Environmental Awareness Officer role (due to an ever-increasing need for carbon reporting and analysis of projects against the different strands of the Green Plan and broadening scope of new guidance). However, this will still leave a shortfall on supporting the delivery of projects and targets, but it is hoped that improvements in data and monitoring will help with future business cases and funding applications. It is anticipated that recruitment will be allowed start in April 2023.

3.4 The YTHFM Energy Manager left at the end of December 2022 and a recruitment process has resulted in a job offer which has been accepted, subject to the satisfactory conclusion of the HR checks. It is anticipated this will be completed shortly with a view to a potential start in late April/ early May 2023. This has

resulted in additional workload for the Head of Sustainability and other staff, taking on additional responsibility as a temporary measure to ensure that this does not impact on the delivery of the PSDS projects.

3.5 Whilst the NHS Standard Contract Service Condition 18 places numerous requirements with regard to developing plans to deliver the NHS net zero carbon targets and adapting to the changing climate, the available resource needed both in terms of capital investment and revenue are well over and above that which is currently provided. Funding opportunities are identified and progressed where grants or business cases may help with this.

3.7 The Head of Sustainability also coordinates the work with the Trust's internal Sustainable Development Group. The Group held its most recent quarterly meeting in February when the following notable progress was highlighted.

- Waste
  - Recycling rate was up by a further 3% in quarter 3 achieving 30%.
  - New Waste Trainer/Auditor to started work in December 2022 to further improve waste segregation through waste audits and training.
  - 37 staff now trained at Bridlington and info graphics to be established
- Energy
  - Insulation cladding and new windows installed to main ward block west elevation at York with external works close to completion. At Bridlington the trenching and ducting had been installed for the heat pump cables.
  - Expressions of interest submitted for Y & NY Net Zero Fund for Scarborough £3million and £1m for BMS, LED lighting, Solar with EV charging.
- Capital Projects
  - Scarborough UECC submitted its pre- construction BREEAM accreditation application (on track for "Excellent" rating) and continuation of this work to ensure that the as built standard also achieves BREEAM "excellent".
  - Scarborough Helipad installed LED landing lights and work on going to create a green and wild space around the perimeter of the pad.
- Travel
  - A new 100 bike capacity Park House cycle store has been installed with opening expected March 2023 once the adjacent electrical works are completed.
  - New signage has been installed on the Bootham Park driveway and the Bootham gates are now opened from 5am-11pm, improving cycle / pedestrian access routes from the city centre to the hospital site (which connects with the new cycle store).
  - There continues to be a gradual increase in usage of the York Hospital Shuttle Bus from the Rawcliffe Bar Park and Ride with regular free taster promotions to encourage staff for try the first 25 journeys for free.
- Medicines
  - Desflurane anaesthetic gas (with a high greenhouse gas content) has now ceased to be used at York, Scarborough and Bridlington hospitals in 2023.
  - ICS inhaler pathways have been updated to incorporate green options
  - Nitrous oxide use has been audited
  - Paperless ordering and invoicing in pharmacy has been introduced

- Procurement
  - Sustainable Procurement Policy created (as recommended by Internal Audit)
- Workforce
  - Extension of Home/Hybrid working. Embedding as Business As Usual in Trust Attraction and Retention plans.
  - Utilising video conferencing rather than travel for Face to Face meetings, wherever possible and appropriate.Supporting a continuation of home/hybrid working
- Climate Adaptation
  - Nigel Watkinson and Edwin Morgan-Sellers have now conducted a audit of all the BMS monitors available for the Scarborough site and created a register of their location. Some inpatient areas are not covered by the monitors and some wards are covered by multiple monitors; work is ongoing to distribute them so that all inpatient areas are covered. This data can then be used to manage the climate of inpatient areas through air conditioning or additional heating.
  - A pilot scheme for installing equipment for monitoring internal temperatures was now on Ward 26 at York Hospital.

3.9 A draft new Sustainable Procurement Policy was included for discussion with the Sustainable Development Group papers for further consideration by the Executive Committee. Ian Willis Head of Procurement highlighted that he had a great deal of support from a graduate working within Procurement, with whom he worked together with across various iterations of the policy The purpose of the sustainability policy statement is to highlight the importance of organisational sustainability, with direct links to the role of NHS procurement in driving this positive organisational change. Not only will there be an indication of what NHS Net Zero is, and what is encompassed within it, but also what the trust is currently undertaking towards achieving the targets of Net Zero. The group agreed to endorse and approve the policy (attached at Appendix 2).

4 Summary

The Trust is following the national guidance and its own Green Plan to make further improvements to deliver the NHS carbon reduction targets and is mindful of the various contractual obligations and the limited resources it has available. A number of initiatives are on-going or in development and whilst there is a clear need to increase our progress, it is also clear that monitoring and reporting plays a key part of demonstrating the effects of the work which is being implemented. Plans are now being implemented to ensure that work continues to collate and analyse the monitoring data on the Trust's 2021/2022 carbon footprint. In addition, priority has been given to ensuring that the available grant funding is used to deliver carbon reduction projects which are to the right quality and, as far as possible on time and on budget. In the last month supply chain issues have led to a shortfall with regard to the delivery of a heat pump system at York hospital but work continues to resolve this issue with continued focus on time, quality and budget.

5 Next Steps

Work will continue to prioritise the delivery of the PSDS grant aided projects at York and Bridlington hospitals to ensure that this programme remains on time and on budget and in accordance with the funder's and the Trust's needs.

Alongside the ongoing sustainability workload, further work is on-going to ensure that the annual data collation is achieved to see what the impact has been of the activities undertaken in 2021/22. The 2021/22 data can then be used to update the Trust Green Plan with more evidence on recent changes and the actions taken and in the pipeline for future years. This can also be used as a basis of further improvements in the context of progress to date and opportunities available for carbon reduction.

The risks of the changing climate and the need to adapt our premises and our services still requires further consideration. The pilot ward temperature monitoring scheme has started and will be used to develop a business case for wider roll out so that the Trust can prioritise areas for delivering better internal climate control and start to understand the investment needed to achieve these changes, but at the present time limited resources prevent this from being undertaken.

Date: 13 March 2023