York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 24th May 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 24th May 2023

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
12:30 – 2:45	Board of Directors - Private	Board of Directors

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors Public Agenda

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

Item	Subject	Lead	Report/ Verbal	Page No	Time
1.	**Welcome and Introductions**	Chair	Verbal	-	9.00
2.	**Apologies for Absence** To receive any apologies for absence	Chair	Verbal	-	
3.	**Declarations of Interest** To receive any changes to the register of Directors' interests or consider any conflicts of interest arising from the agenda.	Chair	Verbal	-	
4.	**Minutes of the meeting held on 26 April 2023** To be agreed as an accurate record.	Chair	Report	07	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Chair	Report	14	
6.	**Patient Story** To receive the patient 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 May 2023-24 Trust Priorities Report	Chief Executive	 Report Report	 To follow 16	9.25
8.	**Risk Management Update – Corporate Risk Register** To receive the latest Corporate Risk Register.	Associate Director of Corporate Governance	Report	53	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
10.	**Workforce Race Equality Standard (WRES) Annual Report** To receive the WRES annual report.	Director of Workforce & OD	Report	63	10.00
11.	**Workforce Disability Equality Standard (WDES) Annual Report** To receive the WDES annual report.	Director of Workforce & OD	Report	70	10.15
12.	**Nurse Staffing Report** To receive the report.	Chief Nurse	Report	79	10.30
13. 13.1 13.2	**People and Culture Assurance Committee** To receive the: • March meeting minutes • May meeting exception report	Committee Chair	 Report Report	 87 92	10.40

Item	Subject	Lead	Report/ Verbal	Page No	Time
Trust Priority: Quality and Safety					
14.	**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	-	10.45
15.	**CQC Update** To receive an update on the CQC actions.	Chief Nurse	Report	93	10.50
16. 16.1 16.2	**Ockenden Report Update** To receive the report including: • Perinatal Clinical Quality Surveillance Update • Maternity Workforce Review Report	Care Group Director of Midwifery	 Report Report	 109 136	11.05
17. 17.1 17.2	**Quality and Safety Assurance Committee** To receive the: • April meeting minutes • May meeting exception report	Chair of Committee	 Report Verbal	 152 -	11.20
Trust Priority: Elective Recovery & Acute Flow					
18.	**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	159	11.25

Item	Subject	Lead	Report/ Verbal	Page No	Time
19.	**Digital, Performance and Finance Assurance Committee** To receive the: 19.1 • March meeting minutes 19.2 • April meeting exception report	Chair of Committee	 Report Report	 184 191	11.35
Governance					
20.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 7.2).	Finance Director	Item 7.2	-	11.40
21.	**Items for Information** 21.1 • Executive Committee Minutes (Blue Box) 21.2 • Star Award nominations (Blue Box) 21.3 • TPR Mandatory Reporting	All		-	-
22.	**Any other business including questions from the public**	Chair	Verbal	-	11.55
23.	**Summary of Actions Agreed**	Chair	Verbal	-	
24.	**Time and Date of next meeting** The next meeting held in public will be on 28 June 2023 9:00am.				
25.	**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.				
26.	**Close**				12.00

Minutes
Board of Directors Meeting (Public)
26 April 2023

Minutes of the Public Board of Directors meeting held on Wednesday 26 April 2023 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:00am and concluded at 11:05am.

Members present:

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

Stakeholder Non-Executive Director
None

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
- Melanie Liley, Interim Chief Operating Officer

Corporate Directors
- Lucy Brown, Corporate Director of Communications

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

Observers:
There were no observers at the meeting

The Chair welcomed everyone to the meeting.

01 23/24 Apologies for absence

Apologies received from:

- Matt Morgan, Stakeholder Non-executive Director

02 23/24 Declaration of Interests

There were no declarations of interest to note.

03 23/24 Minutes of the meeting held on 29 March 2023

The Board approved the minutes of the meeting held on 29 March 2023 as an accurate record of the meeting following the below additions/amends:

169 22/23 (Gender Pay Gap Report) – to include reference to clinical excellence awards when referring to bonus pay for consultants.

174 22/23 (Ockenden Report Update) – amendment to final paragraph to read; *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 the Care Group Triumvirate, the Board suggested the Director of Communications considers a wider communication piece disseminated both internally and externally, to share the significant progress and improvements made since December 2022, providing a degree of assurance to staff and the wider public around the Trust response to the initial CQC findings.*

04 23/24 Matters arising from the minutes

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

05 23/24 Staff Story

Bella Abidakun, Pre-registered Staff Nurse prepared a presentation (copy enclosed) and attended the Board meeting to share her experiences and aspirations as part of the Trust.

BA Staff story.pptx

The Board thanked Bella for her contribution to the Trust and for attending to share her experience. The Board were keen to understand what could be improved in terms of support from the Board for international nurses. Bella shared that the improvement in the process of feeding back on performance to enable individuals to improve their quality of care would be welcomed. Bella also shared challenges for individuals around finding accommodation whilst also facing and completing their OSCE Test of Competence exam(s). There is a considerable amount of pressure on the nurses to support themselves and their families with accommodation. It was acknowledged that the Trust's Head of Equality, Diversity, Inclusion and Participation, Mentors and Professional Nurse Advocate's were all key roles in supporting nurses at the Trust.

06 23/24 Chief Executive's Update

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

- Industrial action – summarising the recent BMA Junior Doctors' industrial action and the anticipated disruption around the upcoming RCN strike action in particular over the 1st May bank holiday. The Trust had been requested to submit explicitly what areas would not be able to be staffed safely
- Travel and Transport – good feedback from the introduction of the new vehicle recognition system. The criteria had been revised following constructive feedback from staff. The Board shared their thanks to the team that have worked on this.
- Cultural awareness week running from 24th – 29th April
- Elective recovery – more confident the Trust was in a position to deliver targets but there was still work to do and the Trust remained in tier 1 for elective recovery. As a consequence of the improved performance in the Trust had been moved into tier 2 for cancer.
- Annual operational and financial planning for 2023-24 – remained in draft stage and awaiting to be signed off and relevant discussions around the position to take place.
- NHS Delivery and Continuous Improvement Review
- The Hewitt Review

07 23/24 Risk Management update – Q4 Board Assurance Framework and Corporate Risk Register

The Board received and noted the Q4 Board Assurance Framework and noted the current Corporate Risk Register.

Karen Stone highlighted that a request would be made at Risk Committee to review PR2 (Access to patient diagnostic and treatment is delayed) as it was felt that this didn't correctly address quality and safety as it should.

Although the Board approved the Board Assurance Framework as a reflection of where things were, it was noted that there was further work required, in particular around more detail where there were gaps of assurance and more clarity of where primary responsibilities fall. The Board accepted that the Risk Committee would discuss further, to include in particular the review of PR2, with a view to then report back to the Board in due course.

08 23/24 Trust Priorities Report: Our People

Polly McMeekin provided an update on progress with the real living wage which payroll were currently processing.

Forward focus was on a number of key initiatives specifically around delivering the Culture and Leadership programme over the next 12 to 18 months. A Programme Manager had been secured to facilitate. It was noted that although there would be significant input from a core team, there remained to be lack of administrative support to drive the programme forward. The programme requires approximately 92 days of internal resources (not an addition to the payroll but a recalibration of priorities on exiting resource). The Board were in agreement that this programme set a clear message or recognising there was a need for change and were committed to finding the resource requirement within the Trusts existing resource capacity.

Jenny McAleese raised sickness rates and requested that the Board revisit this at some stage in the coming months as a means of looking at the way of making the best use of the Trust resources. It was acknowledged that one of the key elements and initiative to drive down sickness levels was less about reactive sickness management and more about preventing it initially.

Polly was asked to consider any key messages for the Board to share to start embedding support around the programme.

09 23/24 Trust Priorities Report: Quality & Safety

The Board received and noted the quality and safety update. Heather McNair touched on the recruitment performance and highlighted her concerns around the IPC performance downfall and acknowledged that this would be discussed further in the private Board meeting.

10 23/24 CQC Update

The Board received and noted the updated position to the action being taken to address the CWC regulatory conditions. Heather McNair highlighted that on 23rd March the Maternity action plan, in response to the section 31 warning notice, was submitted in line with CQC requirements. The Board noted the next submission was due on 21 April 2023. The CQC had written to the Trust on 15 March 2023 to request further assurance and additional data regarding the section 31 for the Emergency Departments in relation to Mental Health Risk assessments and the Board noted that a response was sent by Heather 30 March 2023.

11 23/24 Ockenden Report Update

Sue Glendenning, Interim Care Group Director of Midwifery prepared and presented the report and summarised the key points.

The Board noted the current level of assurance and identified that there were some gaps but recognised the associated risks involved.

The Board also noted the Maternity Workforce Review report. Sue described the workforce development plans which supported the maternity service in addressing current deficit in midwifery staffing cross site against both safe core and integrated staffing requirement, as well as developing specialist, dedicated roles supporting governance, speciality service development and improvement work. One of the greatest risks discussed was relating to the recruitment of key positions in the maternity department.

12 23/24 Q4 Guardian of Safe Hours Report

Karen Stone presented the report prepared by the Guardian of Safe Working. Karen highlighted:

- The £15,000 national funding provided to “enhance junior doctor rest facilities” had been spent
- Staffing and training issues highlighted via exception reports and Junior Doctor Forum (JDF) had led to improvements for FY1 Doctors in Care Group 3 (York).
- A more structured, transparent, co-ordinated approach to managing leave requests was necessary across the organisation
- Updates to the exception reporting software implemented to improve response times.

The Board noted that there were no additional areas of concern that were not described in the report and were assured through examples given by Karen that any issues raised were actively being addressed.

13 23/24 Quality and Safety Assurance Committee

The Board received an update from the Chair of the Quality and Safety Assurance Committee, Steve Holmberg. Steve described discussions that the Committee had covered in relation to Maternity Services and progress following on the CQC actions. A large programme of work had been set around this and good progress had been made. Sharing evidence of the positive impact from the progress made was suggested. The Board were reminded that Ellen Armistead (Quality Improvement Director) was due to attend the Board at its May meeting to present an overview on this.

Care groups were now beginning to attend the Committee, of which Care Group 1 most recently where they had shared their shortcomings with the erostering system (HealthRoster). The Committee had discussed a commitment to invest in improving the rostering system which felt would overall improve time for patient care. Heather McNair advised that there was currently the regional workforce team in the Trust who, as part of their time with the Trust, were looking into the management of erostering and it was hoped that improvements around this would become part of their recommendation in their outcome report.

Steve highlighted the Board on Echocardiogram reporting, he described that on balance there were more staff trained to perform this procedure than there were that were authorised to issue a report. Consequently, there were a number of reports that were in place that are not yet certified. This was highlighted as clinical risk and had been identified as such, the Board were assured that work was ongoing to address this accordingly. Karen Stone advised that roughly 20% had already been reviewed at the time of the meeting.

Steve also highlighted to the Board the medicine safety around care units and the way in which medicines were being dispensed was outside the EPMA (Electronic Prescribing and Medicines Administration) programme, this was creating a clinical risk. The Board acknowledged this risk and were assured that work was underway to address.

There were no further challenges or comments of note.

14 23/24 Trust Priorities Report: Elective Recovery and Acute Flow

The Board received and noted the performance relating to elective recovery and acute flow. Melanie Liley highlighted:

- COVID-19 inpatient numbers have increased across the Trust to 143 from 115 on the 8th of March.
- Recruitment to the Programme team had progressed. The programme team were to work four priority programmes for the organisation; UEC, Elective Recovery, Maternity and People and Culture
- Acute flow performance remained a challenge from both an acute and emergency care perspective and also from the industrial action impact.
- Humber and North Yorkshire would be placed in tier 2 as the national tiering for urgent and emergency care recovery (different to how the elective tiering system as this is by organisation). Consequently, the Trust would be having regional NHS England support and further updates would follow once it was clearer what that meant for the Trust.
- Integrated urgent care – still await formal notification in relation to the contract details and the move to a model of integrated urgent care. Due diligence and engagement workshops were progressing but nothing further to report.

- Virtual wards – was an ICB priority around moving to a single virtual hospital approach. Work already done has been positive and well received. Trajectories would be shared through the board sub-committee(s)
- Discharge support initiatives were ongoing
- Elective recovery - Tier 2 for cancer
- Outpatient transformation programme – recognise the significant amount of work that remained

Concern was raised relating to data on waiting times and how it is displayed. Expressing a point in time target didn't feel adequate to be able to assess the patient safety. Melanie assured that this was being considered through a clinical risk evaluation forum where the waiting times are reviewed and validated and then expedited if required.

The Board noted the update report.

15 23/24 Digital, Performance and Finance Assurance Committee

The Board received an update from the Chair of the Digital, Performance and Finance Assurance Committee, Lynne Mellor. Lynne shared some of the discussions that the Committee had covered.

There were no challenges or comments of note from the Board.

16 23/24 Finance Update

The Board received and noted the income and expenditure Trust position, Andrew Bertram highlighted that the Trust had ended the 2022/23 financial year with an adjusted surplus of £147k. This compared with the annual financial plan agreed by the Board of an adjusted balanced Income and Expenditure position and meant that the Trust had delivered its annual financial plan in 2022/23.

Andrew acknowledged that the Digital, Performance and Finance Assurance had received at its recent meeting, £144,000 adjusted financial performance surplus which had increased to £147,000 as report.

Andrew explained that the statement of comprehensive income within the accounts would actually show a £10.681m surplus for the period but that NHSE normalise this position with a series of technical adjustments to get to the adjusted surplus position of £147k. The most notable of these adjustments was the exclusion of the grant income of £10m associated with the carbon reduction schemes the Trust had undertaken this year. Andrew drew the Board's attention to the reconciliation table between the SOCI position of £10m surplus and the NHSE adjusted surplus of £147k.

Andrew highlighted that the Trust had spent £91m against a total capital programme for 2022/23 of £86.5m, due to additional PDC allocations received late in the year. Andrew described a few of the contributing capital program of works.

The Board acknowledged the significant work gone into bringing the accounts in on balance and the assurance received through the year was a triumph.

17 23/24 Sustainability Update Report

Andrew Bertram presented the report prepared by Jane Money, Head of Sustainability. The board acknowledged that Janes was retiring from the Trust and thanked her for her contribution in driving the Trust forward with this agenda.

Andrew highlighted that the Park House cycle shelter note din the report was now complete since the drafting of the report.
The Board noted the continued 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 Board also noted the continuing progress by the Sustainable Development Group on a variety of carbon reducing measures being developed across the whole Trust, acknowledging the challenges of limited resources to progress and support the wider sustainability programme within the context of a growing agenda.

18 23/24 Any Other Business

There was no other business discussed.

The Associate director of Corporate Governance requested the use of the Corporate Seal for:

- International Nurses and Midwife Staffing at Holgate Park – Licence to Alter for the Fit-Out Work
- Vital Energi and the Heat Pump arrangements
- Facilitating of the Trust and YHFM

19 23/24 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 24 May 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		TBC	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	Red
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

TRUST PRIORITIES REPORT

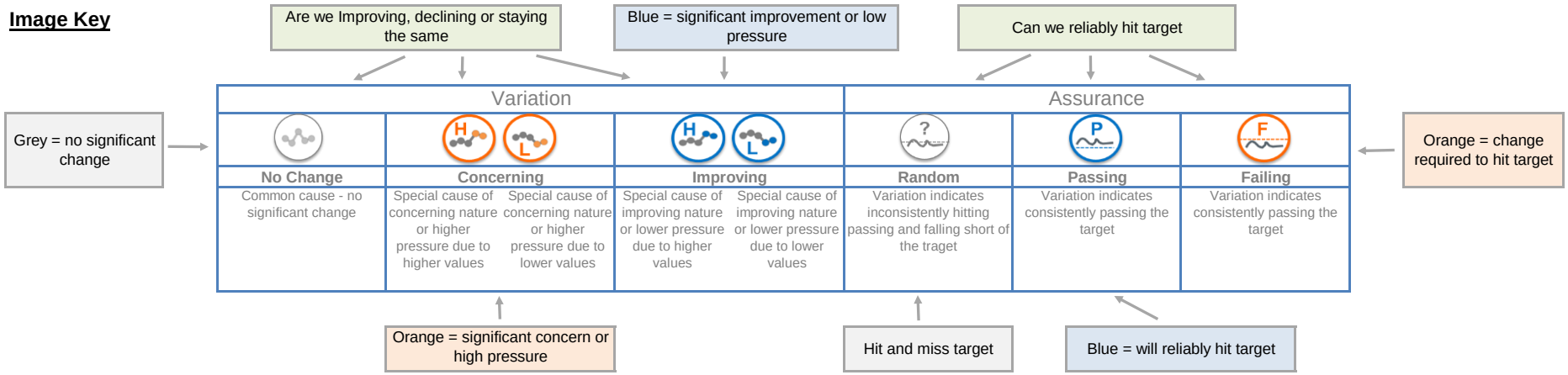
May 2023

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

KEYS

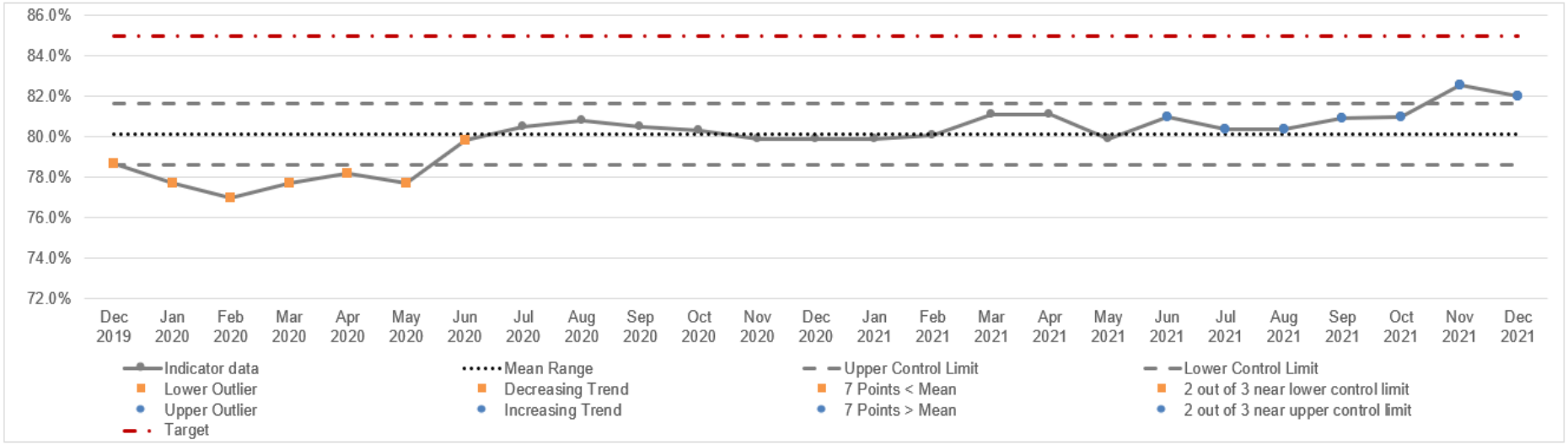
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Image Key



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

SPC Key - example SPC chart



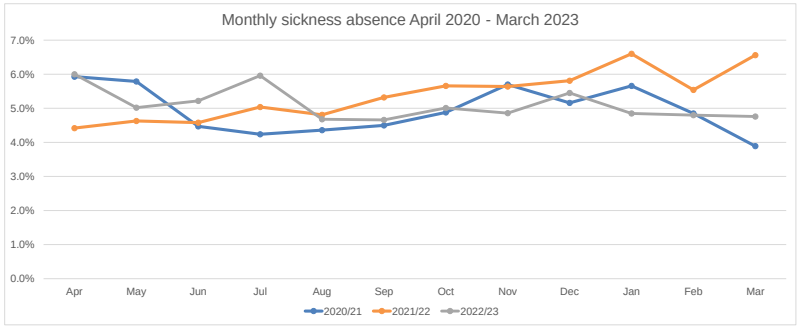
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

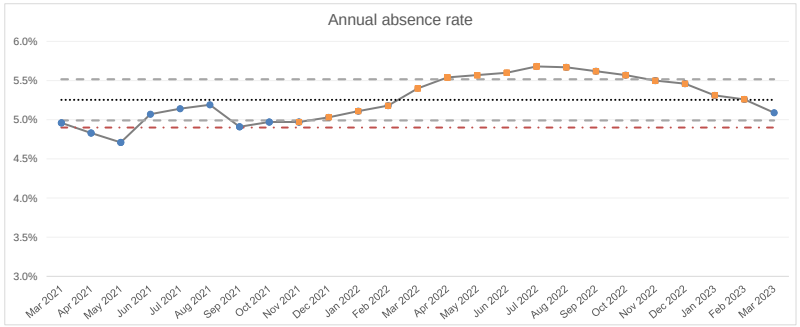
OUR PEOPLE - Sickness Absence and Staff Survey

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

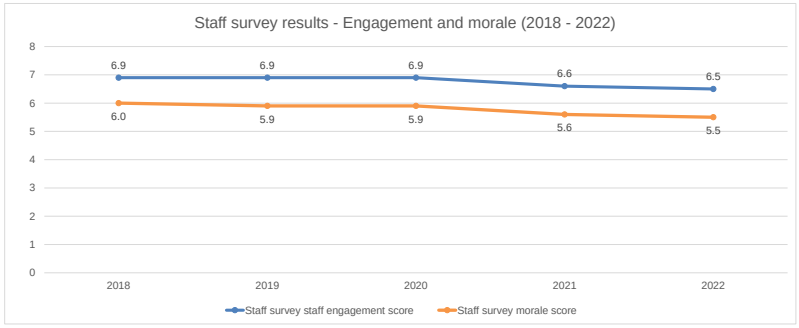
REPORTING MONTH : APRIL 2023



Mar 2023
4.76%
Target
No Target
Variance
Assurance



Mar 2023
5.09%
Target
4.90%
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:

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 Mar 2023 (4.76%) is lower than that seen last year (6.56%).
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 below the mean. The target is slightly below the lower control limit, so is 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

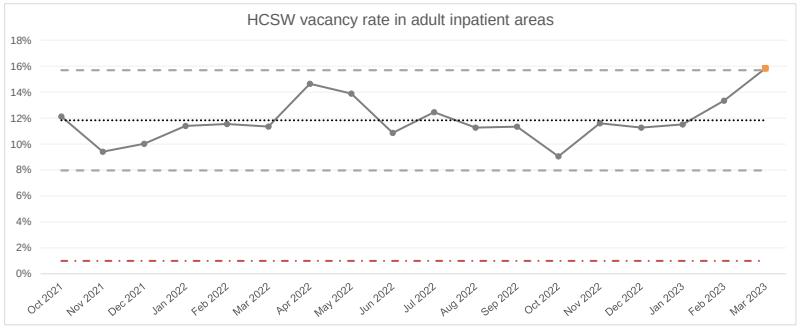
There has been very little change in the monthly absence rates between January and March 2023, and although the annual absence rate for the year to the end of March did reduce for the seventh month in a row it remains above 5%.

The HR teams have been placing a focus on sickness absence to try and understand where additional support is needed to help reduce absence rates across the organisation. This has included targetted support to sickness absence hot spot areas and more creative approches to provision of training around absence mangement to reach wider audiences and improve attendance.

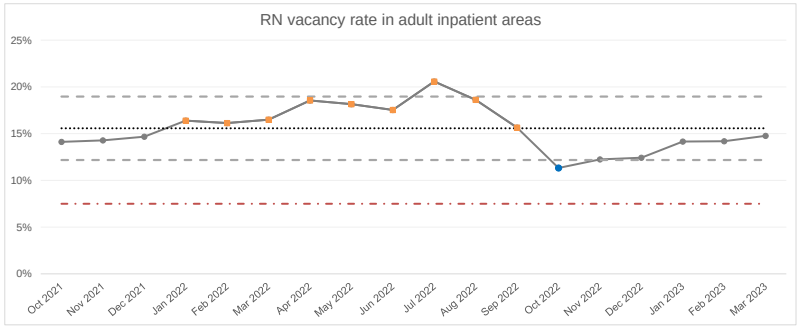
OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

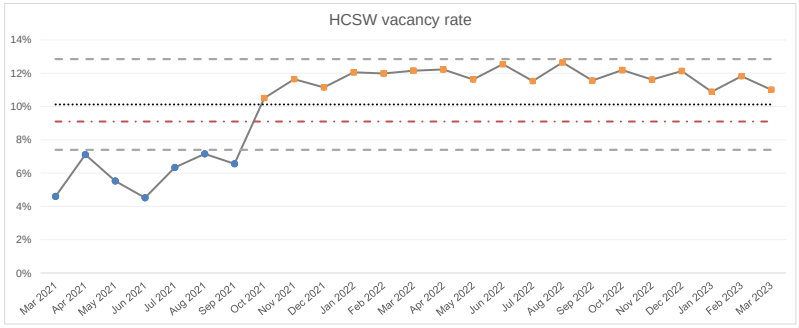
REPORTING MONTH : APRIL 2023



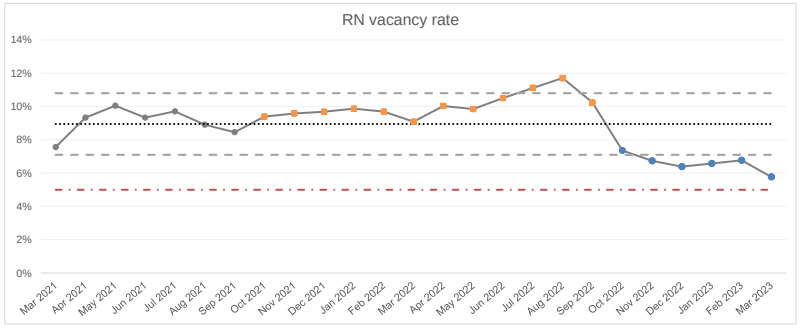
Mar 2023
15.83%
Target
1%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



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



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



Mar 2023
5.77%
Target
5%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
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

It is not possible to provide the most up to date vacancy position as at the end of April as the operational budgets, including budgeted establishments, for the new financial year are still being finalised.

During the last week of April, the Trust welcomed our first cohort of eight nurses from Kerala, along with two physiotherapists who were also recruited during the recruitment trip to India last November. Their arrivals mean we are the first organisation as part of the ICB collaborative to successfully on-board candidates. Further AHPs and nursing cohorts are planned to arrive over the coming weeks/months, although challenges with candidates completing their English language exam is having an impact on the number we expect to convert from the recruitment event. Around 100 nursing posts were originally offered but this reduced to around 80 due to withdrawals and we are predicting the numbers may reduce further to under 50, due to delays with English language exams. To ensure the Trust is on track to meet its NHSE funded target of 90 internationally trained nurses by the end of November, we have recommenced direct international nursing recruitment and are interviewing pre-screened candidates with a view to bolster our cohort numbers. NHSE has confirmed that we have met our target to recruit six international midwives, making us the first organisation in the region to meet their target.

The Trust has recently made 20 offers of employment across site via our generic HCSW advert, in addition to this we have also made 10 offers via our bespoke theatres advert. There is a total of 47 candidates currently in the pipeline. There are 12 candidates booked onto the next York induction which will take place on 22ND May and 14 candidates booked onto the 9th May induction in Scarborough. 142 candidates have registered their interest in the York HCSW Recruitment Event on 15th May and are currently being pre-screened. The next recruitment event for Scarborough will take place 13th June.

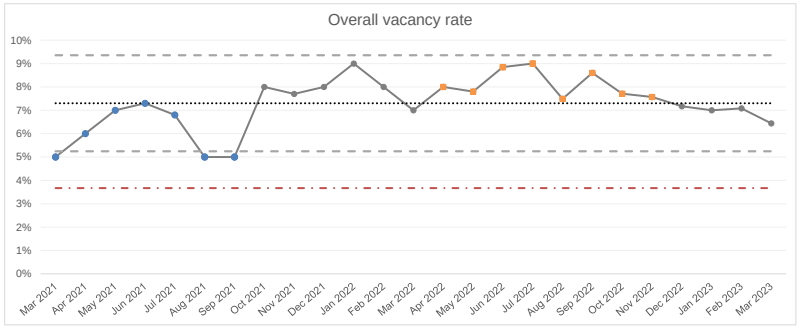
Central funding for Indeed to support NHS recruitment campaigns is no longer available. This is likely to have an impact on terms of reach when advertising HCSW events.

(Additional detail in relation to the HCSW vacancy position is provided on the next sheet)

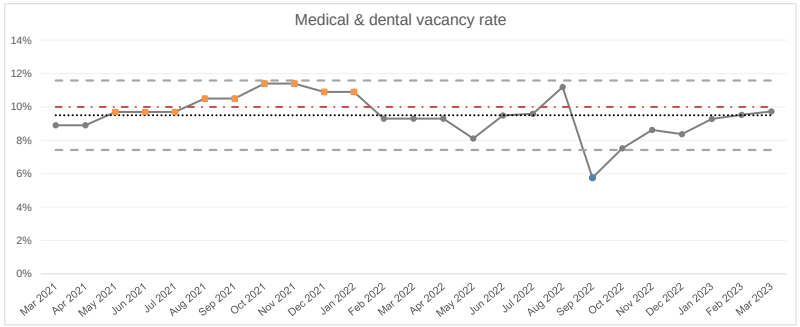
OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

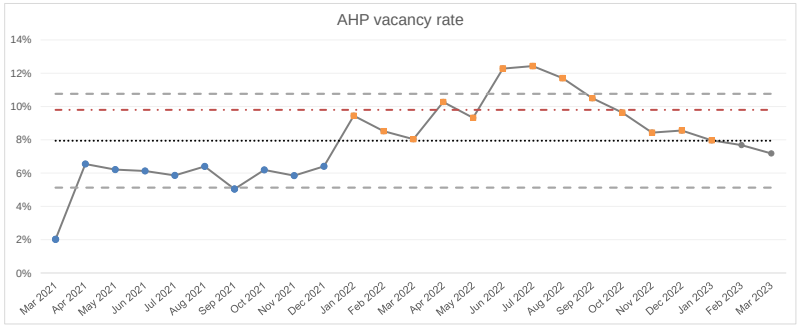
REPORTING MONTH : APRIL 2023



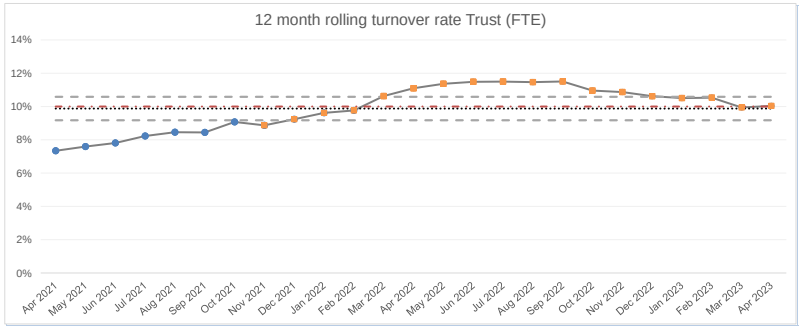
Mar 2023	Target	Variance	Assurance
6.44%	3.67%	Common cause - no significant change	Variation indicates consistently falling short of the target



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



Mar 2023	Target	Variance	Assurance
7.2%	9.80%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
10.04%	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 was 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. The target is showing under the upper control limit.
12 month rolling turnover rate - Trust (FTE): The indicator is showing special cause concern since November 2021. The data points were above the upper control limit from Mar 2022 but, although still above the mean, are now showing a trend back towards the mean. The target is slightly above the mean.

Operational Update

In support of planning the recruitment of HCSWs for the current year, an analysis was undertaken of the HCSW staff in post and vacancy position. Reporting from the Trust's Electronic Staff Record (ESR) underpin the assumptions around expected leaver numbers to incorporate into the planning. The analysis identified however that there are many more changes happening within the HCSW workforce, which are not highlighted through the reporting of starter and leaver numbers but which do affect the staff in post numbers and associated vacancy position. These changes include: substantive staff moving to bank only positions; substantive staff reducing their contracted hours/FTE (this appears to happen far more regularly than increasing hours); HCSWs moving into other support roles or progressing to, for example, the Nursing Associate training programme.

In the year to the end of March 2023, there were 289 FTE HCSWs newly recruited to the organisation. However, between April 2022 and March 2023, the HCSW staffing position only increased by 53.90 FTE.

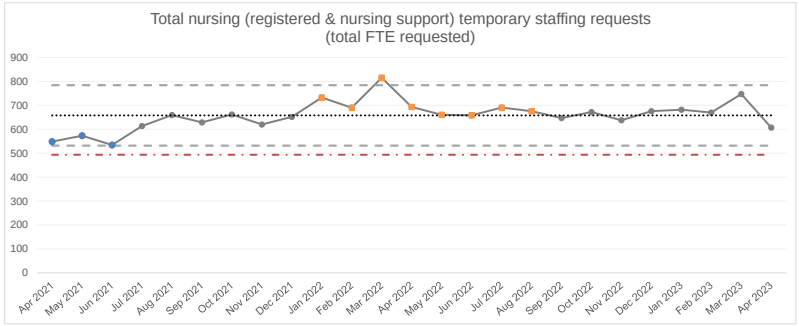
At the start of January 2022, there were 603.46 FTE HCSWs in post in adult inpatient areas. By the end of 2022, 37.81 FTE had left the organisation, whilst almost 70 FTE had moved to bank only posts. In addition, movements to other roles within the organisation, either as progression opportunities or to support roles outside of adult inpatient areas, accounted for over 71 FTE and there was a further net reduction in staff in post of 9 FTE as a result of increasing/reducing hours. Of those 603.46 FTE staff in post at the start of the year, 416.15 FTE remained in the same post at the end of the year (a stability rate of less than 70%).

Discussions are ongoing as to how to incorporate these difficult to predict workforce changes into the planning as, should such changes continue to the level that has been seen recently, HCSW recruitment plans for the coming year are likely to result in a break even position, rather than an overall reduction in vacancies. The issues around why these workforce changes are happening also need to be explored further, for example the significant shift to bank only work and reducing hours indicates that many staff are looking for a level of flexibility that is not being offered at the point that they are being recruited to join the organisation. This needs to happen alongside the work to reduce attrition of those who are actually leaving the organisation.

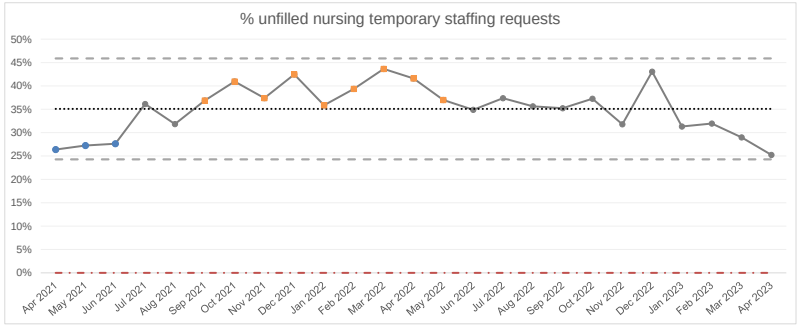
OUR PEOPLE - Temporary Staffing

York and Scarborough Teaching Hospitals NHS Foundation Trust

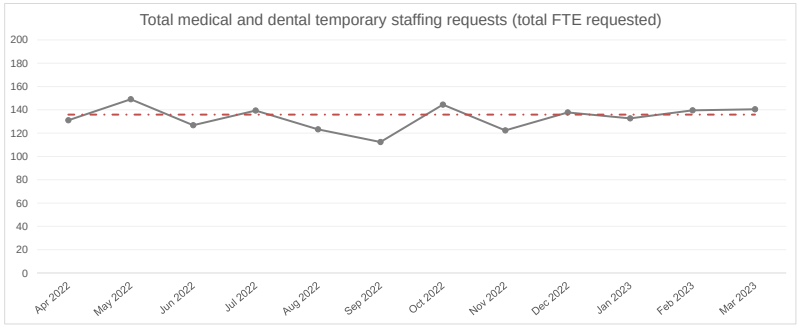
REPORTING MONTH : APRIL 2023



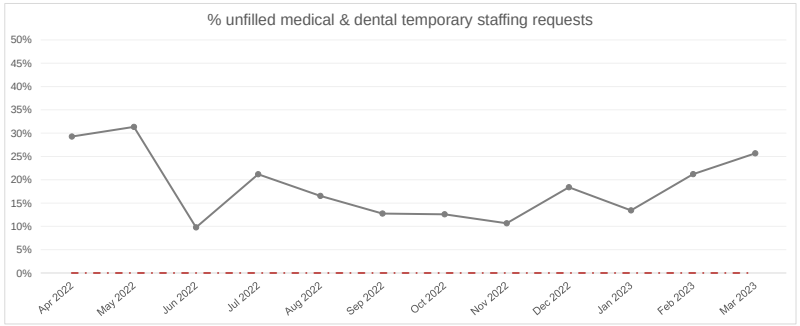
Apr 2023
607.05
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Apr 2023
25.24%
Target
0%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Mar 2023
140.51
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



Mar 2023
25.68%
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 was showing special cause concern above the upper control limit in Mar 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 were extended until 16th April to cover the Easter holidays and junior doctor's industrial action but have now formally ended. Allocation on arrival shifts at double time were offered briefly, to help provide cover for the latest RCN strike.

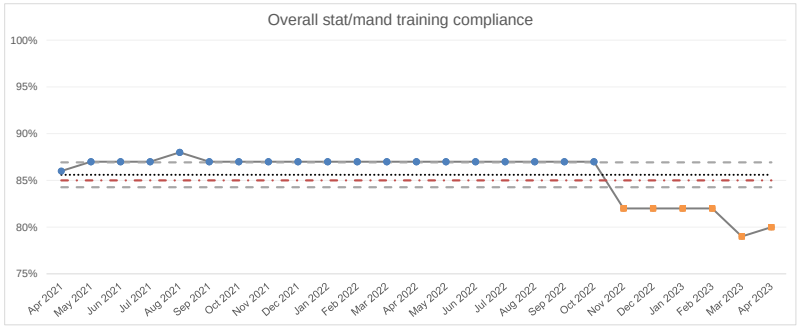
To support the removal of winter incentives and in our efforts to reduce reliance on off framework agency, 16 framework agency nurse block bookings have been made to prioritise cover for areas with high levels of vacancy and staffing pressures, with additional capacity being used to provide allocation on arrival cover to help with staffing issues in the moment. The impact has been positive, and in conjunction with a push to reduce reliance on off framework, the Trust saw a significant reduction in Thornbury bookings by over 50% and a reduction in spend of around £170k for April. It is very positive to note that CG2 had no Thornbury bookings during the month.

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 and improve our utilisation of the workforce through effective eRostering.

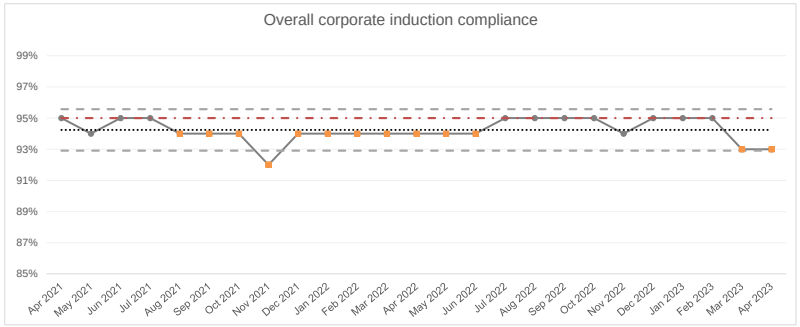
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

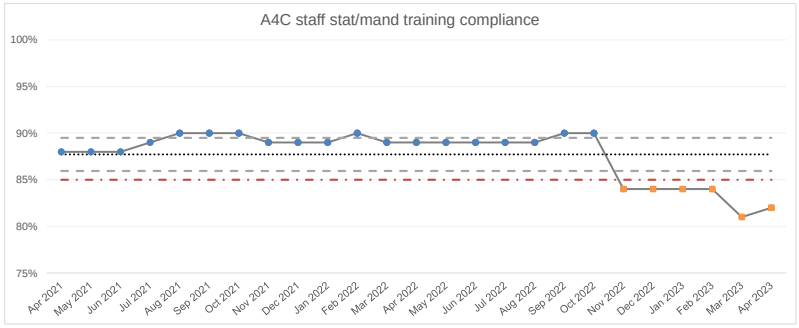
REPORTING MONTH : APRIL 2023



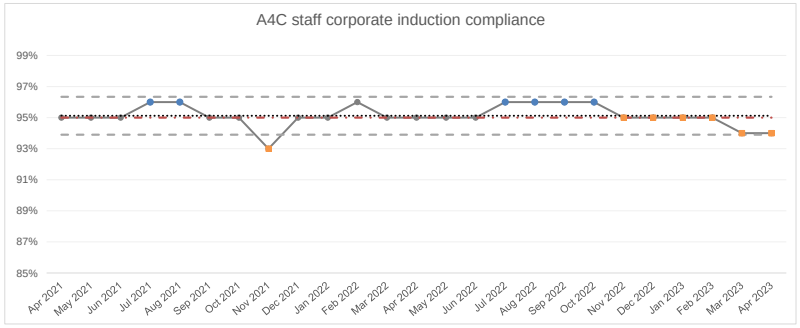
Apr 2023	Target	Variance	Assurance
80%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
93%	95%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
82%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently passing the target



Apr 2023	Target	Variance	Assurance
94%	95%	Special cause of concerning nature or higher pressure due to lower values	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 from Apr 2021 with all data points above the mean and Aug 2021 being above the upper control limit. From Nov 2022 the data points are below both the lower control limit and target, thus showing special cause concern.
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 special cause concern close to the lower control limit in Mar and Apr 2023.
A4C staff stat/mand training compliance: This indicator was showing special cause improvement since Apr 2021 with all data points above the mean. The target is consistently being met, however from Nov 2022 the data points are below both the lower control limit and target, thus showing special cause concern.
A4C staff corporate induction compliance: The indicator is currently showing special cause concern from Nov 2021, with Mar and Apr 2023 close to the lower control limit. The months of Mar and Apr 2023 have also not met the target.

Operational Update

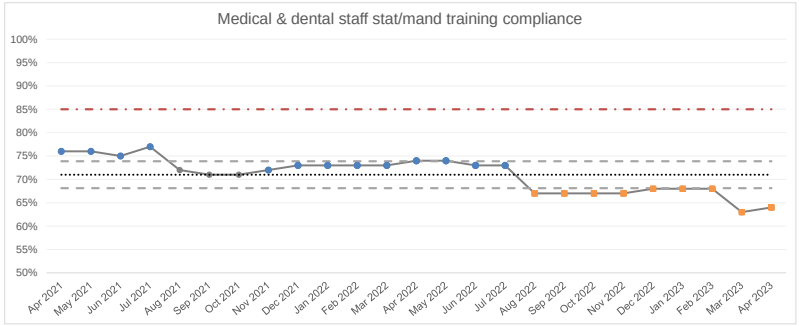
Following the Serious Incident involving Learning Hub which occurred at the start of February, compliance with Statutory & Mandatory Training dropped to 79% at the end of March. The Trust set itself a target of recovering to 82% by the end of June. At the end of April, compliance had recovered to 80%. Automated reminder emails for staff have now been restored which is expected to support further progress against the initial target.

Corporate Induction completion remains at 93%; however, the Trust has re-started its process of flagging non-compliant staff with Management Teams and contacting new starters directly to ask them to complete Induction.

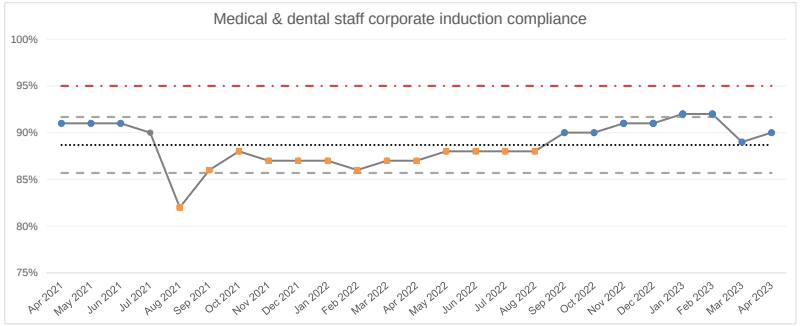
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : APRIL 2023



Apr 2023
64%
Target
85%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



Apr 2023
90%
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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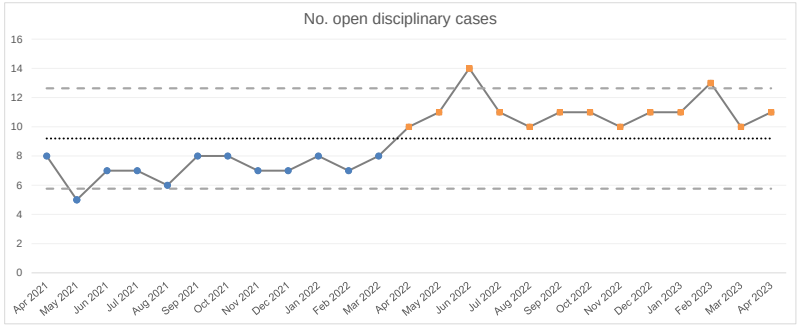
Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

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. The months of Jan and Feb 2023 were both above the upper control limit.

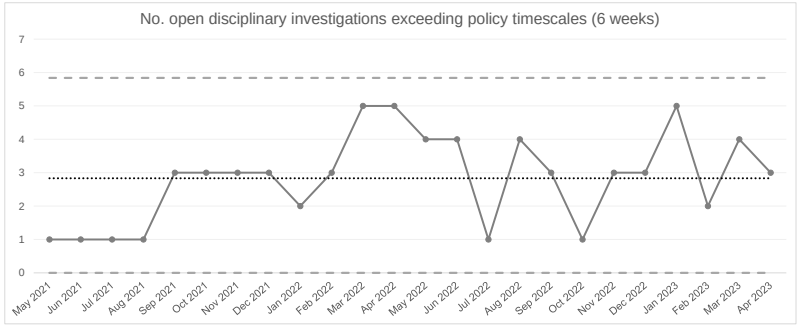
OUR PEOPLE - Employee Relations Activity

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

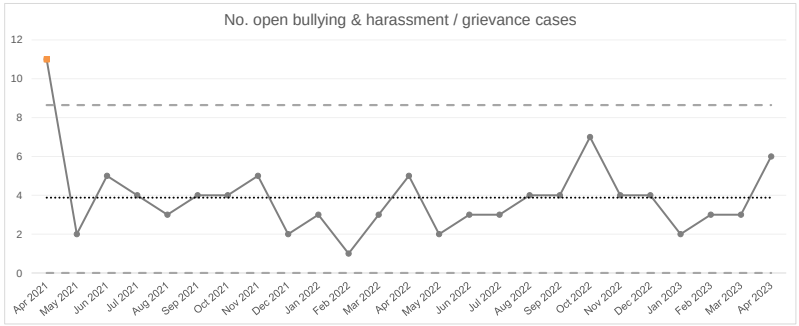
REPORTING MONTH : APRIL 2023



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



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



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

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

Data Analysis:

No. open disciplinary cases: The indicator is showing 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, 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 special cause concern in Apr 2023, which has risen sharply above the upper control limit. Please note the figures are shown from May 2021 only.

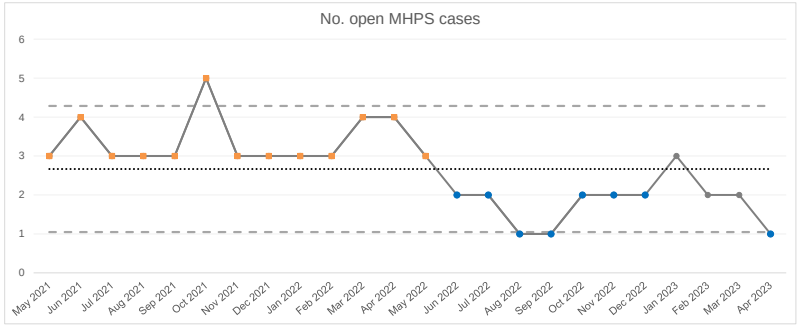
Operational Update

There has been a number of grievances that have exceeded one month policy timescales due to staff absence and time for investigations to be completed to ensure that the panel has sufficient information to reach a decision.

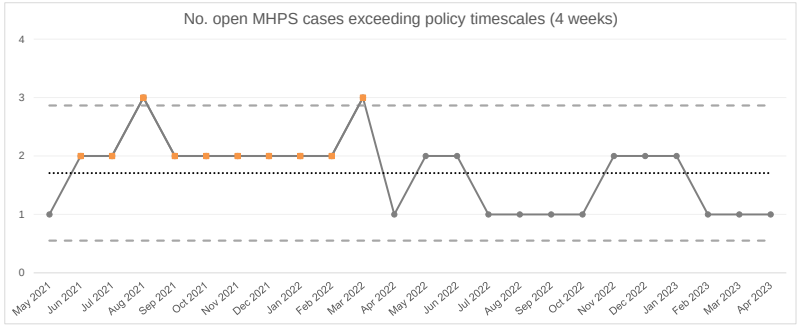
OUR PEOPLE - Employee Relations Activity (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : APRIL 2023



Apr 2023	1
Target	No Target
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	There is no target, therefore target assurance is not relevant



Apr 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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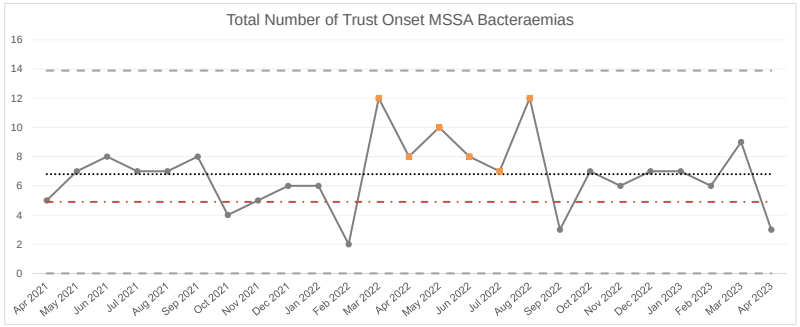
Data Analysis:

No. open MHPS cases: The indicator is showing special cause improvement again, following an earlier seven-month period of improvement, with Aug, Sep 2022 and Apr 2023 near 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.

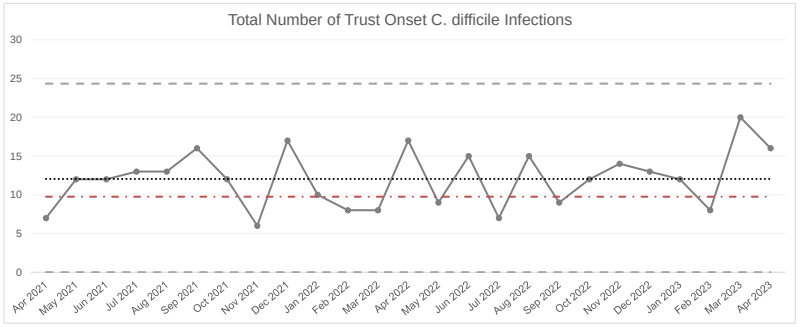
QUALITY AND SAFETY - Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

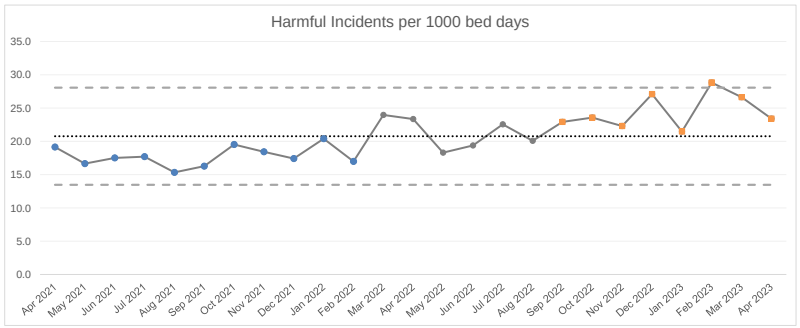
REPORTING MONTH : APRIL 2023



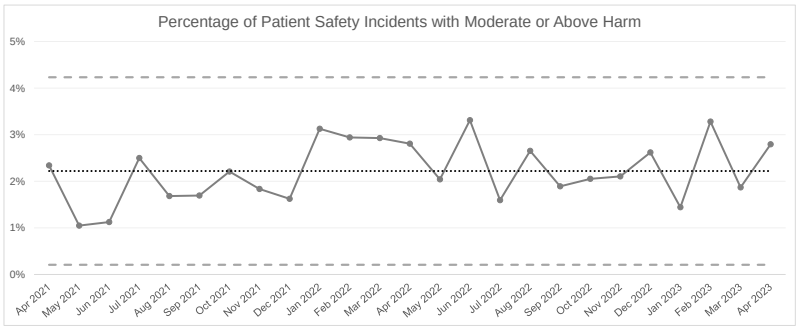
Apr 2023	Cumulative 12-month Target	Variance	Assurance
3	59	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2023	Cumulative 12-month Target	Variance	Assurance
16	117	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



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



Apr 2023	Target	Variance	Assurance
2.8%	No Target	Common cause - no significant change	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. Latest monthly data is the lowest seen since Sep 2022.
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 was an 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.

Operational Updates:

Total Number of Trust Onset MSSA Bacteraemias
There has been a total of 90 hospital attributed cases of MSSA bacteraemia for 2022/23 against an agreed internal target of 59 cases. The incidence shows no improvement from the previous 2 years. Staff practice around cannula management has been identified as an issue requiring improvement in the prevention of Staphylococcus aureus bacteraemia (SAB). A SAB 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.

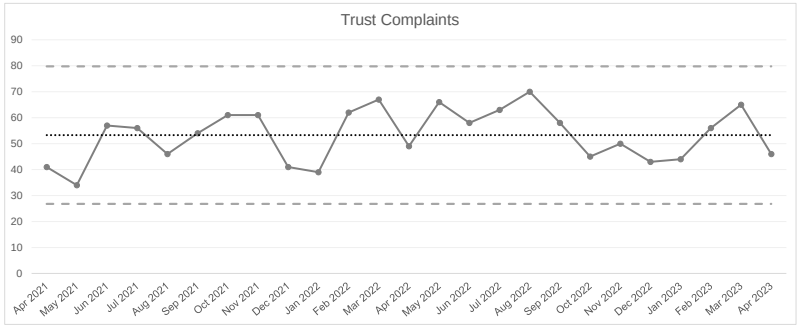
Total Number of Trust Onset C. difficile infections
The annual objective for 2022/23 was set at 117 cases for community-onset healthcare-associated (COHA) and healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. There were 151 trust-apportioned cases; COHA=59; HOHA=92. So, the target was exceeded by 34 cases. This is a deterioration from 2021/22 of 12.69% increase in total cases. Worn and tired clinical environments are a risk of environmental reservoirs for microorganisms such as C.dificile spores. Limited side room capacity results in delayed isolation of patients with diarrhoea thereby increasing the risk of environmental contamination. A CDI Improvement plan has been developed and shared with Care Groups to provide assurance of a reduction strategy for C.difficile.

Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
There are ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams. The pressure on services is especially severe at present with an enhanced level of OPEL 4 in January. There were Junior Doctor strikes for 4 workings days post Easter weekend in April, which could have had an impact on incidents with harm. There is a clear association between pressure on services / staffing issues and patient harms / quality of care. Improvement groups continue to progress initiatives in relation to falls and pressure ulcers. Key risks include pressures on services and capacity and national issues with staff shortages, recruitment and retention as well as the ongoing industrial strikes within nursing and medical staff. Staffing challenges are recognised and various measure in place to mitigate risks as much as possible. Improvement in the availability of nursing staff has been seen in the last few months on Datix.

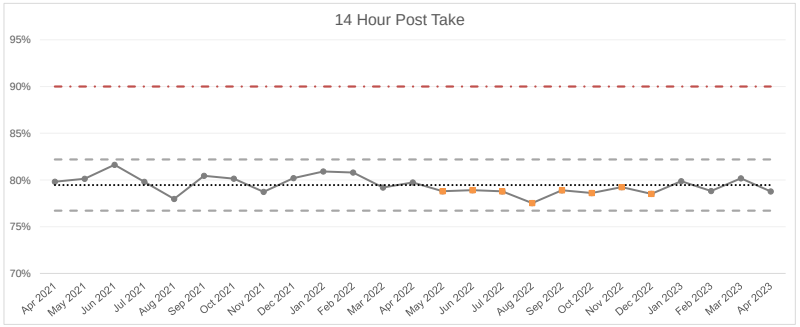
QUALITY AND SAFETY - Priority Metrics (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

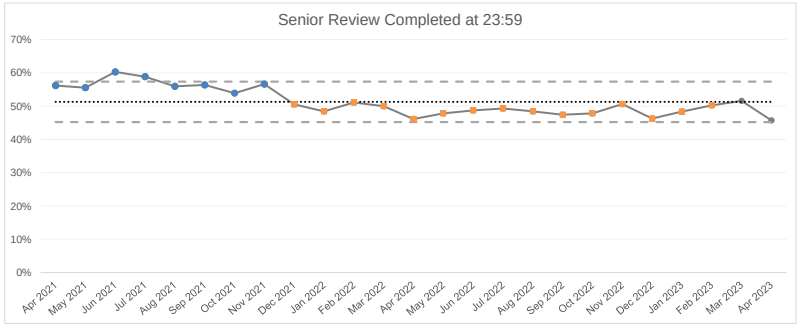
REPORTING MONTH : APRIL 2023



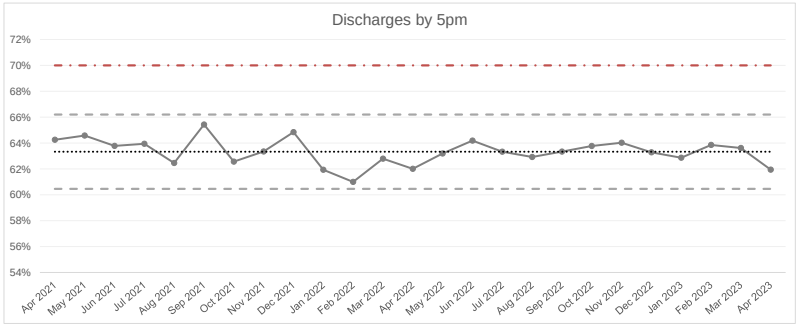
Apr 2023	46
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Apr 2023	78.8%
Target	90%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



Apr 2023	45.7%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Apr 2023	61.9%
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 from 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 from Dec 2021 to Feb 2023. Recent months are showing common cause variation.
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
Key Risks: Care groups continue to struggle 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. This has also been escalated to the deteriorating patient group.

TPR: Icon Summary Matrix (Priority)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

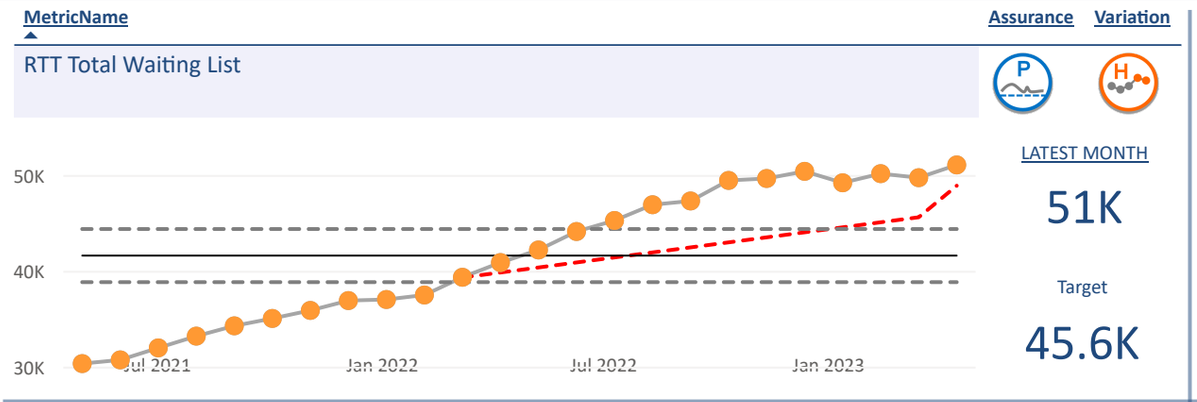
METRIC GROUP

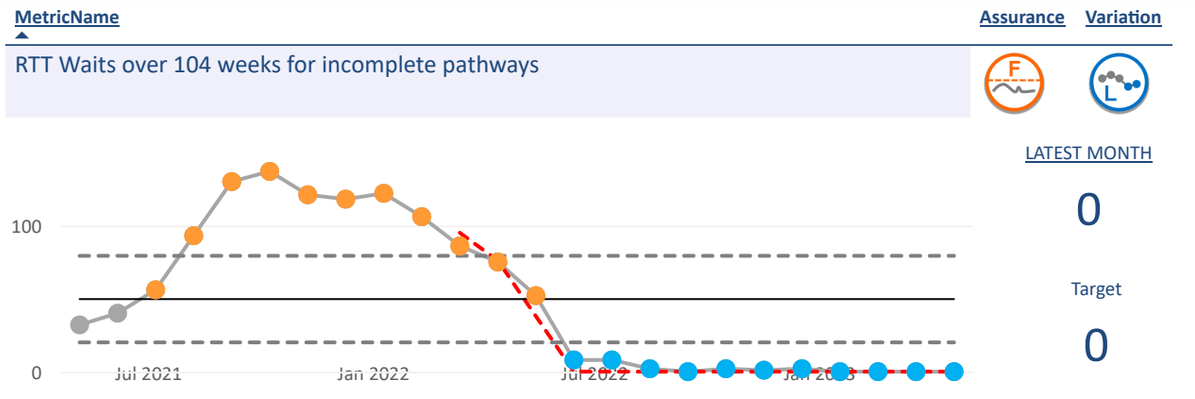
All

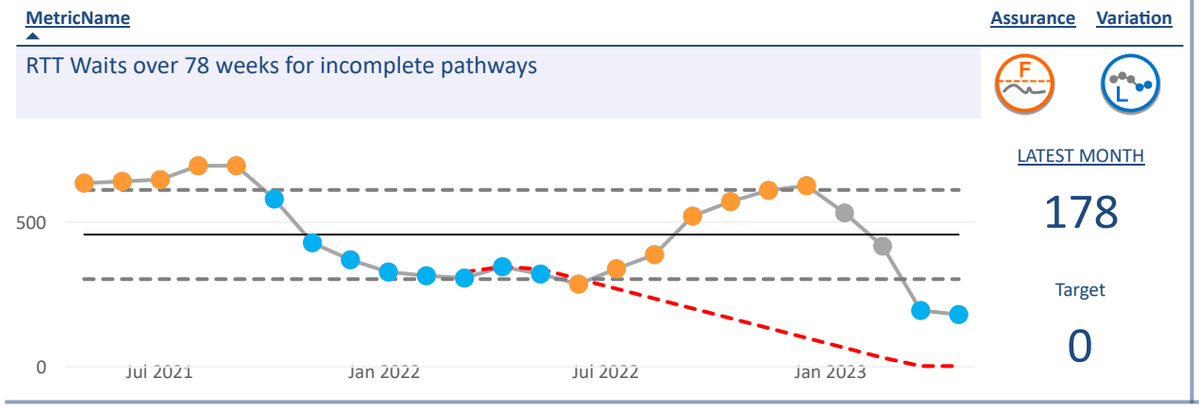
VariationIcon	P	?	F		Total
Improvement			2		2
H					
L			2		2
Common Cause		2	3		5
		2	3		5
Concern	1				1
H	1				1
L					
Neither					
↗					
↘					
Empty					
Total	1	2	5		8

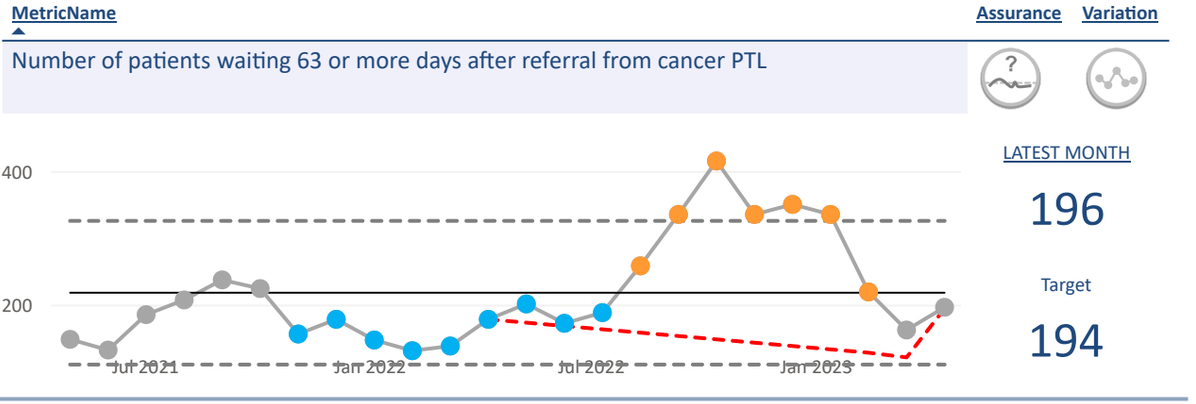
MetricName	Date	Variation	Assurance	Target	Latest Value
Ambulance handovers waiting >60 minutes (%)	2023-04		F	10	17
ED - Total waiting 12+hours - % of all type 1 attendances	2023-04		F	8	16
ED: Median Time to Initial Assessment (Minutes)	2023-04		?	18	14
Number of patients waiting 63 or more days after referral from cancer PTL	2023-04		?	194	196
Proportion of patients discharged before 5pm (70%)	2023-04		F	70	62
RTT Total Waiting List	2023-04	H	P	45589	51050
RTT Waits over 104 weeks for incomplete pathways	2023-04	L	F	0	0
RTT Waits over 78 weeks for incomplete pathways	2023-04	L	F	0	178

TPR: Elective Recovery Priority Metrics









DATA ANALYSIS:

- **RTT Total Waiting List:** The indicator is showing deteriorating performance, with a series of points above the mean since May 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 months. The national target was 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 3 months and is now showing under the mean.

Note: Moving Internal Targets have been updated for 2023-24, this explains the change to the dashed red line on the SPC charts from Apr 2023.

Narrative for Elective Recovery Priority Metrics

Challenges & Risks	Actions & Mitigations
Challenges: The Trust is in Tier 1 Elective Recovery support (National intervention) for RTT and Tier 2 for Cancer (Regional intervention). The Trust is off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 196 against a target of 194 for April. 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. The Trust had 187 RTT 78-week waiters remaining at the end of April below the planned trajectory of 192. 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 mid-June 2023. 5. Waiting List Harms Task and Finish Group established. 6. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with patient specific information ongoing.
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. Further industrial action by BMA Junior Doctors and/or Royal College of Nurses.	Mitigations: Tier 1 fortnightly 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 live for non-admitted and diagnostic patients, the Trust continues to explore the opportunities this presents. 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 April 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	22	34,201	98.22%	94.34%
Black, Black British, Caribbean or African	25	74	0.21%	0.94%
Mixed or multiple ethnic groups	25	150	0.43%	1.26%
Asian or Asian British	22	273	0.78%	2.97%
Other ethnic group	20	122	0.35%	0.49%
Unknown	22	12,801	-	-
Not Stated	22	3,396	-	-
Grand Total	**22**	**51,017**	**-**	**-**

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 April 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	22	5,974	11.95%	8.88%
2	22	7,018	14.04%	13.59%
3	22	10,566	21.13%	20.94%
4	22	10,939	21.88%	20.68%
5	22	15,499	31.00%	35.90%
Unknown	23	1,021	-	-
Grand Total	**22**	**51,017**	**-**	**-**

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.

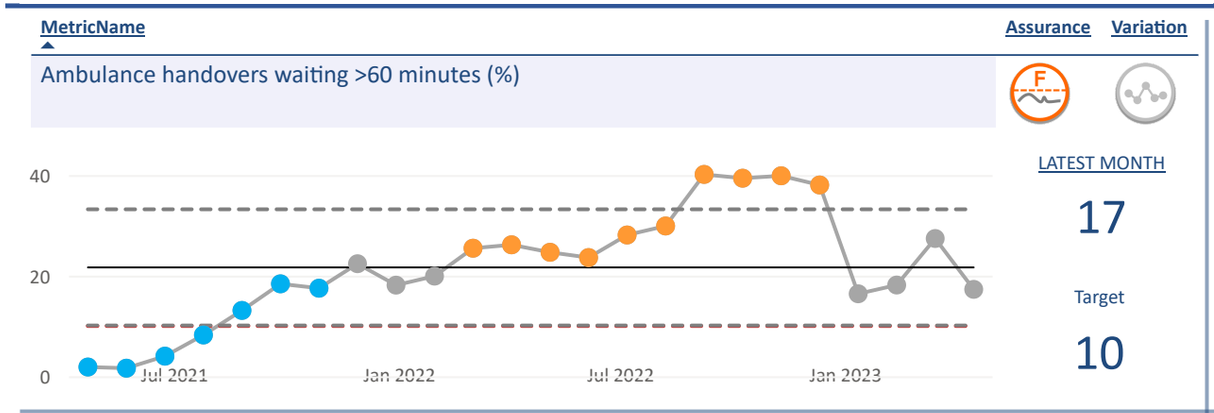
The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation. IMD is a combined measure of deprivation based on a total of thirty seven separate indicators that are grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals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

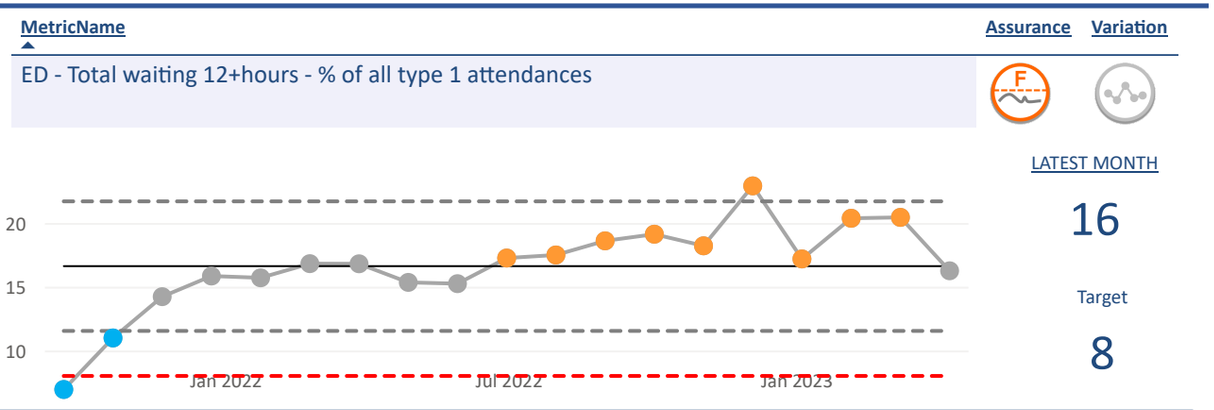
IMD quintiles range from one to five, where one is the most deprived. Please note that IMD quintiles are not available where we have no record of a patient postcode, the postcode is not an English postcode or is an unmatched postcode.

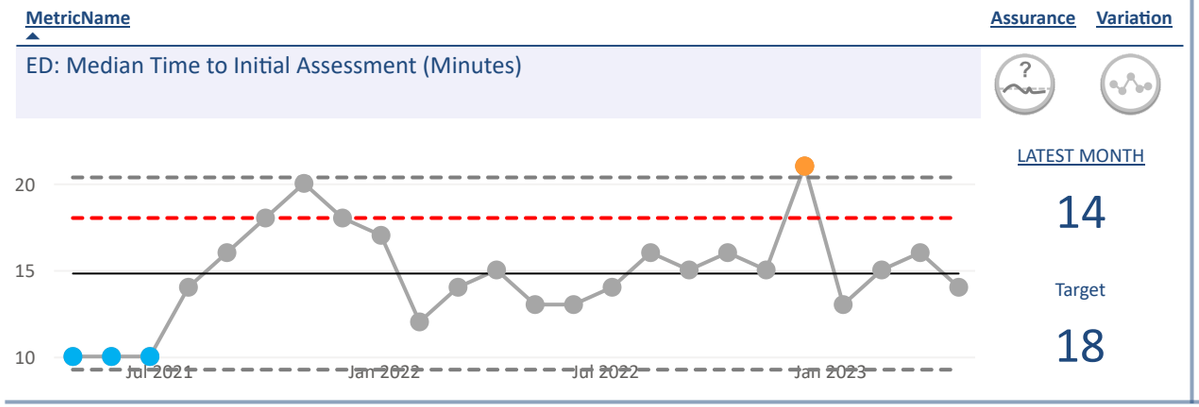
Ethnic codes have been grouped as per the 2021 census. Any patient where Ethnic Group is either 'Unknown' or 'Not Stated' is excluded from the PTL proportions. Areas to take into consideration when interpreting the data include the lack of available site split for Trust Catchment, and the variation that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

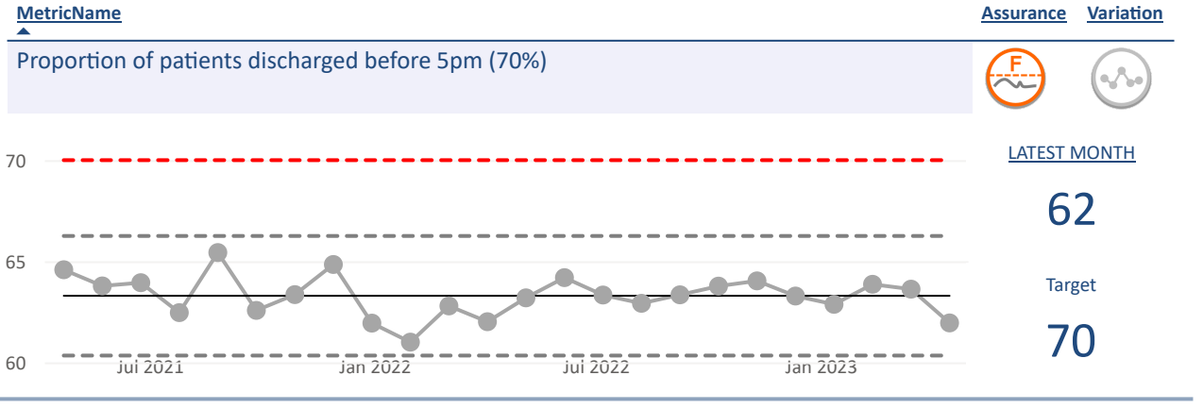
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

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 since Jan 2023.
- **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 was significant improvement since Jan 2023.
- **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 delivery of building materials. High number of patients without a 'Right to Reside' (228 on 9th of May 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 (14 patients on 12th April 2023) and community response teams. High number of patients with COVID-19 in inpatient beds, 99 on 9th of May. 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 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. 2. 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. • The programme was refreshed in late 2021 to develop three areas of focus and 7 priority workstreams. • This was then reviewed in February 2023 against the national UEC recovery plan to confirm the priority areas were in line with the national ask. • As part of the planning work for 23/24 the milestones for the programme have been set in line with the national expectations for achievement of the Emergency Care Standard, Ambulance response times and bed occupancy levels. • The plan indicates key delivery points in the summer and in October ahead of the winter. • 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. Recruitment to the Programme Team has been completed with two Programme Managers, Deputy Programme Manager and two Project Managers all in post. The Programme Team will be working across the four priority programmes for the organisation: UEC, Elective Recovery, Maternity and People & Culture. In addition, work continues with the Quality Improvement team and Corporate Efficiency team to explore joint working opportunities and avoidance of duplication whilst progressing shared approaches. ECIST are working with the programme team and specifically an Improvement Manager for two days a week as well as the required clinical leadership from the ECIST Clinical Leaders team. One of the National NHSE Directors is also working with the Programme team specifically on the Urgent Care Project. Whilst establishing the refreshed programme from August 2022 to March 2023 the following were key achievements: • Revised programme, with detailed metrics, linked to system measures and national targets.

Challenges & Risks	Actions & Mitigations
	• System relationship development. • Scoping provision of a domiciliary care service and agreed direction for integrated intermediate care. • Development of an integrated urgent care specification and initial workshops with all stakeholders for the new model of care. • Establishing the trust strategy on virtual wards, i.e., the development of a virtual hospital infrastructure. As now recognised nationally as the most effective approach. • York Frailty virtual ward beds on trajectory of 5 patients, with 157 bed days saved and excellent patient feedback scores. • Significant analysis of understanding behaviour and populations in relation to children and young people. Identifying factors which drive family presentation and choice of location. • Testing Integrated models of care for children and young people such as the CAT hub. • SDEC benchmarking regionally and nationally identifying the areas which will have the most impact and identifying SDEC direct pathways to be implemented this year. • Development of internal professional standards to address two of the priority seven-day standards and address the requirement for a pan trust discharge framework. The April ECS position was 73% therefore achieving the trajectory (70.1%). The ECS is a system target and our work with system partners will continue. Both the York and North Yorkshire Place UEC plans are aligned with the Trust internal plan to cover Integrated Urgent Care and Transfer of Care projects. Regular meetings take place with partners in relation to the joint plans. Each project within the UEC Programme contributes towards this and has its own detailed metrics to indicate progress with the project specifically. Each of the project's objectives have been highlighted below in terms of how they will contribute to ECS performance. The impact is mainly in terms of reducing attendances in ED and thus reducing overcrowding and associated delays or in terms of reducing bed days (admissions and LOS) which will reduce bed occupancy and improve flow out of the Emergency Department, for those who need to be admitted. It will also improve capacity available in the department for those who need to attend ED. Nationally there is also a focus on Category 2 Ambulance response times which the Trust will support through delivery of these projects which will each contribute to ambulance handover times, enabling improved response times. The Trust has received a formal request from the Integrated Care Board to be the Prime Provider for Integrated Urgent Care services across the Trust's geographical footprint commencing 1st October 2023, subject to due diligence from both parties. The Trust is working through the due diligence and identifying risks and opportunities, an initial paper will be presented in May Trust Board with a detailed business case to be presented at July Board.

Challenges & Risks	Actions & Mitigations
	The new metrics, by project, will be reported from next month once April data is available and routinely included in this report going forward. Community Response Team In relation to Transfer of Care, one key area of focus is the expansion of the Community response team for York. The Community Response Teams are a multi-disciplinary service of health care professionals providing assessment, intervention, rehabilitation and reablement for patients within their own homes, supporting admission avoidance and facilitating timely hospital discharges from Acute Hospital. The service is provided 8am – 8pm, 365 days per year, across the geographical localities of York, Selby and South Hambleton and Ryedale. Over time, the service has grown incrementally, with additional investment supporting the expansion of the clinical model in line with the Trusts Home First Strategy, to improve acute hospital flow and to deliver patient care closer to home. The service originated in the development of the York Intermediate Care Team, twelve years ago, providing rehabilitation and reablement for early supportive discharge, soon after amalgamating with the Community Fast Response Service to include an integrated admission avoidance function. Although the service has been expanded through specific funding streams, ongoing service improvement and economies of the scale have enabled efficiencies and the flexibility to support increasing demand. The service now regularly manages a caseload of between 130 patients and above, up to 171 patients during winter/COVID pressures and national strike action. The service has also responded to the growing needs of acuity, dependency, and complexity of patients on the caseload. The response to growing demand, has however relied heavily upon the good will and dedication of staff, regularly stepping down all non-essential work and the deployment of staff from other services to support patient flow. The current capacity of 109 is short of the demand of 145 patients who could use the service at any one time. Demand also continues to grow for the service and is in line with the strategic direction of the organisation in relation to caring for patients in their own homes. 3. 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.

TPR:

Narrative for Acute Flow Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

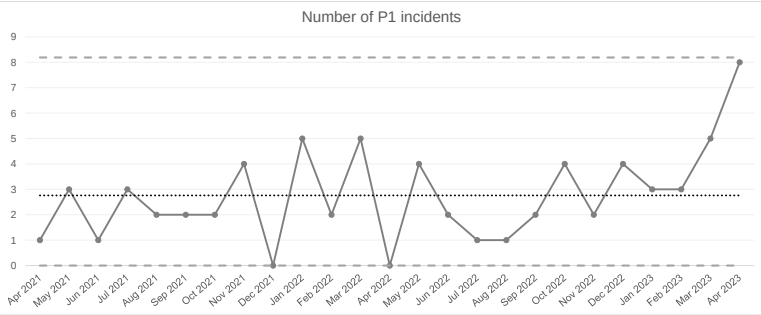
BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
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. Further industrial action by BMA Junior Doctors and/or Royal College of Nurses.	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.

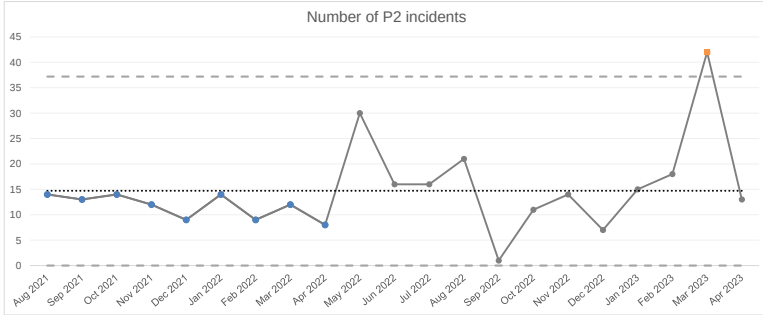
DIGITAL - Digital Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

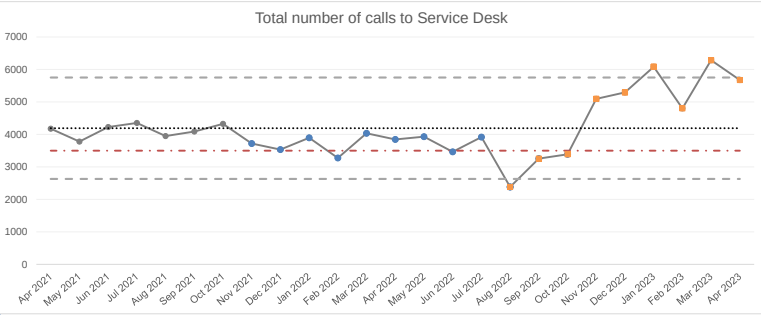
REPORTING MONTH : APRIL 2023



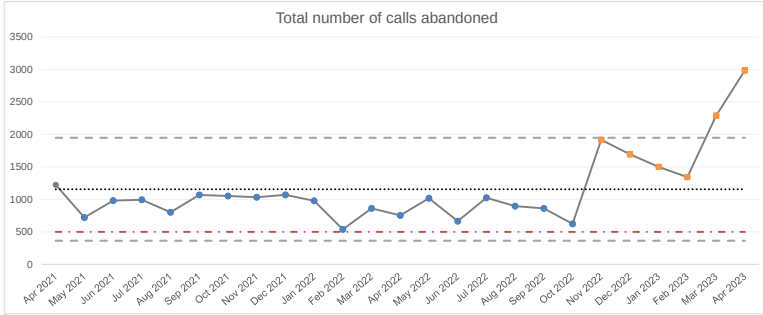
Apr 2023	Target	Variance	Assurance
8	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



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



Apr 2023	Target	Variance	Assurance
5676	3500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Apr 2023	Target	Variance	Assurance
2986	500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

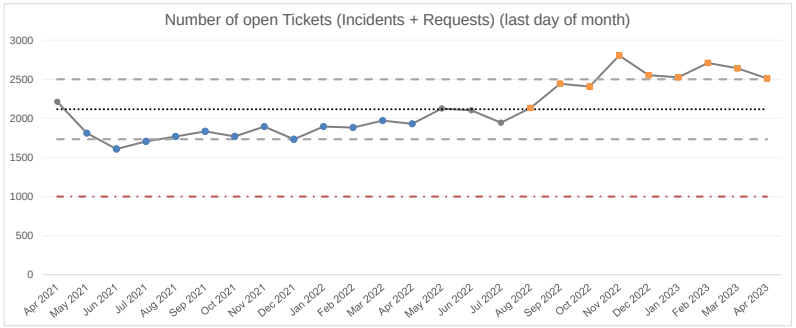
Data Analysis:

Number of P1 incidents: The indicator is currently showing common cause variation, the last five 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 rose 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 and Apr 2023 are sharply 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.

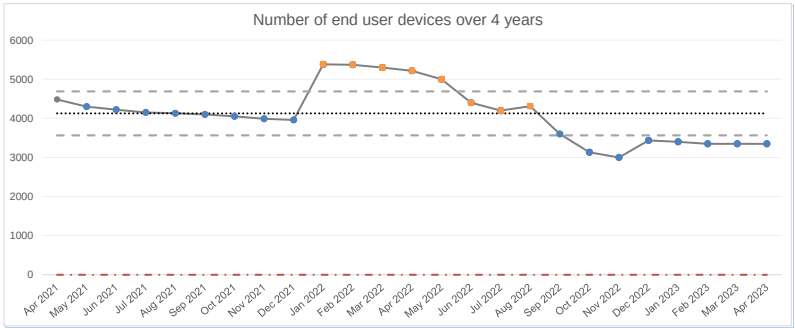
Operational Update:

P1 incidents:
1/4 - G2 system unavailable, licence not renewed by supplier
3/4 - Wireless authentication problem affected Cisco wifi phones and laptops across several locations
4/4 - Ricoh printer issues at Scarborough and Bridlington Hospitals
6/4 - CPD Scanning problem
11/4 - Bridlington incoming phone lines briefly offline
24/4 - Always On VPN connection problems
27/4 - CPD RAC4 server issues (Dev/Test/Training environments) not impacting Live services

Total number of calls / number of abandoned calls
- Increase due to user impacting P1 incidents, and start of migration of user mailboxes to NHSmail commencing at 200/night and increased to 400/night
- Response times/abandon rates spike during P1 incidents



Apr 2023	2511
Target	1000
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Variation indicates consistently falling short of the target



Apr 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 May 2021, however from Aug 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 Oct 2022 onwards, with 3350 devices now over 4 years old.

Operational Update:

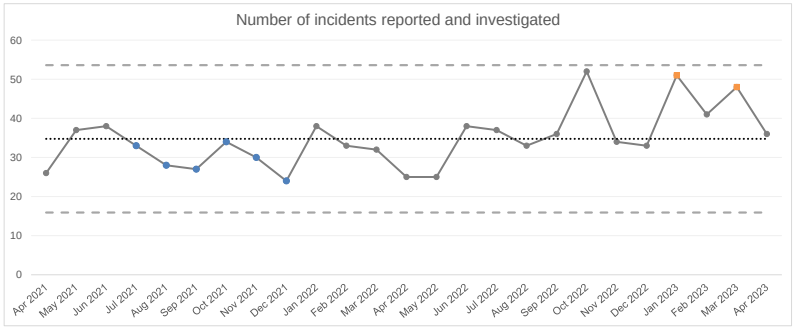
Number of open calls (last day of the month)
- 31% open tickets are deferred awaiting user response/confirmation resolved. 6197 tickets were opened in April
- NHSmail project driving significant demand, user migrations commenced and rate of change at 400/night by end of April
- New Service Desk team members are making progress with reducing deferred ticket backlogs, and processing support incidents

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.

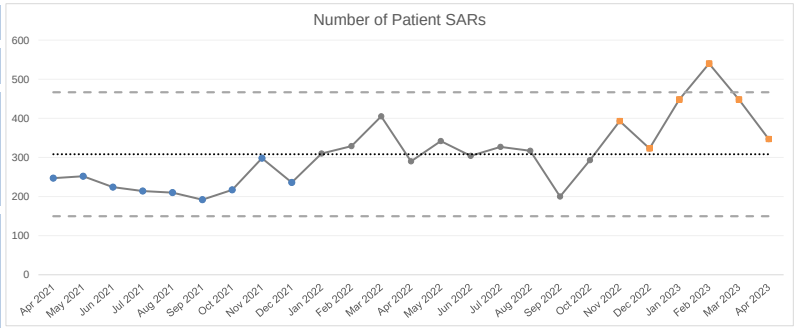
DIGITAL - Information Governance Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

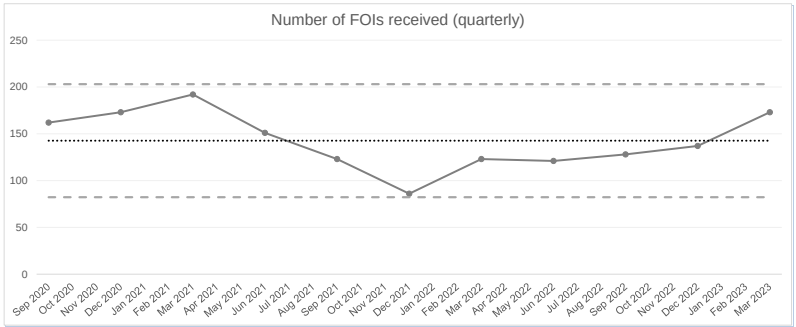
REPORTING MONTH : APRIL 2023



Apr 2023
36
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Apr 2023
347
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 Jan and Mar 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.
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)

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	Financial Position – April 2023 (Month 1)
Director Sponsor:	Andrew Bertram, Finance Director
Author:	Graham Lamb, Deputy Finance Director

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

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

Trust Priorities	**Board Assurance Framework**
☒ Our People ☒ Quality 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 Trust is reporting an adjusted deficit of £3.6m against a planned deficit of £2.6m for the period to April 2023 (month 1). The Trust is £1.0m adversely adrift of plan.

Recommendation:
The Board of Directors is asked to discuss and note the April 2023 financial position.

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

No ☒ Yes ☐

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

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

Meeting	Date	Outcome/Recommendation
Digital, Performance & Finance Assurance Committee	16 May 2023	The report was discussed, and the financial position of the Trust was noted.

Financial Position – April 2023 (Month 1)

1. Introduction

Following an extended period of negotiation with both HNY ICB and NHSE, the Group's final financial plan for 2023/24 was presented to and approved by the Board at its April 2023 meeting. With the agreement of NHSE to vary from a normally required balanced I&E plan, the plan approved by the Board presented a £15.4m I&E deficit.

2. Income and Expenditure Position

Summary Position

The I&E table below confirms an actual adjusted deficit of £3.6m against a planned deficit of £2.6m for April. The Trust is £1.0m adversely adrift of plan.

TRUST PRIORITIES REPORT : April-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Income and Expenditure Account

	Annual Plan	YTD Plan	YTD Actual	YTD Variance	FOT
	£000's	£000's	£000's	£000's	£000's
NHS England	80,464	6,705	7,209	504	80,279
Integrated Care Boards	537,929	44,827	44,819	-8	533,000
Local authorities	4,821	402	402	0	4,815
Non-NHS: private patients	344	29	64	35	426
Other Operating Income from Patient Care	1,466	122	140	18	1,799
Operating Income from Patient Care Activities	**625,024**	**52,085**	**52,633**	**548**	**620,319**
Research and development	1,816	151	248	97	2,557
Education and training	21,580	1,798	2,098	300	25,812
Other income	44,605	3,717	3,402	-315	49,521
Other Operating Income	**68,001**	**5,667**	**5,749**	**82**	**77,890**
Employee Expenses	-473,942	-39,495	-40,367	-871	-457,048
Drugs Costs	-62,599	-5,217	-6,267	-1,050	-66,083
Supplies and Services - Clinical	-65,788	-5,482	-5,326	156	-65,958
Depreciation	-20,401	-1,700	-1,690	10	-17,456
Amortisation	-1,521	-127	-137	-10	-1,521
CIP	31,235	2,017	0	-2,017	0
Other Costs	-104,476	-9,435	-7,383	2,053	-72,647
Total Operating Expenditure	**-697,492**	**-59,440**	**-61,169**	**-1,729**	**-680,713**
OPERATING SURPLUS/(DEFICIT)	**-4,467**	**-1,688**	**-2,787**	**-1,099**	**17,496**
Finance income	830	69	211	142	621
Finance expense	-956	-80	-82	-2	-976
PDC dividends payable/refundable	-10,800	-900	-900	0	-8,014
NET FINANCE COSTS	**-15,393**	**-2,598**	**-3,558**	**-959**	**9,127**
Other gains/(losses) including disposal of assets	0	0	0	0	0
Share of profit/ (loss) of associates/ joint ventures	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0
Movements in fair value of investments and liabilities	0	0	0	0	0
Corporation tax expense	0	0	0	0	0
Surplus/(Deficit) for the Period	**-15,393**	**-2,598**	**-3,558**	**-959**	**9,127**
Remove Donated Asset Income	-800	-67	-67	0	-9,607
Remove Donated Asset Depreciation	740	62	70	8	740
Remove Donated Asset Amortisation	28	2	2	0	28
Remove Peppercorn Depreciation	11	1	0	-1	11
Remove net impact of DHSC centrally procured inventories	0	0	0	0	0
Remove Impairments	0	0	0	0	0
Remove Gains/(losses) from transfers by absorption	0	0	0	0	0
NHSI Adjusted Financial Performance Surplus/(Deficit)	**-15,414**	**-2,600**	**-3,552**	**-952**	**288**

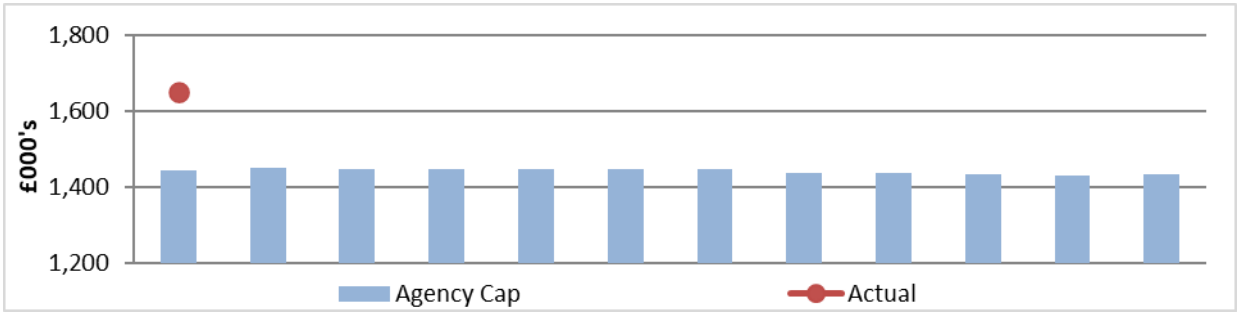
Key Variances

The main drivers of the material variances are explained below:

Variance	Favourable/ (-)adverse £000	Main Driver(s)	Mitigations and Actions
NHS England income	504	Increased usage of high-cost drugs for which income is earned on a pass-through basis. Offset by increased expenditure.	No mitigation or action required
Education & Training income	300	Income received from HEE more than plan. No corresponding expenditure increases.	No mitigation required. To clarify reason for over payment with HEE.
Other income	-315	Reduced income on SHYPS due to the delay in securing the blood contract novation. Offset by reduced expenditure.	No mitigation required. Continue to work to secure the blood contract novation.
Employee expenses	-871	Agency spending ahead of plan (£0.2m). Balance spending ahead of plan primarily linked to York ED and GP trainees.	To control agency spend within the cap. To investigate and confirm whether extra HEE income is to cover the additional spending on GP trainees. To investigate reasons for overspending; develop and implement an appropriate response.
Drug expenses	-1050	Increased spending on high-cost drugs (£0.5m), offset by additional income. Balance spending ahead of plan.	To investigate reasons for overspending; develop and implement an appropriate response.
CIP	-2017	CIP behind plan	Continued focus on delivery of the CIP.
Other expenses	2053	Delay in SHYPS securing the blood contract novation (£0.3m). Balance is primarily budgets in reserve not yet released, and for which no spending.	Budgets to be released as spending for which they were designed to meet commences.

Agency Controls

2023/24 has seen the reintroduction of controls around agency spending, which had been suspended since the Covid-19 pandemic. The Trust's agency spend is capped at 3.7% of its overall pay spend, and this has been factored into the plan. The table below illustrates the Trust's actual agency spend against the plan and shows in April agency spend at £1.65m is £0.2m ahead of plan.



3. Cost Improvement programme

The total cost improvement programme for 2023/24 is £37.9m, with the table below detailing the full programme. Of this the core efficiency programme requirement is £21.4m, which is the core value to be removed from operational budgets as we progress through the financial year and deliver cash-releasing savings.

The Board will be aware through the financial plan presentations that NHSE required technical efficiencies, covid spend reductions and estimated productivity gains to be expressed as CIPs. These total a further £16.5m (shown against Corporate CIP below).

2023/24 Cost Improvement Programme - April

2023/24 Cost Improvement Programme - Technical CIP - April

		April Position			Planning Position		Planning Risk		
	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
Technical CIP	**£16,525**	**£371**	**0**	**£371**	**£16,525**	**£0**	**£14,877**	**£0**	**£1,648**

2023/24 Cost Improvement Programme - Core CIP - April

		April Position			Planning Position		Planning Risk		
Care Group	**Full Year CIP Target**	**Target**	**Delivery**	**Variance**	**Total Plans**	**Planning Gap**	**Low**	**Medium**	**High**
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£4,592	£383	£9	£374	£1,061	£3,530	£923	£82	£56
2. Acute, Emergency and Elderly Medicine (Scarborough)	£2,379	£198	£1	£198	£1,607	£772	£918	£689	£0
3. Surgery	£4,913	£409	£4	£406	£2,209	£2,704	£1,754	£455	£0
4. Cancer and Support Services	£3,084	£257	£16	£241	£2,384	£700	£891	£190	£1,303
5. Family Health	£2,073	£173	£53	£120	£1,982	£91	£975	£0	£1,007
6. Specialised Medicine	£1,863	£155	£22	£134	£977	£886	£871	£106	£0
7. Corporate Functions									
Chief Exec	£105	£9	£0	£9	£0	£105	£0	£0	£0
Chief Nurse Team	£270	£22	£4	£18	£154	£115	£154	£0	£0
Finance	£92	£8	£0	£8	£235	-£143	£235	£0	£0
Medical Governance	£83	£7	£0	£6	£130	-£47	£130	£0	£0
Ops Management	£187	£16	£0	£16	£5	£182	£5	£0	£0
Corporate CIP	£0	£0	£0	£0	£5,128	-£5,128	£450	£200	£4,478
DIS	£205	£17	£4	£13	£138	£67	£138	£0	£0
Workforce & OD	£145	£12	£0	£12	£535	-£391	£535	£0	£0
Sub total	**£19,988**	**£1,666**	**£113**	**£1,553**	**£16,545**	**£3,443**	**£7,979**	**£1,723**	**£6,845**
YTHFM LLP	£1,400	£117	£23	£93	£1,237	£163	£332	£730	£175
		-							
Core Programme - Group Total	**£21,389**	**£1,782**	**£136**	**£1,646**	**£17,783**	**£3,606**	**£8,311**	**£2,453**	**£7,020**
CIP PROGRAMME TOTAL	**£37,914**	**£2,153**	**£136**	**£2,017**	**£34,308**	**£3,606**	**£23,188**	**£2,453**	**£8,668**

Delivery in month 1 of the Core Programme is £1.6m behind plan. Recurrent delivery is 7.6% of the Target which in the main is the full year effect of schemes delivered in 2022/23 and schemes delivered non-recurrently last year.

Non-core CIP relating to technical efficiencies, covid spend reductions and estimated productivity gains will be reflected from May reporting, but the Board are asked to note that the April target of £0.4m has been met but not transacted.

4. Elective Activity: Variable Element of the Clinical Contract

For 2023/24, the Trust's main clinical contract with its commissioners (ICBs and NHSE) includes a variable and fixed element. The variable element primarily covers all elective activity, other than outpatient follow up activity. All other activity is captured under the fixed element of the contract.

For elective activity captured under the variable element of the contract, income is earned based on actual activity delivered to which the appropriate tariff under the NHS Payment Scheme is applied. Income is therefore directly variable based on activity delivered, and therefore presents both a risk and an opportunity depending on whether actual activity is under or over plan.

For month 1, the Trust is not yet in possession of fully coded elective activity data due to the natural time delay in the full coding of all the elective activity before a tariff can be applied. The normal time frame before activity is near fully coded is usually 3-4 weeks following the month in question.

However, to give an early indication of how well the Trust is performing we have developed an early 'heads-up' approach using the first three weeks of April partially coded actual elective activity data and extrapolated this for the full month before applying average tariff income to the activity. Whilst acknowledging the limitations of using partially coded activity and estimates, the early indications are that activity is down against plan and potentially presents a £1m shortfall on planned income for the period. It should be noted that some data anomalies have been identified and require further investigation and clarification. It is likely that the impact of the strike action during April in terms of cancelled elective will have contributed materially to this position, and a process is to commence to identify and value the lost activity should any national recognition be made for lost income due to strike action.

Given the limitations of this approach, the early data anomalies and the early stage of the financial year, it has been decided not to factor the £1m potential income loss into the reported position at this stage, but clearly this will be monitored closely against position once activity is fully coded and corrective action taken as necessary.

5. Current Cash Position

The Group's cash plan for 2023/24 is for the cash balance to reduce from £50.3m at March 2023 to £40.6m at March 2024, with clearly the planned I&E deficit being a key driver in the reduced balance.

April's cash balance showed a £8.4m adverse variance to plan, which is mainly due to payment of capital & other invoices from the March position. The table below shows our current planned month end cash balances.

Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	47,455	37,960	40,729	39,099	37,524	29,841	32,947	34,072	32,068	34,842	41,691	40,625
Actual	39,054											

There are no cash issues to bring to the attention of the Board.

6. Current Capital Position

The total capital programme for 2023/24 is £45.9m; this includes £7.3m of lease budget that has transferred to capital under the IFRS16 accounting standard and £19.4m of external funding that the Trust has secured via Public Dividend Capital funding (nationally funded schemes) and charitable funding.

Capital Plan 2023-24 £000s	Mth 1 Planned Spend £000s	Mth 1 Actual Spend £000s	Variance £000s
45,852	**2,266**	**592**	**1674**

The capital programme at month 1 is £1.7m behind plan. £500k of this relates to IFRS 16 leases, mainly influenced by delays in completion of equipment leases.

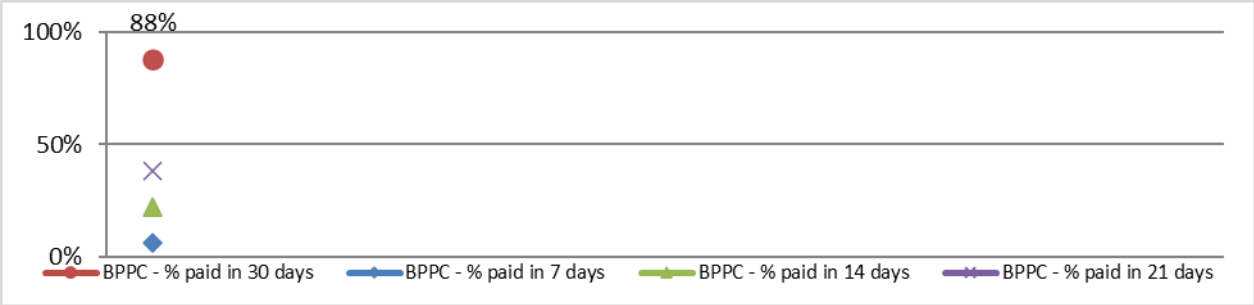
If we remove the impact of IFRS 16 figures the capital programme is £1.2m (66%) behind plan. This is due to the Scarborough UEC scheme (£1.5m) running behind the plan expenditure profile partially offset by other schemes running ahead of plan.

Most capital schemes have been approved and are commencing. There remains final agreement to be reached with Care Groups on the prioritisation of the £4m discretionary element of the capital programme. This is expected to be concluded by the end of May 2023.

7. Better Payment Practice Code (BPPC)

The BPPC is a nationally prescribed target focussed on ensuring the timely payment by NHS organisations to the suppliers of services and products to the NHS. The target threshold is that 95% of suppliers should be paid within 30 days of the receipt of an invoice. Although this target has been around for several years, its delivery has recently regained increased focus by NHSE, with Julian Kelly (NHSE Finance Director) frequently making reference to its delivery.

The table below illustrates that in April the Trust managed to pay 88% of its suppliers within 30 days.



8. Risk Overview

The financial plan includes significant risk, discussed, and acknowledged at the time of Board approval. The table below summarises the final remaining risks as we move to close the current financial year. These are current risks being managed.

Risk Issue	Comments	Mitigation/Management	Current Update
Delivery of the efficiency requirement	At £21.4m (3% of turnover) the cost out efficiency programme is comparable to pre-covid years, however the Trust is still getting back up to speed following the programme being halted during the Covid-19 pandemic, and clinical teams are focused elsewhere in terms of workforce issues and elective recovery. Also risk in terms of the proportion of the programme being met historically through non-recurring means, and its legacy impact on following years.	The Corporate Efficiency Team providing a full support programme. The Urgent & Emergency Care Transformation Programme and Elective Recovery Programme are linked to efficiency delivery opportunities. Rigorous reporting of CIP progress and action planning through the efficiency panel meetings with the CEO. Greater focus on recurrent delivery of the programme including Care Groups being asked to review the prospects for converting existing non-recurrent CIPs onto a recurrent basis.	In full year terms £1.6m (7%) of the programme has been delivered.
Delivery of cost reduction/ cost avoidance targets.	Delivery of the plan is dependent on finding £17.5m of cost avoidance/ reductions within the Trust's plan.	Reviews undertaken by both the central finance and Operations teams. FD direct request to the Exec committee, and Care Groups to review: • Covid spend plans considering reduced income to support.	Cost reduction/ avoidance savings of £7.7m (44%) have been identified to date.

		• Budget lines for non-essential spending in 2023/24. • Investments not supported by income.	
Delivery of the elective variable element of the clinical contracts.	The elective variable income element of the clinical contracts is lost/ gained at 100% of the NHS payment scheme tariff. As a minimum delivery of elective activity consistent with the activity levels underlying the income in the financial plan is crucial if the plan is not to be undermined.	A full activity plan has been devised with the Care Groups to deliver the 103.8% required elective improvement on 2019/20 outturn activity. The income associated with this is implicit in the financial plan. Full monitoring of delivery is being implemented and reported through to Care Groups in terms of early 'heads-up' feedback, and more detailed reporting when activity has been more fully coded.	Fully coded activity data is not available until 3-4 weeks after the month end; however an early 'heads-up' estimated approach suggests activity and income is below plan by £1m. It is expected that strike action will have materially contributed to cancelled elective activity, and an exercise is to commence to try and identify and value the impact of this.
Expenditure Control	Formal budgets identified through this planning process will require careful management to ensure expenditure compliance and to ensure that any investments made are matched with identified funding sources.	Finance reporting will require enhanced variance analysis and assurance processes. Reporting into the Exec Committee and Board of Directors will be refined to provide greater assurance and transparency. Compliance with financial governance including the scheme of delegation regarding expenditure approval is being promoted and monitored.	A 'back to basics' approach in terms of raising awareness of financial governance arrangements is being prompted through the Finance Managers within Care Groups.
Management of the Capital Programme	The 2023/24 capital programme is £45.9m. There is significant risk in managing to approved CDEL limits; both in terms of pressure on the programme for additional spend but also difficulty in spending due to construction industry difficulties associated with Brexit, the pandemic, and the Ukraine conflict.	The programme is managed by CEPG. Monitoring provided at Board level. A key focus is given to managing with in CDEL.	Approved capital schemes have been given permission to proceed and account for most of the programme. Just £4m of the programme is still subject to the conclusion of a prioritisation exercise of Care Group bids, which is expected to be concluded by the end of May 2023.

9. Income and Expenditure Forecast

As the financial year progresses, we will continue to review and update our I&E forecast tool to assess our likely year end outcome. The tool takes current trends, adjusted for non-recurrent issues and new expected issues, and extrapolates forward to March 2024.

As we are reporting the first month of the financial year against the new plan, the tool has not yet been employed with the assumption that at this early stage of the year the plan will be delivered. The tool will be employed in earnest after quarter 1 once further data on actual performance against the plan has become more established.

10. Recommendation

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

Date: May 2023

Research & Development Performance Report : Apr-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 made a slow start to our accruals this year (does with financial year) but that is nothing unusual or alarming at this stage. We have included a section on our recruitment to time and target figures within the accrual report as this is now the main metric that the CRN will look at (both open and closed studies)

•We have submitted three grants this month to try and win some funding

•£98,827.00 to Glaucoma UK the study is called Application of Artificial Intelligence in Glaucoma Diagnosis Utilising Multimodal Imaging Approach: Led by Dr Pouya Alaghband

•£29,772.40 to National Institute of Academic Anaesthesia the study is called Multimodal prehabilitation in patients awaiting open AAA repair to reduce postoperative complications, improve perioperative functional capacity and quality of life: Led By Dr David Yates

•£505,992.02 to National Institute for Health Research the study is called Shift Workers and Menopause (SWaM): Understanding lifestyle and workplace risk factors for menopausal symptoms among perimenopausal and menopausal NHS shift workers to support the development of a workplace intervention strategy: Led by Dr Sarah Baker

•We have heard that two of our recent grant submissions have been successful Haemochromotosis UK (small Fellowship Grant Simran Singh) £20K and an NIHR RfPB application looking at co-designing an intervention for implementing and sustaining supported for self-management in chronic breathlessness with HYMS £154K

•We have been shortlisted in a capital bid to convert two rooms (one each at York and Scarborough sites) to see research patients, which is a major block to us currently. The Department of Health are considering our request now. This will allow us to support commercial vaccine trials that will offer significant income to the Trust and means we can still compete with the large Trusts such as Leeds and Sheffield.

•We have kindly been offered 4 research PAs from HYMS and have 8 staff who have applied, we are currently reviewing applications.

•We have agreed to submit an NIHR Research for Patient Benefit bid to evaluate the new Acute Care Model at Scarborough along with University of York colleagues, this will be submitted in July.

•Upcoming event- Our second Celebration of Research event that will be held on 15th November at the Principal Hotel, York

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: May-2023

TRUST PRIORITIES REPORT : April 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-24	139												139
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

Breakdown as of end April 2023

Care Groups	Accruals Running Total 23/24
CG1 Total	41
CG2 Total	8
CG3 Total	9
CG4 Total	10
CG5 Total	0
CG6 Total	7
RP's Total	64
Cross Trust Studies Total	0
ACCRUAL TOTALS	139

Accruals Still Required	3361
Trials Open to Recruitment	108

Non-Commercial Studies 23/24 - 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	31%	35%	*Weighted 11*
Observational	62%	12%	*Weighted 3.5*
Large Interventional	4%	6%	*Variable weighting by study*
Large Observational	4%	46%	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	6%
Non Commercial	94%

Recruitment to Time & Target (RTT)

RTT is a key NIHR Higher Level Objective that measures the Trust's performance at achieving target participant recruitment for each study within the planned study timelines.

The below demonstrates the overall % of studies that are achieving to RTT alongside the target set by the NIHR.

Open studies	Percentage to Date	Target
Non-Commercial	75%	60%
Commercial	20%	60%

Closed FY 2023-2024	Percentage to Date	Target
Non-Commercial	100%	80%
Commercial	N/A	80%

If you would like a breakdown of Accruals in each CG, please contact jordan.toohie@nhs.net

APPENDIX : National Benchmarked Centiles

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

REPORTING MONTH : APRIL 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 09/05/2023
* 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%)	Apr-23	63.6%	70%	82	23/121	*Feb 23
	UEC	ED: Median Time to Initial Assessment (Minutes)	Apr-23	16	18	26	92/124	*Feb 23
	RTT	RTT Total Waiting List	Apr-23	51050	48878	29	121/171	*Feb 23
	RTT	RTT Waits over 104 weeks for incomplete pathways	Apr-23	0	0	100	1/171	*Feb 23
	RTT	RTT Waits over 78 weeks for incomplete pathways	Apr-23	178	0	15	146/171	*Feb 23
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Apr-23	3	59 (12-month)	4	132/137	*Feb-23
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Apr-23	16	117 (12-month)	19	111/137	*Feb-23
	Patient Experience	Trust Complaints	Apr-23	46	No Target	23	162/210	*Q4 21/22

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	Risk Management Update - Corporate Risk Register
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 ☒ Sustainability

Summary of Report and Key Points to highlight:

To note the current Corporate Risk Register that are risks rated 15 or greater following the formal risk assessment process and consideration at the Risk Committee.

Recommendation:

The Board of Directors is asked to note the current risks on the Corporate Risk Register.

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

Meeting	Date	Outcome/Recommendation
Risk Committee	Each Month	Approved

Risk Management Update – Corporate Risk Register

1. Introduction and Background

Risk and its assessment are an integral part of the services provided by the York and Scarborough Teaching Hospitals NHS Foundation Trust.

The management and mitigation of risks is essential to safeguard the Trust's staff, assets, finance, and reputation and is fundamental to the provision of high-quality care for patients and staff by creating a control environment centred on continuous improvement.

2. 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 is 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.

3. Risk updates

The May Risk Committee has approved the following new risks on the CRR:

- Inability to deliver clinical services due to being unable to maintain the Trust estate and equipment
- Deteriorating patients
- Steam Mains at Scarborough General Hospital

Appendix 1 presents the severity and likelihood descriptors from the risk management policy, with appendix 2 the full latest CRR with recent amendments presented in red text.

4. Next Steps

The risks on the Corporate Risk Register and any further risks for escalation will next be reported at the 7 June Risk Committee.

Appendix 1

Table 1 Severity score (s): How do I assess the severity?

Severity is the term given to the resulting loss, injury or disadvantage if a risk materialises. Remember – there are likely to be a range of outcomes for this event.

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the severity score, which is the number given at the top of the column. (Consider how severe the impact, or consequence, of the risk would be if it did materialise) **Note the Score**

Severity score (severity levels) and examples of descriptors - this is not an exhaustive list					
Domains	**1 No Harm**	**2 Minor Harm**	**3 Moderate Harm**	**4 Severe Harm**	**5 Catastrophic Harm**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death(s) Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint /inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources / organisational development / staffing / competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff On-going unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an on-going basis
Statutory duty / inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating, critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity / reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives / projects	Cost increase /schedule slippage <1% over project budget /plan	Cost increase /schedule slippage >1<5% over project budget /plan	Cost increase/schedule slippage >5<10 % over project budget /plan	Cost increase/schedule slippage >10<25 % over project budget /plan Key objectives not met	Cost increase /schedule slippage >25% over project budget /plan Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results , Claim(s) >£1 million
Service / business interruption Environmental impact	Loss or interruption of >1 hour Minimal or no impact on the environment	Loss or interruption of >4 hours Minor impact on environment	Loss or interruption of >1 day Moderate impact on environment	Loss or interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L): How do I assess the likelihood?

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever possible to identify a frequency. Consider how likely it is that the risk will occur using the following descriptors: **Note the Score**

	1	2	3	4	5
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Somewhat Likely**	**Very Likely**
Frequency (general) How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency (timeframe)	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not	<5 per cent	6-25 per cent	26-50 per cent	51-75 per cent	76-100 per cent

Table 3 Risk Scoring: Severity x Likelihood (S x L)

Then **multiply** the two scores together from the table below.

L↓ S→	No Harm	Minor Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Very Likely	**5**	**10**	**15**	**20**	**25**
Somewhat Likely	**4**	**8**	**12**	**16**	**20**
Possible	**3**	**6**	**9**	**12**	**15**
Unlikely	**2**	**4**	**6**	**8**	**10**
Extremely Unlikely	**1**	**2**	**3**	**4**	**5**

For grading risk on Datix, the scores obtained from the risk matrix are assigned the following grades.

Very Low (1 – 3)	Low (4 – 6)	Medium (8 – 9)	High (10 – 12)	Significant (15 – 25)

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR1 PR2 PR4	CRR ID - 16 27/03/2023 CRR 05/04/2023	**Failure to observe IPC policies and guidance -** 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.	Nurse, Chief	5x4 Significant	1. Improved completion of IPC mandatory training.	1. Care Groups	1. Monthly Updates	5x2 High
PR1 PR2 PR3 PR5	CRR ID - 17 27/03/2023 CRR 05/04/2023	**Impact of built environment on infection prevention and control -** 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.	Nurse, Chief	5x4 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 allieviate 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	5x2 High
PR1 PR2 PR3 PR6	CRR ID - 4 01/11/2018	**Cyber Security** - 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)	Chief Digital and Information Officer	5x4 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	5x3 Significant

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR1 PR2 PR3 PR4	CRR ID - 7 17/10/2022	**Sustained significant pressure in ED -** 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.	Operating Officer, Chief	5x4 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	5x4 Significant
PR1 PR2 PR5 PR7	CRR ID - 18 27/03/2023 CRR 05/04/2023	**CQC Section 31 Notice Served on The Trust -** 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	Chief Nurse	5x4 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	01-Oct-23	5x2 High
PR1 PR2 PR3 PR5	CRR ID - 14 04/03/2022 CRR 05/04/2023	**Deterioration of reinforced autoclaved aerated concrete (RAAC) Pathology Roof Scarborough** - 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. Portacabins have been delivered and are currently being fitted out. Occupation is expected in May 2023	Finance, Director	5x4 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	1x1 Very Low

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR1 PR2 PR3 PR5	CRR ID - 20 21/08/2018 CRR 03/05/2023	**Inability to deliver clinical services due to being unable to maintain the Trust estate and equipment** - Due to the age and backlog maintenance liability within the estate there is a high risk of unplanned failure of plant and equipment and availability of accommodation. A large part of the Trust estate is well beyond the design lifecycle and requires significant investment to address and reverse backlog maintenance through a prioritised programme of investment. Current levels of backlog maintenance are broadly comparable with the annual level of deterioration. Without increased levels of investment this could potentially result in the inability to deliver clinical services, damage to reputation and potential for regulatory intervention.	Being monitored & included MSA with YTHFM 5 year maintenance plan and clause 25. Multi disciplinary backlog maintenance group established to develop and oversee backlog maintenance investment programme with direct reporting into CPEG In addition review of governance structures and committees to ensure data is gathered from technical sub groups to support the contract management process. The Health and safety dept. is undertaking inspections and audits to review compliance with stated standards. 1. Several surveys are currently being undertaken by the Estates teams to ascertain the condition of the Y&STH Estates. 2. Backlog maintenance increased for next financial year and is being planned	Finance, Director	4x5 Significant	Several condition surveys being reviewed across all sites to ascertain the current condition of Y&STH Estate.	Head of Estates	April 2023 depending on sufficient funding being made available	2x2 Low
PR1 PR2 PR3 PR6	CRR ID - 8 17/10/2022	**Workstream Funding** - There is a risk that the Trust will be unable to deliver key work streams within the Maternity Transformation programme, due to a lack of available funding both Capital and Non-Capital. This could result in risk to patient safety, patient experience, regulatory non-compliance and reputational damage.	1.Review (discussion with Senior Leadership) current service and delivery processes which entail a risk assessment to determine the impact on patient experience, regulatory non-compliance and reputational damage. 2.Consultancy commissioned confirmed the outcome of the risk assessment, gaps in compliance and inform ongoing Transformation workstreams and inform the Senior responsible Officer. 3. The Maternity Transformation Group that reports to the Executive Committee was made aware of the Risk description and the impact on Maternity Department. 4. Frequent safety huddles 5. Schedule of audits to monitor compliance	Nurse, Chief	4x4 Significant	1. Feasibility study plan is to be undertaken to identify the resourcing requirements.	1. Sue Glendenning	1. May 2023	3x3 Medium
PR1 PR2 PR3 PR4 PR5 PR7	CRR ID - 9 01/05/2022	**Failure to deliver the National Activity Plan** - 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	Operating Officer, Chief	4x4 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	3x3 Medium

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR5 PR7	CRR ID - 6 11/05/2022	**Failure to deliver our Annual Financial Plan** - 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.	Finance, Director	4x4 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	3x3 Medium
PR1 PR2 PR3	CRR ID - 2 20/08/2018	**Deteriorating Patients** - Poor management of Deteriorating Patients. 1. Failure to recognise the deteriorating patient. 2. Failure to follow the appropriate escalation pathway. 3.Poor management of the deteriorating patient inclusing re-assessment. This could result in serious patient harm/death, regulatory scrutiny/censure, financial costs and reputational damage.	1.Critical Care Outreach Team cover 24/7 across the acute sites. 2.Recent implementation of hospital out of hours mobile tasking, all jobs are triaged by B6 outreach team at York. 3.All incidents reviewed daily by the the Care group govenrnace team and the Patient Safety Team and immediate action taken as required. 4. Incidents feed into the Deteriorating patient group for discussion and shared leanring. 5.Monitoring observation compliance on signal and feed into Deteriorating patient group. 6.Annual audit of deteriorating patients (CCOT) and currently CQUIN also National Cardiac Aarrest tearly audit (resus team) 7.Individual escalation protocols 8.National Early Warning Scores and escalation prompts (and associated pathways NEWS, MEWS and PAWs) 9.Staff training Acute Illness Recognition and Assessment, RN/HCA/FY1 induction training, BLS training 10.Deterioration Adult Patient Monitoring and Escalation Policy 11.Treatment Escalation Plan and DNACPR Policy 12.Treatment Escalation Plan compliance monitoring on signal, revewed by DNACPR TEP group	Director, Medical	4x4 Significant	1.A complete review of Sepsis within the organisation inline with current national reccomendations. 2. Review of observation compliance and barriers. 3. Review process of monitoring deteriorating patients incidents and considering replicating the falls process. 4.Undertake a review of the deteriorating patient audits with dissemination of learning and actions.	1. Daniel Palmer 2.Clare Scott 3.Dan Palmer 4.Jon Redman	1.June 2023 2.October 2023 3.October 2023 4.January 2023	4x2 Medium
PR1 PR2 PR3 PR4	CRR ID - 3 16/12/2022	**Insufficient staff** - 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	Workforce & Organisational Development, Director	4x4 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	4x3 High

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR1 PR2 PR3	CRR ID - 12 18/10/2022 CRR 16/01/2023	**Patients With No Criteria to Reside** - 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.	Operating Officer, Chief	4x4 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 Trusted 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	2x2 Low
PR1 PR2 PR3 PR6	CRR ID - 5 18/12/2020	**Major IT Failure -** 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. 3. Purchase of ITSM solution in line with the IT Service Management Strategy. March 2023	Chief Digital and Information Officer	5x3 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. 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. Stuart Cassidy	1. Action completed for 2022/23 (9.2m invested) 2. 30 June 2023 3. 1 December 2023 4. 1 December 2023	5x2 High
PR1 PR2 PR3 PR4	CRR ID - 11 30/11/2022 CRR 19/12/2022	**Outpatients Services -** There is a risk of missed/delayed appointments Due to CPD not being an administrative tool there is a large amount of manual work and a high level of back log due to sickness and vacancy This could result in harm to patients	Agency staffing in place (2). Capacity for a further 4 agency staff, but limited interest from the 200+ agencies approached. All Care Groups advised of capacity issues and asked to support with slot filling and giving suitable notice to the team to fill clinics. All Care Groups asked to let admin staff know of opportunity to undertake additional overtime/bank within the team to support with backlogs.	Operating Officer, Chief	5x3 Significant	1. Continue to try to recruit to agency posts. 2. Continue to try to recruit substantive staff. 3. Deep Dive Review @DPF Committee	1. Karen Priestman 2. Karen Priestman 3. Karen Priestman / Melanie Liley	1. June 2023 2. June 2023 3. July 2023	5x2 High
PR1 PR2 PR3 PR5	CRR ID - 19 25/07/2022 CRR 03/05/2023	**Steam Mains SGH -** The steam mains and condensate line serves the entire hospital site via a single system, 40+ years old. This remains a single point of failure and given there is no relevant secondary steam supply point in an appropriate location. There is a risk that 95% of the site would lose heating and hot water effectively closing the hospital due to the loss of the steam mains.	The risk is mitigated by undertaking NDT ultrasonic testing every year due to the age of the system (No funding identified for this work this financial year).Vital Energy to undertake the NDT ultrasonic testing as part of annual inspection.	Finance Director	5x3 Significant	Funding options are being explored to de-steam the Scarborough Hospital site which ultimately will result in the steam main being redundant, decommissioned and removed. It should be noted that a catastrophic failure of the steam main could occur, however with the inspection and testing regime in place if a failure was to occur it is more likely to result in a leak initially that could be repaired through a managed shutdown(s) depending on the severity.	Head of Estates	April 2025 depending on sufficient funding being made available	2x2 Low

BAF REF	CRR ID Opened	Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk Level Target
PR1 PR2 PR3 PR4	CRR ID - 13 21/09/2022 CRR 16/01/2023	**Fragility of Gastroenterology Service -** 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.	Operating Officer, Chief	3x5 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	3x2 Low
PR1 PR2 PR3 PR4	CRR ID - 15 18/03/2021 CRR 05/04/2023	**Risk of routine patients referred to Paediatric SLT having delayed assessment and intervention -** 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.	Chief Nurse	3x5 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	3x2 Low

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	Workforce Race Equality Standard (WRES) Annual Report
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion and WRES Expert

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

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

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

Summary of Report and Key Points to highlight:

This report is for assurance and will be shared with the People and Culture Committee for information and discussion. It sets out the Trust's 2023 WRES data.

The reporting submission date for the WRES data was brought forward in February 2023, from 31 August 2023 to 31 May 2023, this provided short notice for organisations. The purpose of the change of date was to provide more time for staff engagement to co-design an action plan to address any disparities. The action plan is required to be approved and uploaded to the Trust's website by the 31 October 2023, therefore this report only addresses the data.

The National WRES team requested that Trust's did not include the Black and Minority Ethnic (BME) data for bank and medical staff as they would be included in the Bank WRES (BWRES) and Medical WRES (MWRES). The submission dates for this data are slightly different than the WRES and is 30 June 2023.

At the time of writing this report the BWRES and MWRES standards had not been published and there was no notification of when this would be. The consequences of this are that the metrics are relatively unknown. The MWRES was previously published in 2020 and had 11 metrics but it is not known if this has changed with phase 2. The lack

of information and communication has been raised at the North East and Yorkshire (NEY) Equality, Diversity and Inclusion (EDI) Leads Regional meeting. The respective teams will report of the MWRES and BWRES.

Recommendation:

Board of Directors is asked to note the content of this WRES Annual Report and approve the submission and publication of the data.

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

NHS Workforce Race Equality Standard Report, 2023

1. Introduction and Background

The Workforce Race Equality Standard (WRES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust is required to comply with. Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at improving the experiences of BME colleagues. The data is required to be submitted to NHS England (NHSE) by 31 May 2023. An action plan is to be co- produced, submitted to NHSE and published on the Trust's website by 31 October 2023.

The WRES covers 9 Metrics regarding the career progression and work experiences of BME colleagues. The data was collected for the period of 1 April 2022-31 March 2023 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey, with a snapshot of the data as of 31 March 2023. The Staff Survey data is from the 2022 Staff Survey.

This report provides an analysis of the 2023 data for the 9 Metrics covering the last three years. For the purposes of the WRES the term BME is defined as non-white, which means that staff from white minority groups are not included. Given this it is important to note that any wider inclusion work within the Trust must consider the needs of white minority colleagues.

Bank, medical and dental workers were not included in this year's data as separate BWRES and MWRES documents are to be published with a submission deadline date of 30 June 2023. This will be reported on by the respective teams. The reason for this is because of their unique experiences and that organisations could determine whether they included Bank staff in their WRES submissions or not.

Considerations

The National WRES Team has provided the Trust with a Trust specific report, which provides information against the 2021/22 data submission. This has not been referred to within this report but will be used to better understand the Trust's data.

2. Current Position/Issues

2023 Data Analysis

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

Total White Staff Headcount & Percentage (for 2023)	Total BME Staff Headcount & Percentage (for 2023)	Total Staff Trust Headcount and Percentage (for 2023)	Total Headcount and Percentage of Staff Not Stated (for 2023)
7099, 85.9%	893,10.8%	8262 (100%) (Exc. Bank and Medical)	270, 3.3%

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

2021 Total BME	2022 Total BME	2023 Total BME
Nonclinical BME • Bands 1-4 = 1.72% • Bands 5-7 = 1.11% • Bands 8-9 = 0.11% • VSM = 0% **Clinical** • Bands 1-4 = 2.84% • Bands 5-7 = 5.01% • Bands 8-9 = 0.1% • VSM = 0.01% • Consultants = 1.29% • Career Grades = 1.01% • M&D Trainees = 3.22%	**Nonclinical BME** • Bands 1-4 = 3.31% • Bands 5-7 = 0.98% • Bands 8-9 = 0.1% • VSM = 0.03% **Clinical** • Bands 1-4 = 1.21% • Bands 5-7 = 8.84% • Bands 8-9 = 0.13% • VSM = 0% • Consultants = 1.81% • Career Grades = 1.74% • M&D Trainees = 3.26%	**Nonclinical BME** • Bands 1-4 = 1.9% • Bands 5-7 = 0.5% • Bands 8-9 = 0.1% • VSM = 0.01% **Clinical** • Bands 1-4 = 0.8% • Bands 5-7 = 7.3% • Bands 8-9 = 0.07% • VSM = 0%

Metric 1 has not seen any improvement in the number of BME staff employed in the Trust under Agenda for Change. Whilst there has been international recruitment, this has not impacted on numbers. It is suggested that the recruitment team have a deep dive into this data and establish whether it is impacted by the number of BME staff leaving the Trust.

Metric	Description	2021 Total BME	2022 Total BME	2023 Total BME
2	**Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts**	1.76	2.61 	2.5

Metric 2 compares the relative likelihood of White colleagues being appointed from shortlisting compared to that of BME colleagues being appointed from shortlisting across all posts. The relative likelihood focuses on a figure of 1 being equity. As you can see from the above figures, the Trust the has been no significant statistical change this year.

Metric	Description	2021 Total BME	2022 Total BME	2023 Total BME
3	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process**	0	0.51	0.67

There has been a slight negative statistical increase in the relative likelihood of BME staff entering the disciplinary process compared to white staff, but the likelihood is the same. It is important that experiences do not deteriorate any further.

Metric	Description	2020 Total BME	2021 Total BME	2022 Total BME
4	**Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff**	0.86	1.06	0 Data unavailable due to deletion of learning hub system

It has not been possible to provide a statistical analysis for Metric 4 as the Learning Hub System has been unavailable.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
25.5%	22.5%	28.0%	25%	32.9%	23.1%

There has been a significant deterioration over the last two years with the number of BME staff experiencing unwanted behaviour from those who use our services, this figure is high and is above the Staff Survey benchmark group average of 30.8%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
31%	24.8%	31.4%	25.1%	28.2%	22.9%

Metric 6 has seen a positive decrease in the 2023 data, which is also slightly below the Staff Survey benchmark group average of 28.8%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
46.7%	55.6%	41.9%	56.8%	43.3%	56.2%

After seeing a negative decrease in 2022, there has been a positive increase in 2023, but this needs to continue to improve to be above the Staff Survey benchmark group average of 47.0%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
BME	**White**	**BME**	**White**	**BME**	**White**
16.0%	6.3%	20.3%	6.1%	19.8%	6.1%

After seeing a steep deterioration in 2022 compared to 2021, there has been little statistical improvement in 2023. The Trust's data is currently above the Staff Survey benchmark group average of 17.3%.

Metric	Description	2021 Total BME	2022 Total BME	2023 Total BME
9	**BME Board Members**	0	1	1
	Percentage difference between the organisations' Board voting membership and its overall workforce		6.25%	-4.9%
	Voting Board Members	0	0	0
	Non-voting Members	0	1	1

Metric 9 has seen no statistical improvement in the number of BME staff on the Trust's Board of Directors and as voting board members.

1. Summary

There are several metrics that have either deteriorated or not made any statistical improvement. These are:

- Metric 1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff
- Metric 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts

- Metric 3 Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process
- Metric 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months
- Metric 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleague
- Metric 9 Percentage difference between the organisations' Board voting membership and its overall workforce

The results will be shared with BME staff for them to determine the metric that require the most focus, whilst the 2022 actions are still being implemented.

It is noted that improvement will take several years to become evident, so the Trust needs to consistently work to improve racial inequality.

2. Next Steps

- Engage and co-design an action plan to address the disparities.
- Report to the Trust Board on the action plan in October 2023.
- The Trust Board is asked to review and approve the data ahead of submission and publication.

Date: May 2023

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	Workforce Disability Equality Standard (WDES) Annual Report
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion and WRES Expert

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

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

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

Summary of Report and Key Points to highlight:

This report is for assurance and will be shared with the People and Culture Committee for information and discussion. It sets out the Trust's 2023 WDES data.

The reporting submission date for the WDES data was brought forward in February 2023, from 31 August 2023 to 31 May 2023, this provided shorter notice for organisations to analyse their data. The purpose of the change of date was to provide more time for staff engagement to co-design an action plan to address any disparities. The action plan is required to be approved and uploaded to the Trust's website by the 31 October 2023, therefore this report only addresses the data.

At the time of writing this report the National WDES Annual Report had not been published so there is no comparison data within this report.

Disability equality continues to improve within the Trust, especially in relation to harassment, bullying and abuse. The Trust should continue to engage, listen and support staff. Continuing to implement a variety of interventions that are designed to improve the work experiences and careers of staff that identify as disabled will continue to improve their outcomes.

It is suggested that the Trust ensures that there are adequate resources within the Trust to continue to improve in this area.

Recommendation:

The Board of Directors is asked to review and approve the data within this 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

NHS Workforce Disability Equality Standard, 2023

1. Introduction and Background

The Workforce Disability Equality Standard (WDES) is a national annual reporting scheme which York and Scarborough Teaching Hospitals NHS Foundation Trust is required to comply with. Trusts are required by the NHS Standard Contract to use this data to develop action plans aimed at improving the experiences of Disabled colleagues. The data is required to be submitted to NHS England (NHSE) by 31 May 2023. An action plan is to be drawn up and published on the Trust's website by 31 October 2023.

The WDES covers 10 Metrics regarding the career progression and work experiences of Disabled colleagues. The data is collected for the period of 1 April 2022-31 March 2023 and is taken from the Electronic Staff Record (ESR) and the national Staff Survey, with a snapshot of the data as of 31 March 2023. The Staff Survey data is from the 2022 Staff Survey.

This report provides an analysis of the 2023 data for the 10 Metrics covering the last three years. The report presented in October will provide an overview of the progress made with the 2022/23 action plan and the action plan for 2023/24.

Considerations

There have been two changes. Previously, the definitions of Very Senior Manager (VSM) used in the WDES and the WRES were slightly different. These have been harmonised to use the definition previously used in the WRES. This is:

- Chief Executives
- Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post
- Other senior managers with Board level responsibility who report directly to the Chief Executive

As there is now a requirement for separate data collection for Bank staff, for the WRES (BWRES), due to their unique experiences, they are to be excluded from Metric 1. This is to allow for a consistent number to be provided to both collections.

Current Position/Issues

2023 Data Analysis

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

Total Disabled Staff Headcount &	Total Non-Disabled Staff Headcount &	Total Trust Staff Headcount and	Total Headcount and Percentage of Staff Not Stated (for 2023)

Percentage (for 2023)	Percentage (for 2023)	Percentage (for 2023)	
431, 4.6%	7140, 76.7%	9,314 100%	1743, 18.7%

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

2021 Total Disabled	2022 Total Disabled	2023 Total Disabled
Non-clinical Disabled • Bands 1-4 = 3.5% • **Bands 5-7 = 2.9%** • **Bands 8a - 8b = 3.4%** • **Bands 8c – 9 & VSM = 2.6%** **Clinical** • **Bands 1 - 4 = 3.3%** • **Bands 5 - 7 = 3.2%** • **Bands 8a – 8b = 1.5%** • **Bands 8c – 9 & VSM = 0%** • **M&D Consultants = 0.7%** • **M&D Career Grades = 1.7%** • **M&D Trainee Grades = 2.3%**	**Non-clinical Disabled** • **Bands 1-4 = 4.5%** • **Bands 5-7 = 4.7%** • **Bands 8a - 8b = 5.5%** • **Bands 8c – 9 & VSM = 3.6%** **Clinical** • **Bands 1 - 4 = 3.9%** • **Bands 5 - 7 = 4.6%** • **Bands 8a – 8b = 2.1%** • **Bands 8c – 9 & VSM = 0%** • **M&D Consultants = 0.7%** • **M&D Career Grades = 2%** • **M&D Trainee Grades= 2.2%**	**Non-clinical Disabled** • **Bands 1-4 = 5.1%** • **Bands 5-7 = 6.7%** • **Bands 8a - 8b = 6%** • **Bands 8c – 9 & VSM = 3.8%** **Clinical** • **Bands 1 - 4 = 4.9%** • **Bands 5 - 7 = 4.7%** • **Bands 8a – 8b = 2.4%** • **Bands 8c – 9 & VSM = 0%** • **M&D Consultants = 0.7%** • **M&D Career Grades = 1.4%** • **M&D Trainee Grades = 3.3**

Metric 1 has seen various statistical changes in 2023 with five being positive, four statistically static and one deterioration. It is advised that the Trust continues with its plans to encourage staff to update their equality monitoring information, this will help determine who is in the workforce. This should be supported by the Workforce Information and Communication Teams and at a Care Group and Directorate.

Metric	Description	2021 Total Disabled	2022 Total Disabled	2023 Total Disabled
2	**Relative likelihood of Disabled staff being appointed from shortlisting compared to non-Disabled staff**	6.27 of overall workforce	1.87 of overall workforce 	0.26.4 

Metric 2 has seen a vast improvement in 2023 and the data shows that there is no inequality in the relative likelihood of disabled staff being appointed from shortlisting compared to non-Disabled staff.

Metric 3	Description	2021 Total Disabled	2022 Total Disabled	2023 Total Disabled
	Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	1.40	1.35	0.56

Metric 3 has seen a positive decrease and means that they are treated with inequity within the Capability process.

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

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

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

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

Metric	2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
4a	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
	30.9%	20.2%	31.2%	23.2%	27.2%	22.9%
4b	18.2%	10.9%	19.4%	9.4%	15.8%	9.2%
4c	29.7%	16.2%	28.8%	17.8%	25.1%	16.3%
4d	48.7%	43.1%	45.0%	41.6%	47.9%	44.6%

Metric 4a has seen a positive decrease of 4.1% and is below the Staff Survey benchmark group average of 33.0%.
Metric 4b has seen a positive decrease of 4.4% and is below the Staff Survey benchmark group average of 17.1%.
Metric 4c has seen a positive decrease and is below the Staff Survey benchmark group average of 26.9%.
Metric 4d has seen a positive increase in reporting and is just below the Staff Survey benchmark group average of 48.4%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
49.3%	56.5%	52.1% 	56.9%	51.4% 	56.3%

Metric 5 has seen a slight negative decrease in 2023 but is equal to the Staff Survey benchmark group average, which has remained the same since 2021.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
27.7%	21.9%	26.9% 	18.9%	24.4% 	18.6%

Metric 6 has seen a positive decrease and is below the Staff Survey benchmark group average of 30%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
33.3%	46.3%	30.6% 	39.6%	31.5% 	39.1%

Metric 7 has seen a positive increase but is below the Staff Survey benchmark group average of 32.5%.

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

2021 (2020 Staff Survey)	2022 (2021 Staff Survey)	2023 (2022 Staff Survey)
Disabled	**Disabled**	**Disabled**
77.1%	74.4% 	80.3% 

The 2023 Staff Survey report for Metric 8 does not provide a caparison with previous years. Looking at the 2022 Staff Survey report, the only difference within the Metric description is the word 'adequate'. Regardless of this, the 2021 and 2022 results have been inputted into the above table to show the change which is a positive increase.

Metric 8 has seen a positive increase and the Trust's results are above the Staff Survey benchmark group average of 71.8%.

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

2021 (2020 Staff Survey)		2022 (2021 Staff Survey)		2023 (2022 Staff Survey)	
Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**
6.4%	7	6.2	6.7	6.1	6.6

The staff engagement score for the Trust is 6.5 and the score for Disabled colleagues is below this. The Staff Survey benchmark group average for Disabled people is 6.4 and the Trust's is also slightly below this.

Metric 9 b – information about Disability engagement

This metric asks for qualitative information and has been submitted regarding the disability engagement work and action plan progress.

Metric	Description	2021 Total Disabled	2022 Total Disabled	2023 Total Disabled
10	**Disabled Board Members**	0 out of 15 board members	1 out of 16 board members	1 out of 17 board members
	Percentage difference between the organisations' Board voting membership and its overall workforce	(0%)	(6.25%) 	(-5%) 

	Voting Board Members **Non-voting Members**	0 0	0 1	0 1

Metric 10 has seen a decrease in the number of staff who identify as Disabled, this is due to an increase in the number of Board members and how they identify.

1. Summary

Disability equality continues to improve within the Trust, especially in relation to harassment, bullying and abuse. Out of the 10 metrics, the four that the action plan needs to focus on are:

- Metric 1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff
- Metric 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.
- Metric 9 The staff engagement score for Disabled staff, compared to non-Disabled staff
- Metric 10 Percentage difference between the organisations' Board voting membership and its overall workforce. It is acknowledged that the identity of the Board is as such that the Disability status might not change. It is advised that recruitment process ensure that a diverse pool of applicants is attracted and recruited from.

It is suggested that the Trust continues to engage, listen and support Disabled staff. Also continue to implement a variety of interventions that are designed to improve the work experiences and careers of staff that identify as disabled will continue to improve their outcomes.

It is recommended that the Trust ensures there are adequate resources to continue to improve in this area.

2. Next Steps

- Engage and co-design an action plan to address the disparities.
- Report to the Trust Board on the action plan in October 2023.
- The Trust Board of Directors is asked to acknowledge the progress made with Disability equality and to review and approve the data prior to submission to NHSE and publication on the Trusts website by 31 May 2023

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Date: May 2023

Report to:	Board of Directors
Date of Meeting:	17 May 2023
Subject:	Nursing Workforce Report
Director Sponsor:	Heather McNair, Chief Nurse
Author:	Emma George, Assistant Chief Nurse

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

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

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

Summary of Report and Key Points to highlight:

To provide information and assurance to the board on how the Trust has responded to provide the safest and effective nurse staffing levels during February and March 2023. This will include the requirement to submit the safer staffing metrics using Care Hours per Patient Day (CHPPD). Provide assurance that nursing establishments have been reviewed utilising best practice guidance and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce are in place.

Recommendation:
To receive the report
To decide whether further actions or additional information is required
To consider items for assurance

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**

Nursing Workforce Report

1. Introduction and Background

This report provides the monthly Nurse and Midwifery Staffing data to describe the key workforce data and complies with the National Quality Board (NQB), 2016 guidance and the NHS England, Operational Productivity and Performance report, 2019, Care Hours Per Patient Day (CHPPD) requirements for reporting.

2. Considerations

The Trust has complied with the submission of CHPPD data for February and March 2023 submission (tables 1 and 2).

Table 1 CHPPD February 2023

Care Group	Day				Night			
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
CG1	83%	84%	60%	-	101%	122%	23%	-
CG2	82%	93%	12%	-	96%	105%	45%	-
CG3	78%	93%	-	-	89%	122%	-	-
CG4	71%	86%	-	-	95%	98%	-	-
CG5	73%	76%	-	-	86%	93%	-	-
CG6	-	-	-	-	-	-	-	-
Total	79%	88%	56%	-	94%	114%	52%	-

Table 2 CHPPD March 2023

Care Group	Day				Night			
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
CG1	86%	85%	59%	-	101%	125%	18%	-
CG2	84%	94%	16%	-	97%	107%	25%	-
CG3	79%	94%	-	-	90%	126%	-	-
CG4	77%	90%	-	-	95%	101%	-	-
CG5	79%	76%	-	-	88%	95%	-	-
CG6	-	-	-	-	-	-	-	-
Total	82%	89%	60%	-	94%	117%	36%	-

Tables 1 and 2 indicate the CHPPD for each Care Group in February and March this is the total for the organisation. The average day fill rate in February for Registered Nurses was 79% and January 2023 82% indicating an increase. The night fill rate has also continued to demonstrate above 80% for all domains in both months.

The day fill rate for HCSW has achieved above 80% for both night shift and day shifts during D. Nights have achieved over 100% in Care Groups 1,2, 3 and 4 reflecting the requirement for enhanced supervision and increases in dependency. This indicates an improving picture for fill rates within the organisation during February and March 2023.

3. Current Position/Issues

Nurse Vacancies

Registered Nurse

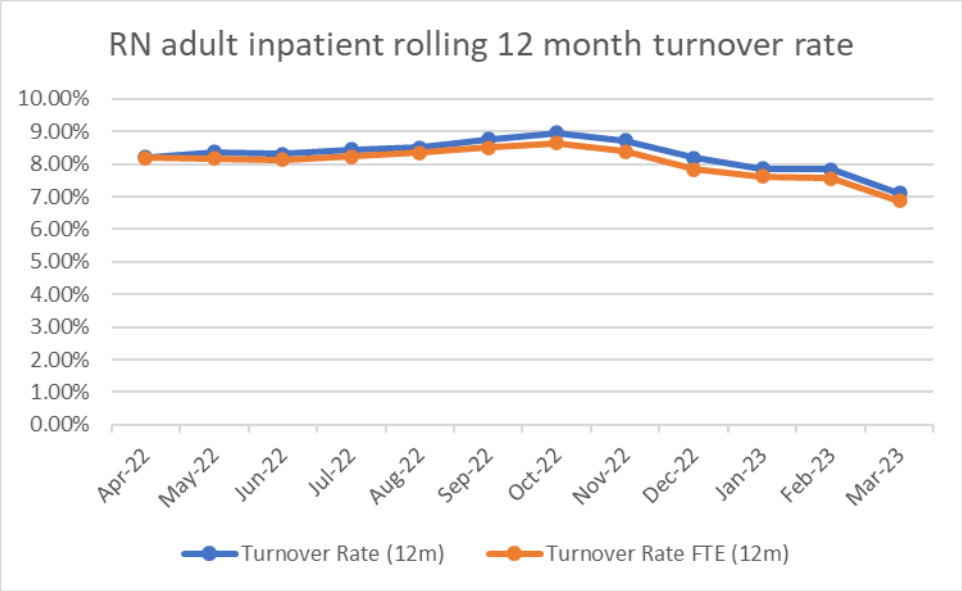
Table 4 below shows the current RN projections as of March 2023 and actual starters and leavers are available. The table indicates a positive position for adult inpatient wards by September 2023 on the current trajectory.

Table 3 Registered Nurse Vacancy levels Trust Wide projected and actual

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Establishment	**937.03**	**937.5**	**937.41**	**942.83**	**942.83**	**942.47**	**942.47**	**942.47**	**942.47**	**942.47**	**942.47**	**942.47**
Projected in post	*851.3*	*865.61*	*892.45*	*882.01*	*879.87*	*877.73*	*887.27*	*895.81*	*894.35*	*902.89*	*911.43*	*961.97*
Actual in post (ESR as at 310323 + 25 INs awaiting PIN as advised by IN team)	**850.55**	**873.99**	**879.15**	**862.2**	**865.72**	**858.37**						
Projected leavers	*5.33*	*5.88*	*5.72*	*5.32*	*5.32*	*5.32*	*4.64*	*4.64*	*4.64*	*4.64*	*4.64*	*4.64*
Actual leavers	**10.24**	**2.64**	**2.6**	**3.6**	**2.8**	**1.57**						
Projected International Recruits	*16.4*	*14.76*	*17*				*11*	*10*		*10*	*10*	
Projected UK qualified starters	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*
Projected NQs/direct apprenticeships	*56.2*	*3*	*4*	*5*								*52*
Total projected new starters	*75.78*	*20.94*	*24.18*	*8.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*3.18*	*55.18*
Actual new starters	**45.6**	**24.28**	**17**	**2.8**	**4**	**2.8**						
Vacancies	-86.48	-63.51	-58.26	-60.82	-62.96	-64.74	-55.2	-46.66	-48.12	-39.58	-31.04	19.5

There has been an improvement in RN leavers figures since October 2023, where the average has reduced from 5.32 to 4.64 per month (Table 5 below). February and March indicate less than this at 2.8 and 1.57 WTE each month. These figures will be presented every month to monitor the projected against the actual. The table indicates all the starters, including NA who are topping up to RN, international nurses, and PRNs (newly qualified). Projected starters have reduced over the 2 months due to a pause in International Recruitment and newly qualified nurses commencing in post. A RN recruitment event took place in March in York, 75 Registered Nurses have been offered a post so far and another planned for the Scarborough site. The Trust is represented at the HEI recruitment events in the region. There is an agreement with NHSE for 90 International Nurses for 2023. The manifesto ends in March 2024, with the supported funding for International Nurses ceasing. As an organisation we are collaborating with the ICB to consider the options for International Recruitment beyond 2024, with the relationship we have built with Kerala and the Schools of Nursing there to develop a pipeline for newly qualified nurses. The organisation has welcomed the first cohort of Keralan nurses this month.

Table 4 Turnover rate for Registered Nurses April 22 – March 2023



Health Care Assistant

Table 5: HCA Vacancy Levels Trust wide projected and actual 2022/23

Band 2/3	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Establishment	684.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34	695.34
Projected in post	*626.43*	*630.2*	*631.15*	*631.05*	*624.98*	*639.04*	*646.77*	*654.5*	*662.23*	*669.96*	*677.69*	*685.42*	*693.15*	*700.88*	*708.61*
Actual In post	609.5	614.66	616.99	610.92	601.7	608.48									
Projected leavers	*6*	*5.7*	*6.11*	*5.94*	*5.94*	*5.94*	*6.27*	*6.27*	*6.27*	*6.27*	*6.27*	*6.27*	*6.27*	*6.27*	*6.27*
Actual leavers	6.64	7.35	3.53	8.84	7.33	5.96									
Projected New Starters	*25*	*25*	*25*	*20*	*20*	*20*	*14*	*14*	*14*	*14*	*14*	*14*	*14*	*14*	*14*
Actual new starters	24.73	26.2	17.93	31.27	12.51	21.35									
Vacancies	-74.84	-80.68	-78.35	-84.42	-93.64	-86.86	-48.57	-40.84	-33.11	-25.38	-17.65	-9.92	-2.19	5.54	13.27

The table includes projections for the coming 12 months which indicate how planned recruitment activity and expected leaver numbers will impact staff in post numbers and the resulting vacancy position.

Reporting from the Trust's Electronic Staff Record (ESR) underpin the assumptions around expected leaver numbers to incorporate into the projection calculations. Recent analysis has however identified that there are many more changes happening within the workforce, particularly affecting the HCSW workforce, which are not highlighted through the reporting of starter and leaver numbers, but which do affect the staff in post numbers and associated vacancy position. These changes include substantive staff moving to bank only positions; substantive staff reducing their contracted hours/FTE (this appears to happen far more regularly than increasing hours); HCSWs moving into other support roles or progressing to, for example, the Nursing Associate training programme.

In the year to the end of March 2023, there were 289 FTE HCSWs newly recruited to the organisation. However, between April 2022 and March 2023, the HCSW staffing position only increased by 53.90 FTE.

At the start of January 2022, there were 603.46 FTE HCSWs in post in adult inpatient areas. By the end of 2022, 37.81 FTE had left the organisation, whilst almost 70 FTE had moved to bank only posts. In addition, movements to other roles within the organisation, either as progression opportunities or to support roles outside of adult inpatient areas, accounted for over 71 FTE and there was a further net reduction in staff in post of 9 FTE because of increasing/reducing hours. Of those 603.46 FTE staff in post at the start of the year, 416.15 FTE remained in the same post at the end of the year (a stability rate of less than 70%).

Discussions are ongoing as to how to incorporate these difficult to predict workforce changes into the projections as, should such changes continue to the level that has been seen recently, HCSW recruitment plans for the coming year are likely to result in a break-even position, rather than an overall reduction in vacancies. The issues around why these workforce changes are happening also need to be explored further, for example the significant shift to bank only work and reducing hours indicates that many staff are looking for a level of flexibility that is not being offered at the point that they are being recruited to join the organisation. This needs to happen alongside the work to reduce attrition of those who are leaving the organisation.

There is still a fluctuating picture with the number of leavers for HCSW and the turnover rate, the graph below indicates this.

Graph 7 HCSW Inpatient 12 month turnover

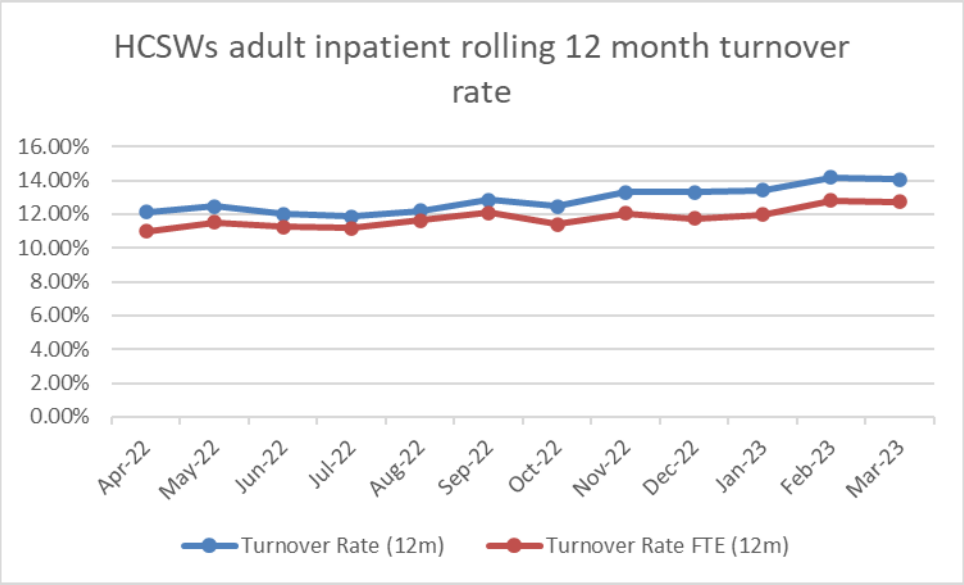


Table 5 above details the current HCSW position for adult inpatient wards for the Trust. The leavers figure does fluctuate but there has been a slight improvement in the attrition rate. We continue to recruit HCSWs at trajectory. Detailed work continues through the HCARRG, with a detailed improvement plan providing a clear structure with measurable initiatives to support the trusts overall recruitment and retention of HCSW's.

As part of the retention strategy the retention of HCSW's is key, alongside celebration events, providing pastoral support on the ward areas and a pilot "The Yellow Dot" initiative will commence in June for the trust. The Yellow dot is an initiative which has been successful at Gateshead identifies the HCSW as new to the trust and may need additional support from the MDT whilst settling into their work environment.

Mapping Sessions were completed with key members of the team, and in January reviewed the recruitment process, which heralded some quick wins for improvement, one of which was to agree and populate a yearly generic recruitment schedule. The second mapping session in March which looked at the journey of the HCSW once accepting the post and commencing within the trust.

Both sessions were well attended with ideas to improve the overall HCSW experience, which will ultimately support attrition of our new recruits. Some of the ideas could be enacted quickly and have already been actioned (uniform sizing and name badge ordering) and some required further discussion (workforce planning schedule of events and induction content and process).

As the HCSW role is an important role in providing safe and effective patient care, we aim to celebrate the role again later in the year at the national HCSW day, the planning of the event is underway via a working group with representative from all stakeholders who can ensure the day is a fantastic event.

Temporary Staffing

The Trust is being supported by NHSE to reduce our high off framework agency spend in nursing. An improvement plan has been developed to focus on key areas that can help reduce our reliance on agency, these include our utilisation of eRostering, processes for engaging temporary staffing and recruitment. A workshop took place on in February 2023 from NHSE to support this ongoing work. NHSE have also undertaken a York site visit where feedback indicated several areas that require improvement, including efficiencies to reduce the temporary staffing costs.

The graph below shows the peaks in demand for temporary nurse staffing, the amount of filled and unfilled shifts. Demand has shown a decrease over the past year, but various factors will have affected agency spend due to the increase demand for inpatient beds, industrial action and the increase in acuity of patients over winter.

The Trust continues to report a significant unmet need in relation to temporary staffing requests for registered and unregistered nurses (Graph 7) with an ongoing demand for temporary workforce.

Graph 8 Temporary staffing demand

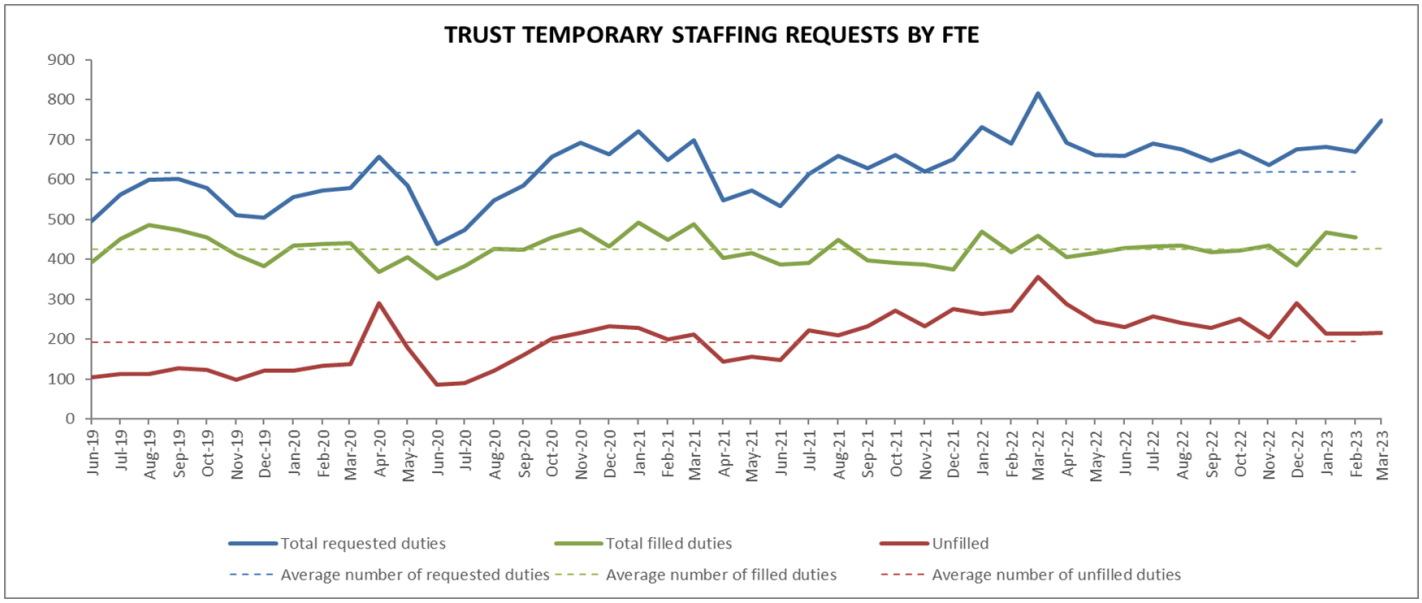


Table 9

SUMMARY OF TRUST TEMPORARY STAFFING REQUESTS

	Requested			Agency Filled			% of requested duties	Bank Filled			% of requested duties	Total % of duties filled	Unfilled			% Unfilled
	HCA	RN	Total	HCA	RN	Total		HCA	RN	Total			HCA	RN	Total	
Trust	6743	7095	13838	553	1535	2088	15%	3999	3334	7333	53%	68%	2191	2226	4417	32%
York	4312	4765	9077	552	1192	1744	19%	2397	2219	4616	51%	70%	1363	1354	2717	30%
Scarborough	2431	2330	4761	1	343	344	7%	1602	1115	2717	57%	64%	828	872	1700	36%

The table above indicates that 32% of shifts remained unfilled by bank and agency in March 2023.

4. Summary

This report highlights the current workforce analysis of CHPPD for February and March 2023, vacancies for Registered Nurses and Health Care Assistants (HCA), actual and projected figures and the amount of temporary workforce requested, filled and unfilled. Moreover, the HCSW figures and how further analysis is required to ensure the figures are accurate and the reasons underlying the increase in HCSW leaving substantive posts to join the bank.

Date: May 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13.1

Minutes

People and Culture Assurance Committee
15 March 2023

Attendance:
Jim Dillon Non-Executive Director, (The Chair), Matt Morgan Non-Executive Director, Polly McMeekin Director of Workforce & Organisational Development, Lucy Brown Director of Communications, Heather McNair Chief Nurse, Maya Liversidge (Governor observing)

Apologies:
Lorraine Boyd Non-Executive Director, Karen Stone Medical Director, Mike Taylor Associate Director of Corporate Governance.

Welcome and Introductions

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

23/14 Declaration of interest

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

23/15 Minutes of the meeting held on 18 January 2023

The Committee acknowledged receipt of minutes from the 18 January 2023.

The Committee:
- **Received and agreed the minutes of the 18 January meeting.**

23/16 Matters arising from the minutes and any outstanding actions

Following on from the minutes of 18 January, the Occupational Health paper was not presented to the Executive Committee as it was postponed due to industrial action. An update will be provided at the next meeting.

In terms of an Occupational Health resource Polly McMeekin spoke about a future collaboration with Hull and feels greater cross site working should be encouraged.

Action 142: The Chair reflected on the recent data incident regarding Learning Hub and the importance of long-term alternatives being considered as he felt this will be fundamental in a culture change within the Trust. PM clarified the appraisal data relating to non-medical staff is held on Learning Hub and has been retrieved, and the data relating to appraisals for medical staff is held on a separate system. The committee discussed e-rostering and workforce systems and it was recognised that the implementation of e-rostering across the whole of the Trust is a priority in order to achieve effective and efficient activity planning for the workforce.

Action: The Chair asked for scoping work to be carried out in relation to HR systems.

23/17 Escalated Items

No escalations were received from other Committees.

23/18 Risk Management Report; Board Assurance Framework and Corporate Risk Register

In Mike Taylor's absence the report was considered by the committee and agreed that it remains unchanged and the issues surrounding nursing and workforce are being addressed.

The Committee:

- **Received and noted the report**

23/19 Nursing Workforce Update

Heather McNair discussed the report included with the agenda.

HM provided an overview of the current recruitment drive of international nurses and the forthcoming visit to Kerala. It was explained that a different approach is being taken with a more bespoke solution for the Trust. It was deemed previous recruits struggled with the English language and was felt earlier investment in their development will help to make the nurses feel part of a team who will be integrated with all new starters as a newly qualified workforce.

It was requested that future reports should include information regarding the recruitment of international nurses.

The Committee discussed recruitment and retention of HCA's and perhaps a failure to support them particularly following long shifts on difficult wards as some staff have become accustomed to their working environment. Matt Morgan queried how a newly appointed HCA is allocated their ward and whether they have a choice, and it was confirmed efforts are made to meet their choice, but some are automatically assigned according to vacant positions. The "Stay and Thrive" initiative has proven successful and gives an opportunity for nurses to experience different areas.

HM advised consideration is being given into an alternative workforce to look after patients in a way that keeps them occupied/distracted whilst on the wards not just providing healthcare.

Action: The Chair asked for the recruitment plans of Registered Nurses, Health Care Assistants and alternative roles to be presented back to the Committee.

23/20 Staff Survey – Preliminary Report

PM discussed the report included with the agenda and advised the overall picture being a deteriorating one. A separate report will be issued for both the LLP and Bank.

Experiencing harassment from patient, relative or members of the public was an area of particular deterioration and PM advised the committee that a paper is due to be presented to QPAS in relation to the introduction of a "red/yellow card system". Further discussions confirmed that the paper should be discussed at Board.

The Staff Survey will develop a Corporate Action Plan with Care Group and Directorate specific action plans. In relation to harassment/bullying key HR policies have been rewritten in an attempt to move away from a grievance and harassment policy to a more stability and respect policy which will be more resolution focused.

Action: Staff Survey results for the LLP and Bank to be brought back to the Committee.

Action: The Chair asked for the Action Plans to be presented to the Committee seeking assurance that the issues will be addressed.

23/21 Gender Pay Gap

PM identified two anomalies contained within the report and highlighted them to the Committee.

- The Associate Specialist Group states -66% gap – this is distorted by two females who were highly paid on a particular day and is not an area which will be corrected.

- The personal salaries category, which BSM falls into. The report details a 16.3% gap but there are 4 anomalies (1 GP and 3 admin/clerical) which fall into the personal salaries category. Work will be undertaken to transition them on to national contracts. Therefore, the personal salary gender pay gap is 11.3% rather than the 16.3% reported.

The Committee discussed Clinical Excellence Awards/bonuses and it was confirmed the criteria is under review and negotiations are in a prolonged transitional period.

23/22 Workforce and OD Update (including the Trust Priority Report)

PM presented the Workforce and OD update.

The committee discussed the following:

- "Fix the basics" – it was queried why the slow progression and whether this was a budgeting issue, however, it was felt that it was more the LLP's capacity and their ability to prioritise. For example, the delay in securing a suitable location for hot food vending machines is due to priority being given to the location which would generate the most revenue. The machines are a staff benefit and the focus seems to have been forgotten.

- Car parking has been launched and feedback received. Clarification of the criteria will be provided over the coming weeks.

- In addition to the report PM provided an update regarding Personalised Onboarding. There is now an intention to have weekly face to face inductions focusing more on "Welcome to the Organisation" and providing key messages about the Trust Strategy.

The Committee suggested the possibility of seeking the staff's thoughts on the implementation of recent provisions such as free tea and coffee as they may feel funds should be best placed elsewhere particularly if being funded by the Charity. Lucy Brown clarified that the Charity has only funded the tea and coffee in the short term and will seek reimbursement from the Trust.

23/23 Issues to escalate to Board, other Committees, BAF or CRR

No escalations to Board.

23/24 Any Other Business

No other business was discussed.

23/25 Summary of actions

Action: The Chair asked for scoping work to be carried out in relation to HR systems.

Action: The Chair asked for the recruitment plans for Registered Nurses, Health Care Assistants and alternative roles to be presented back to the Committee.

Action: Staff Survey reports from the LLP and Bank to be brought back to the Committee.

Action: The Chair asked for the Action Plans to be presented to the Committee seeking assurance that the issues will be addressed.

23/26 Date of next meeting

17 May 2023, 1pm

Item 13.2

People and Culture – Chair's Assurance Report

Date of Meeting:	17 May 2023			**Quorate (yes/no):**		Yes	
Chair:	Jim Dillon (Chair)						
Members present:	Lorraine Boyd (NED), Matt Morgan (NED), Polly McMeekin, (DW&OD), Karen Stone (MD), Lucy Brown (Dir Comms), Heather McNair (CN)			**Key Members not present:**		Heather McNair (CN) apologies given	
Trust priorities assured to Committee	**1. Our People**	**X**	**2. Quality and Safety**			**3. Elective Recovery**	
	4. Acute Flow						
BAF Risks assured to Committee	**PR1 - Quality Standards**		**PR2 - Safety Standards**			**PR3 - Performance Targets**	
	PR4 - Workforce	**X**	**PR5 - Inadequate Funding**			**PR6 - IT Service Standards**	
	PR7 - Integrated Care System		**Comments:**				

Key Agenda Items	RAG	Key Assurance Points	Action
10. Nursing Workforce		Workforce planning and resource management significantly hindered by the lack of an effective e-rostering facility. Consideration should be given to the acquisition and implementation of a state of the art e-rostering system as a matter of urgency.	Escalation

Low	Assurance indicates poor effectiveness of controls
Medium	Some assurance in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve
High	Full assurance provided over the effectiveness of controls

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	CQC Update Report
Director Sponsor:	Heather McNair, Chief Nurse
Author:	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 21 April 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 23 May 2023.

Five CQC enquires have been received in May 2023. These are detailed in the main body of the report.

Recommendation:
For the Board of Directors to receive the assurance provided in this report.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
QPAS	10 May 2023	Presented
QASC	23 May 2023	*Meeting not held when the paper was written*

CQC Report

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)

2. CQC Enquiries

2.1 CQC Response Needed

Reference	Date Received	Overview of Request	Current Position
ENQ1-14536425811	08/12/2022	We have heard reports that staff are not checking patients have been fed, need assistance with feeding or can access fluids. They are not maintaining privacy and dignity by drawing curtains for patient treatment. In addition, staff are ignoring calls for help and assistance from patients and relatives. Please can you return answers to these questions by close of play on Monday 12 December 2022. • What assurances can the trust provide around the fundamental standards of care on this ward. • Please can we have copies of the perfect ward monthly and weekly audits results for the last two months (including this week's results if possible) . • Numbers of planned and actual staff working from Monday 28 November to Friday 8 December 2022 • Number of patients and their acuity from Monday 28 November to Friday 8 December 2022 • Audit results for food and fluid balance charts for all patients on this ward (where applicable)	Reports were submitted, however CQC requested that Tendable audits and ward improvement plan were submitted monthly. Last submitted 9/5/23
ENQ1-15499543117	04/05/2023	We were notified by United Response York DCA about the clinical care of a patient who died on ward 34 at York Hospital in April 2023. This patient had learning and physical disabilities. Please can you provide a summary of what happened during this patient's admission, care and treatment and send any relevant reports.	Received ME1B form, and information from Alison Sawyer on 12/05/2023. The response is being drafted for approval by the Chief Nurse.

Reference	Date Received	Overview of Request	Current Position
ENQ1-15688147776	10/05/2023	We have received a complaint directly to the CQC from a family member of a patient who died in April 2023. The compliant relates to the poor care and treatment on various wards at Scarborough Hospital, Chestnut, cherry, Lilac and Ash wards. • Poor multiple pressure ulcer care • safeguarding • inadequate pain relief • no dignity or respect on death • incorrect antibiotics for wound infection • miscommunication • poor discharges. She also received poor care and treatment GP community services and I have passed these onto the appropriate CQC (GP) inspector. Please can you forward any known investigation reports relating to this patient's care and copies of the trust's complaint response when completed.	The patient experience team received an email from NHSE on 9 May 2023 regarding this patient. NHSE are leading the complaint investigation and the Trust has been asked to contribute to this. The investigation report is due mid-June.
ENQ1-15861915915	15/05/2023	We have been notified by Gravers Care Home about an unsafe discharge from A&E York Hospital. The patient had significant mental health issues and had made attempts to end their own life. It is alleged that the crisis team refused to assess the patient and the mental health team said it wasn't a mental health issue. Allegedly the patient was sitting outside the hospital after discharge and contacted York Mind themselves for help and support. The police and local safeguarding teams were involved in this case. Please can you provide any copies of investigations or reports on this case (once completed).	Contacted the Head of Safeguarding for an update on 15/05/2023.

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2.2 CQC Response Not Need – Internal Review

Reference	Date Received	Overview of Request	Current Position
ENQ1-15687630543	03/05/2023	CQC were notified by a Nursing Home on 28/04/23 there was a poor discharge in relation to a patient discharged from Oak Ward in Scarborough Hospital. He was found to have several deep tissue injuries and although the patient had a wound care passport the home did not anticipate the extent of some of these pressure ulcers. The home completed a safeguarding concern to the local authority and the patient is now being cared for in the home.	CG2 advised that a fast track form was sent to the nursing home prior to discharge which included details of pressure ulcers. An update will be presented to QRAG on 25 May 2023.

Reference	Date Received	Overview of Request	Current Position
ENQ1-15751121862	09/05/2023	Enquiry relates to a poor family and patient experience of end-of-life care. This complaint was originally provided face to face to Healthwatch colleagues, and they passed it onto CQC. The concerns raised included the following. - Undignified death at home due to poor cancer care - Terminal cancer not picked up by GP – diagnosed in A&E. - Sent home from hospital with no equipment, catheter, compression socks, - No ongoing medical or palliative support from anyone - Had to ask for things like syringe drivers and other equipment	Information has been sent to Lee Fry for information / any themes / links to other complaints.
ENQ1-15751121865	09/05/2023	It relates to a poor family and patient experience of Maternity services. This complaint was originally provided by an email to Healthwatch colleagues, and they passed it onto myself (From March 23). After being in labour for three hours (out of hours at night) the patient called York Maternity unit but was told they were closed. They were diverted to Darlington and triage told her she was experiencing irregular contractions. 40 mins later her contractions reduced to two minutes. They were declined an ambulance to meet them halfway and baby was born in the car. They were taken to York where there were spare rooms but not enough midwives to keep unit open. Patient had heard of 13 women who had been previously turned away and that 1 woman and baby had died as a result.	CQC have not requested an information regarding this enquiry. Maternity have been made aware of this complaint through Healthwatch. An update will be provided.

3. 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

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

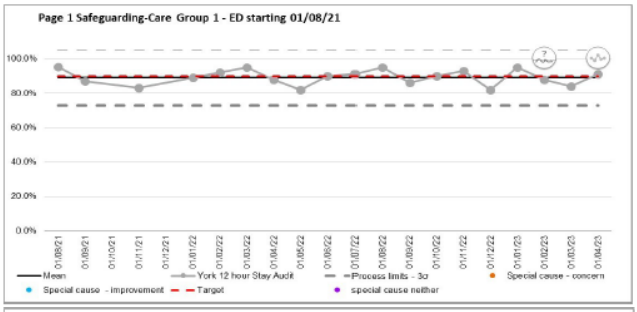
The CQC were not assured that patients who presented to the emergency departments with mental health needs were being assessed and cared for safely.

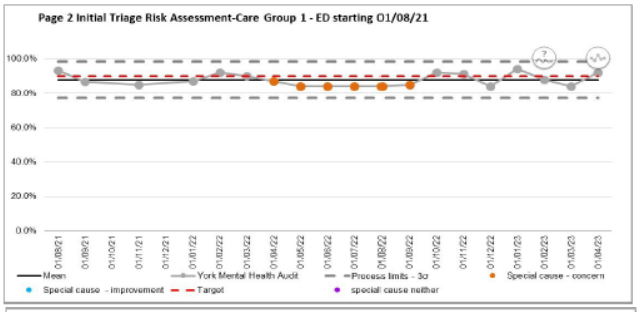
The CQC wrote to the Trust on 15 March 2023 to request further assurance regarding the section 31 for the Emergency Departments in relation to Mental Health Risk assessments. A response was sent by the Chief Nurse on 30 March 2023. Aside from acknowledging receipt of the information, no further correspondence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

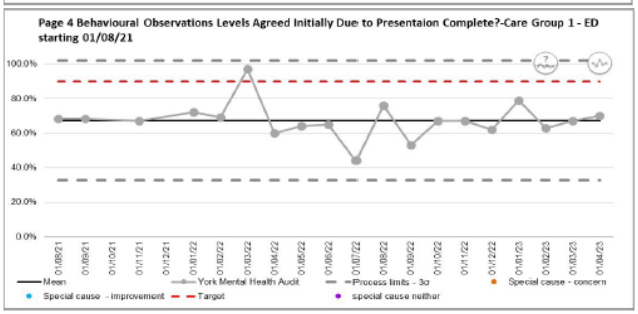
The tool used for the Mental Health Risk Assessment audit will be reviewed at the 9 May 2023 meeting of the Mental Health Steering Group. The update will facilitate the capture and review of more qualitative information.

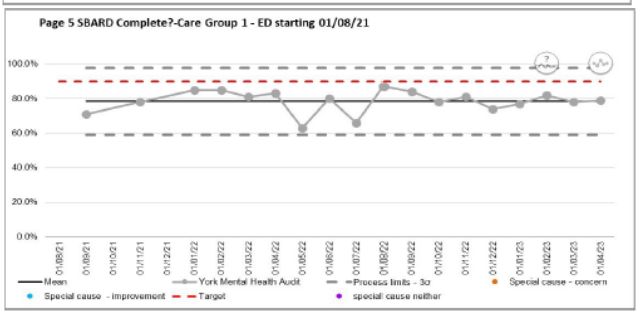
The results from the Mental Health Risk Assessment audits, with data until 1 April 2023, can be seen below:

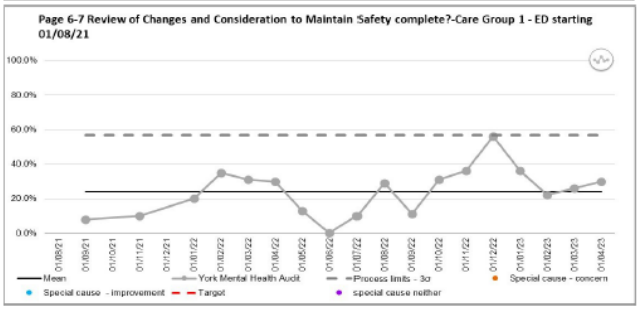
4.1 York Emergency Department Mental Health Risk Assessment Audit Results





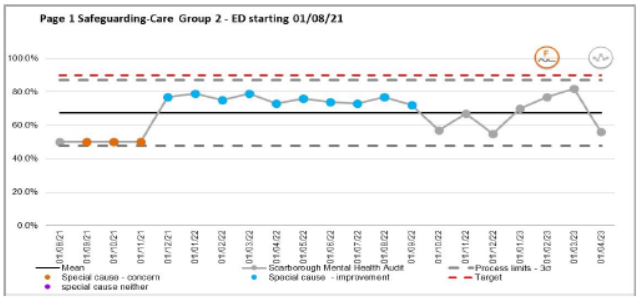


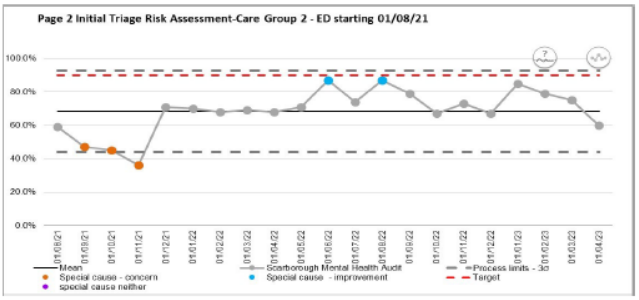


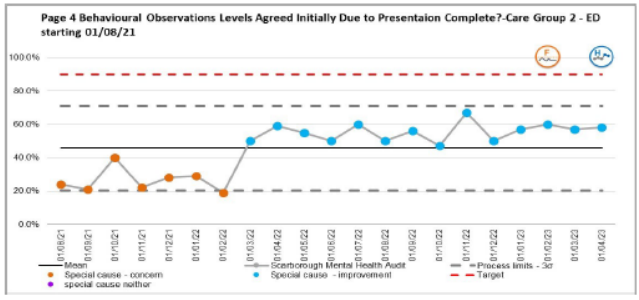


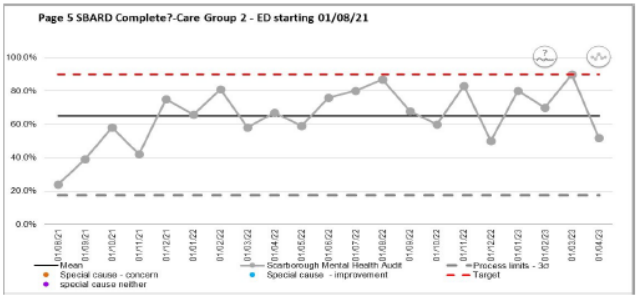
The ED Sister (Sarah Tugwell) reported that 69 patients came under the mental health umbrella and were audited at York. Only nine booklets were completed in full, although, if the booklets that just did not have the back page completed were disregarded, then there would have been 30 perfectly filled in booklets. Two patients also had had it stated in their notes that they had had booklets commenced but they were not scanned onto CPD. Feedback is given to staff via the safety brief and the results are emailed to everyone. If it is noticed that any individuals have training issues, we do speak personally to them, to gain an insight into what went “wrong” and how we can support them going forward.

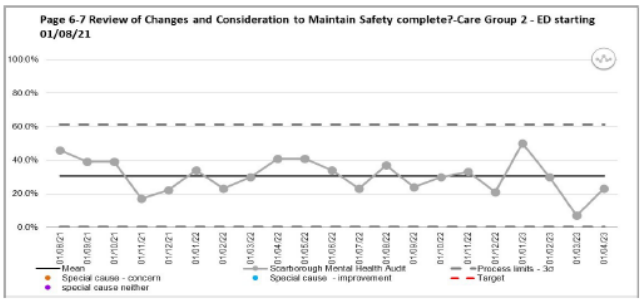
4.2 Scarborough Emergency Department Mental Health Risk Assessment Audit Results











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

5.1 Overview of Section 31 Action Plan Progress (InPhase)

Off track	1
At risk of exceeding timescale for delivery	16
On track	0
Complete	48

The actions at risk of exceeding the timescales for delivery are currently under review within Maternity. An update will be provided in the June 2023 paper.

On the 21 April 2023, the Trust submitted to the CQC:

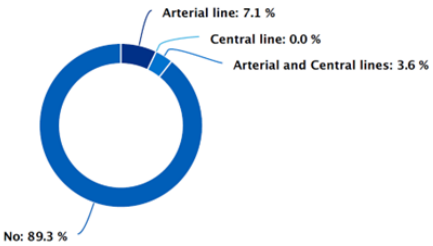
- A copy of the InPhase action plan as at 21 April 2023.
- The Maternity CQC Update paper (approved by the Quality and Safety Assurance Committee).
- Maternity dashboard

Highlights from the assurance provided in April 2023 includes:

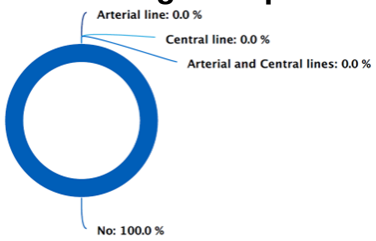
5.2 Management of Arterial Lines

All women requiring enhanced maternity care are entered into the Yorkshire and Humber Maternity Clinical Network's Maternal Enhanced and Critical Care (MEaCC) Audit. The data for April 2023 is shown below:

York Hospital



Scarborough Hospital



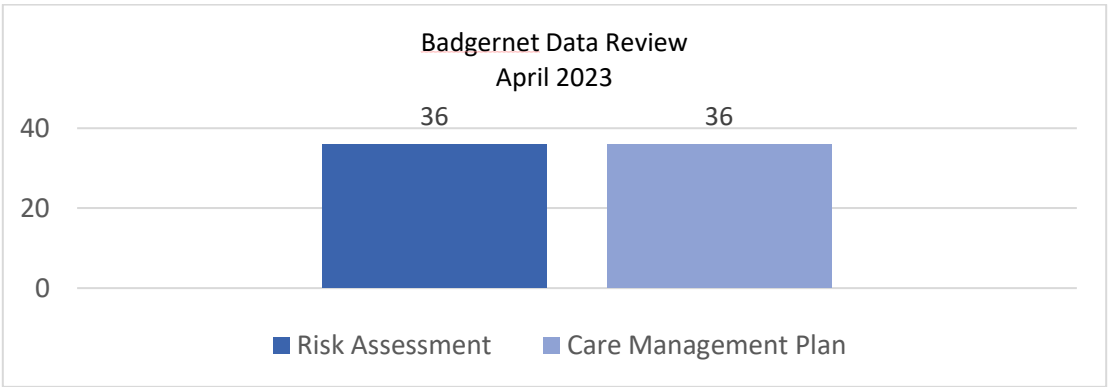
The audit confirmed that all women at the York site who had an arterial line sited were cared for in the obstetric theatre and had the line removed before leaving theatre.
No incidents have been reported within the maternity department in relation to the management of obstetric patients requiring an arterial line since the CQC reported their concerns in November 2022.

5.3 Availability of CTG Machines

- 70% increase in the availability of CTG machines at York Hospital since the CQC inspected (six to 20)
- 67% increase in the availability of CTG machines at Scarborough Hospital since the CQC inspected (five to 15)

5.4 Risk Assessment

- The CQC found evidence in patient records which showed incomplete assessments of risk and plans of care to mitigate such risks.
- Badgernet was rolled out to the Antenatal Teams in April 2023. The software mandates that an antenatal risk assessment is completed at every contact.
- All appointments held between 26 to 28 April 2023 were reviewed (36 records). All records had a completed risk assessment and care management plan.

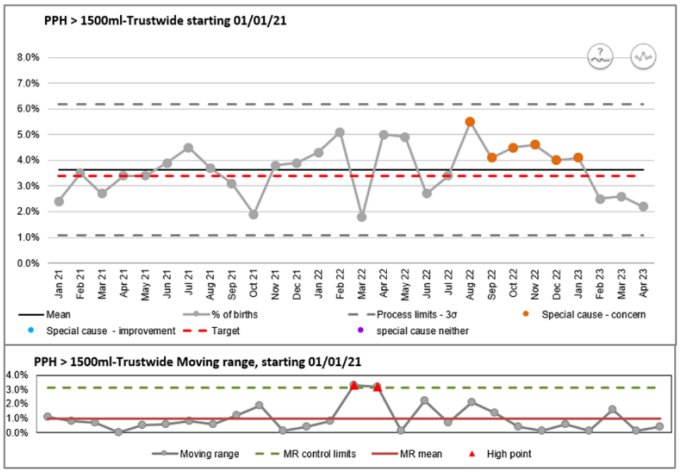


5.5 Post Partum Haemorrhage

PPH over 1.5 litres

National Average	Trust Average
30/1000	41/1000

The last three data points are now below the national average. The Trust will continue to monitor to determine that early signals are sustained and can be then seen as improvements.



6. York Hospital Medicine Inspection (March 2022)

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.

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

Off track	5
At risk of exceeding timescale for delivery	0
On track	1
Complete	59

Detail relating to the outstanding actions is held in **Appendix A.**

6.2 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 was the focus of the QRAG meeting on 27 April 2023.

Updates included:

- The MCA improvement group commenced in May 2022 with terms and reference agreed in August 2022.
- The staffing establishment has increased with two full time MCA Lead practitioners – this has led to:
  - Increased visibility on ward/and in departments
  - Opportunities for bitesize/bespoke training on ward or within governance meetings
  - Using existing systems (Datix/nucleus, care group governance structures) to escalate and raise awareness
  - Development of an audit process to provide initially a base line then monitor improvement and target specific areas where there are gaps in compliance
  - Quality control on DOLS applications
  - Capacity to provide Face-to-face training for Stat/Mand Programme
  - Joining regional networking to share good practice

The addition of two lead practitioners focusing on MCA compliance has seen an improvement in the Trust Deprivation of Liberty (DoLS) applications. These have increased from 102 application in quarter one (with little evidence of MCA assessment) to 385 applications in quarter four (with 99% of applications with capacity assessments).

The MCA Advisors are also leading on a qualitative audit of MCA compliance at ward / service level. The first round of audits highlighted lapses in compliance with the MCA. Immediate action was taken and actions plans established to support improvement.

The second round of audits will commence in May 2023 to identify whether the agreed actions from the initial audits have been implemented and have improved compliance.

6.3 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).

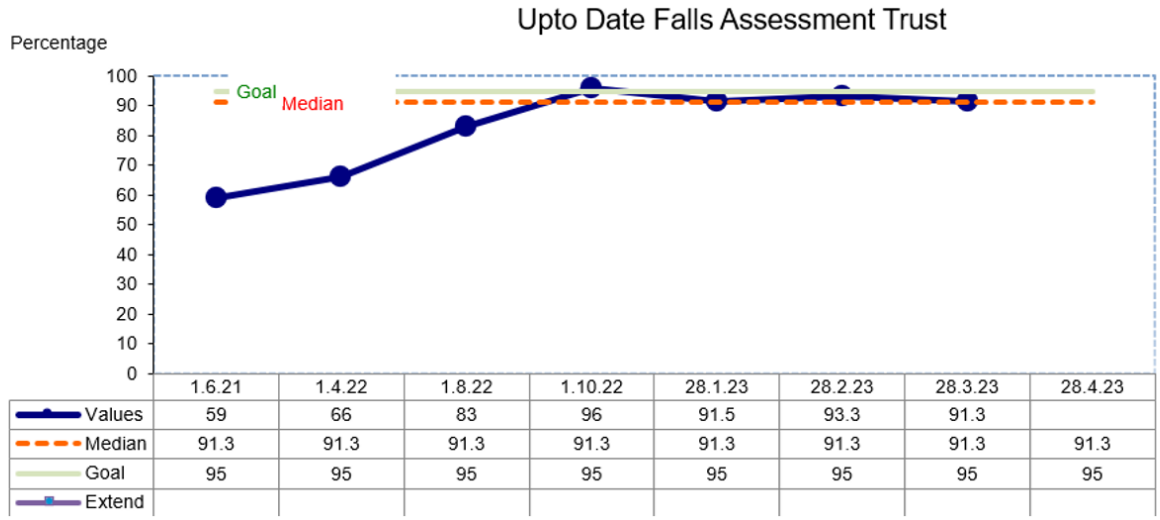
6.4 Nucleus

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 April 2023 is shown below:

	Trust Jan	Trust Feb	Trust March	Trust April
% of patients with an up to date falls assessment	92%	93%	91%	94%
% of patients with an up to date bedrails assessment	92%	92%	93%	96%
% of patients with an up to date MUST assessment	72%	78%	79%	83%
% of patients with an up to date actual weight	79%	79%	80%	84%
% of patients with an up to date Purpose T	89%	92%	91%	95%
% of patients with up to date skin checks	76%	72%	78%	79%
% of patients with up to date documented hygiene care	93%	86%	92%	88%
% of patients with up to date rounding tasks (within 1 hour)	69%	74%	80%	79%
% of patients with at least two digital evaluations in last 24 hrs	71%	66%	48%	57%
Average	**81%**	**81%**	**81%**	**84%**

There is evidence that since the risk assessments were launched on Nucleus, compliance has steadily increased. The completion of the falls assessment is evidenced below:

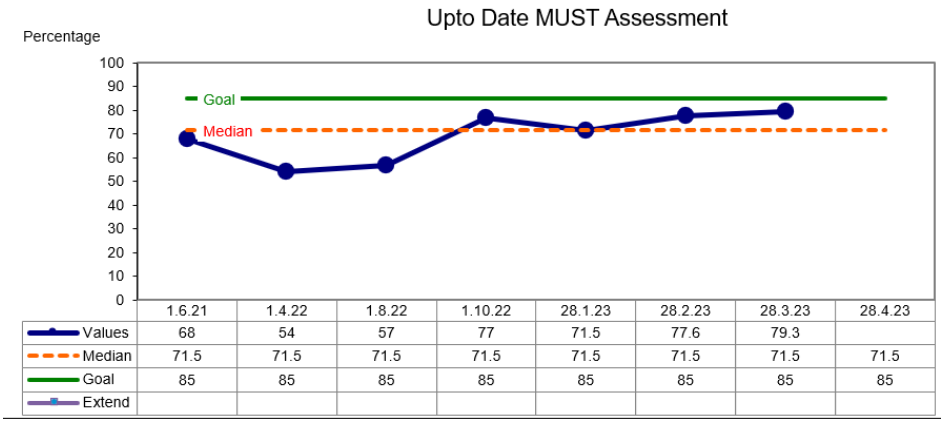


The service must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1).

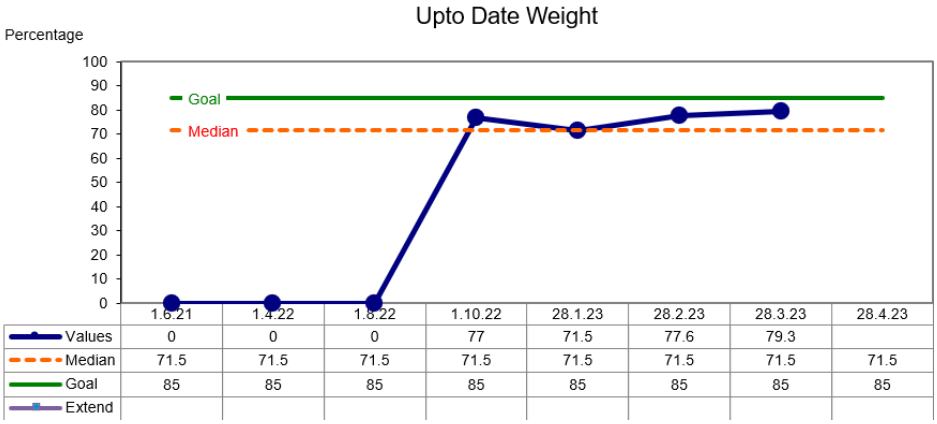
6.5 MUST Assessments

- The trajectory goal for nutrition is set at 85%, to be achieved consistently by Q4.
- Compliance with MUST has continued to be a challenge, with a median of 70% achieved. Following engagement with front-line staff, and discussion within the Nutrition Steering Group, one contributing factor identified was the timeframe within which MUST is required (<24 hours of admission, as per NICE guidance).

- A decision was taken to align the timeframe to mirror the MFRA and PURPOSE T (<6 hours of admission) to form part of an holistic nursing assessment. Once 85% is achieved, a further 'stretch target' will be agreed, with a suitable timeframe, aiming towards achievement of 95%. This change was enacted from 17 April 2023.



	1.6.21	1.4.22	1.8.22	1.10.22	28.1.23	28.2.23	28.3.23	28.4.23
Values	68	54	57	77	71.5	77.6	79.3	
Median	71.5	71.5	71.5	71.5	71.5	71.5	71.5	71.5
Goal	85	85	85	85	85	85	85	85
Extend								



	1.6.21	1.4.22	1.8.22	1.10.22	28.1.23	28.2.23	28.3.23	28.4.23
Values	0	0	0	77	71.5	77.6	79.3	
Median	71.5	71.5	71.5	71.5	71.5	71.5	71.5	71.5
Goal	85	85	85	85	85	85	85	85
Extend								

7. York ED Inspection October 2022

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

Off track	3
At risk of exceeding timescale for delivery	0
On track	0
Complete	22

Detail relating to the outstanding actions is held in **Appendix A.**

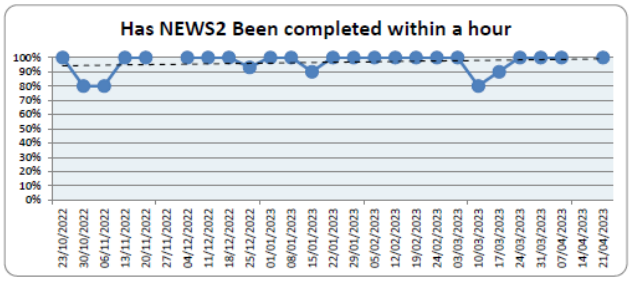
7.1 ED delays (including 12 Hour Stays)

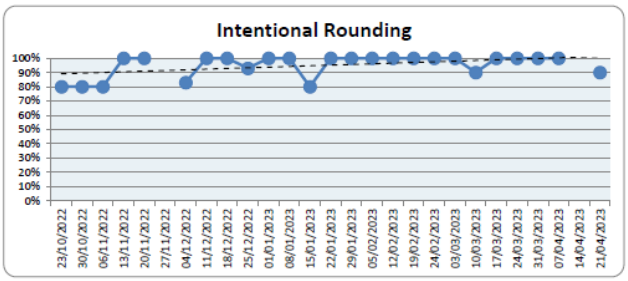
On a weekly basis the ED team undertake audits of key safety metrics for the 10 longest waits in both ED departments. The most recent audits are shown below.

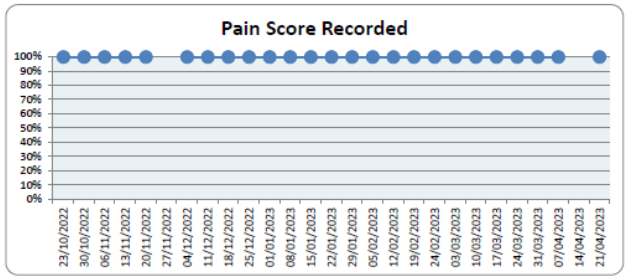
The ED are reviewing their action plans to ensure that the actions required are being implemented. Assurance of the action plan delivery is overseen through the Care Group Quality and Safety meeting.

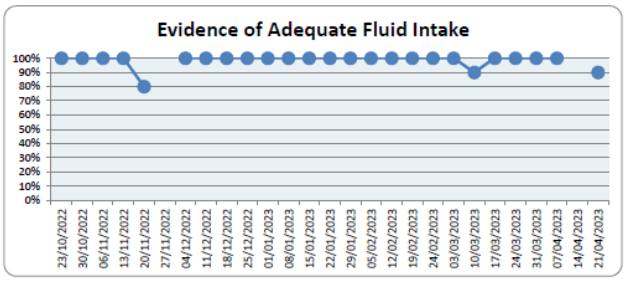
The audit results are shown below.

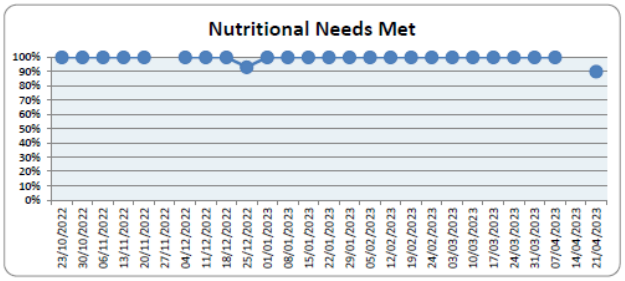
7.2 Scarborough Emergency Department +12 hour stay audit results

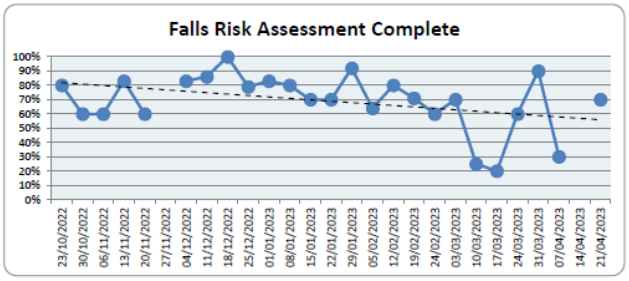


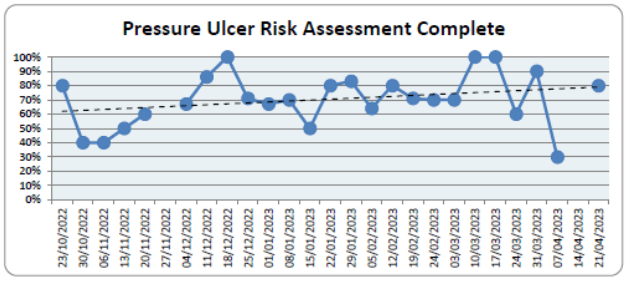


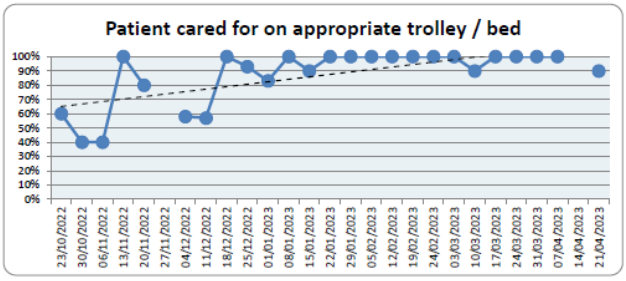


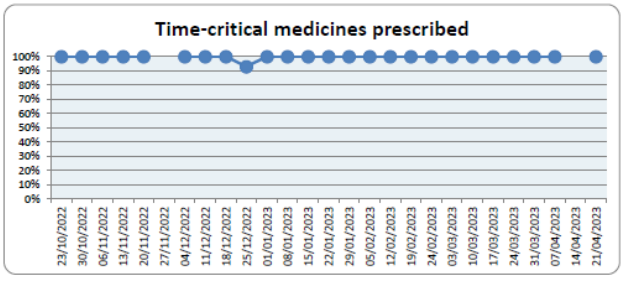


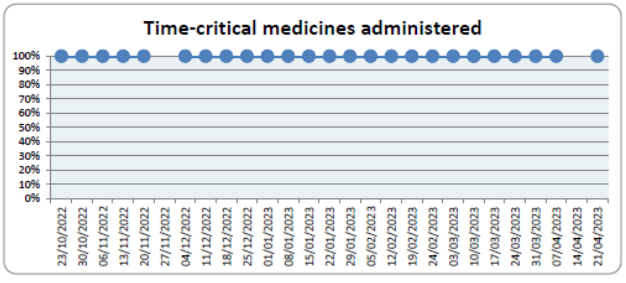


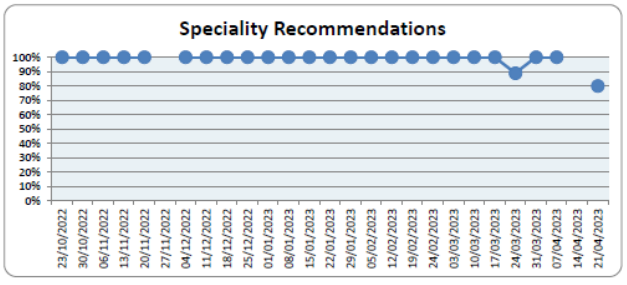


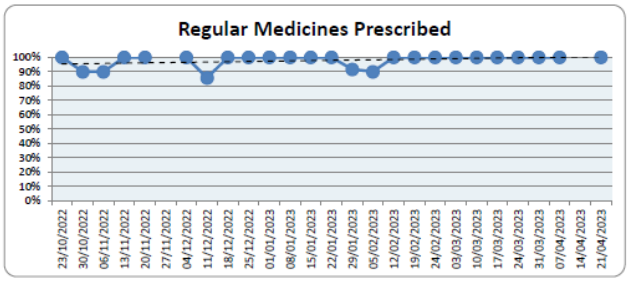


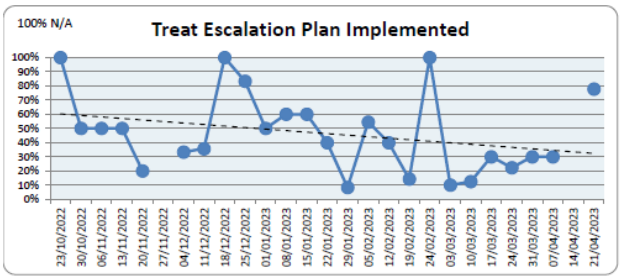


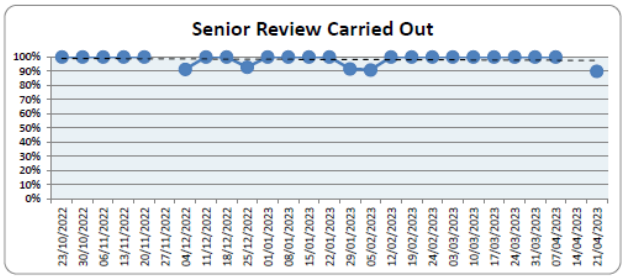


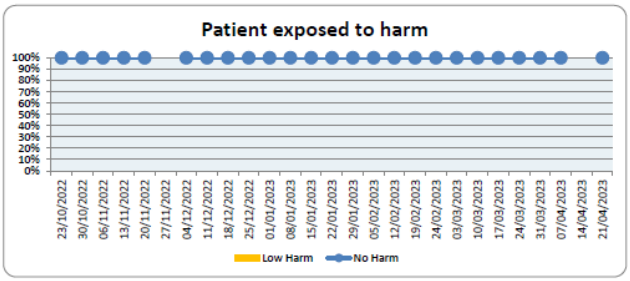




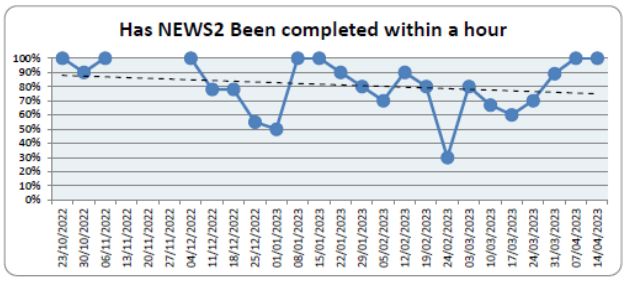


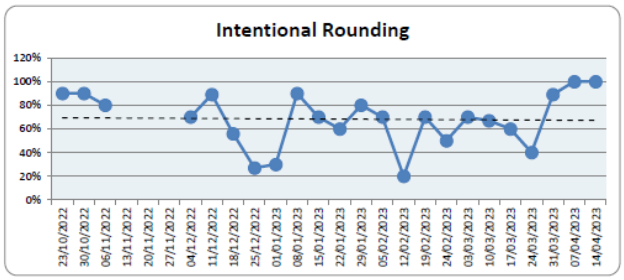


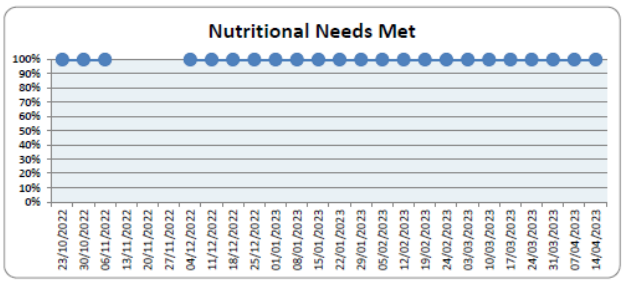


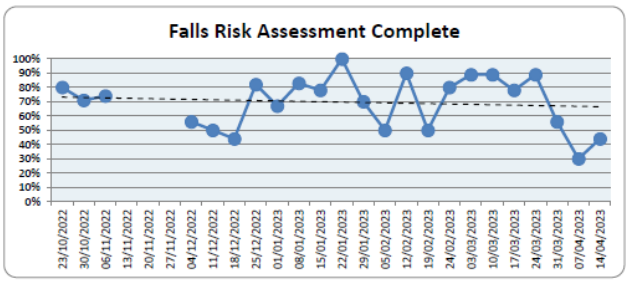


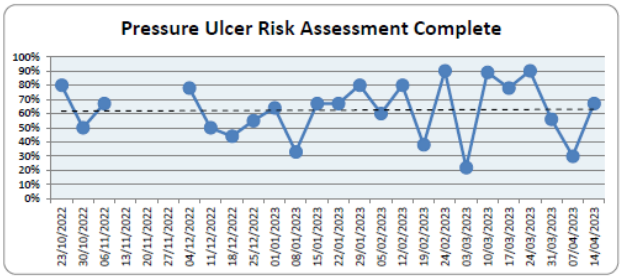
7.3 York Emergency Department +12 hour stay audit results

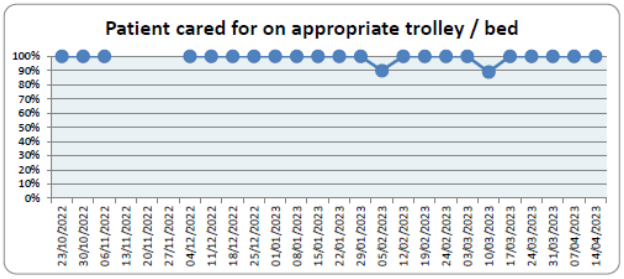


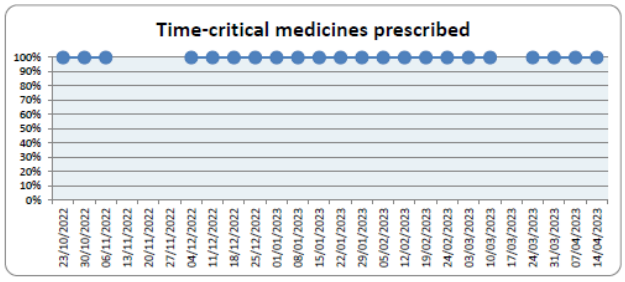


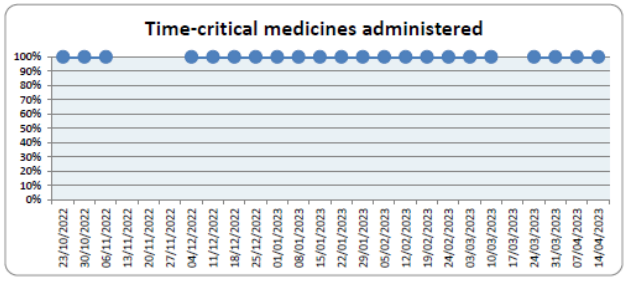


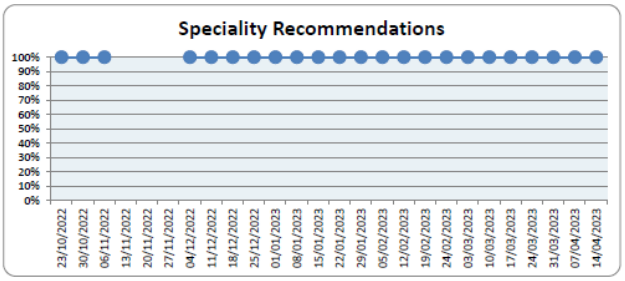


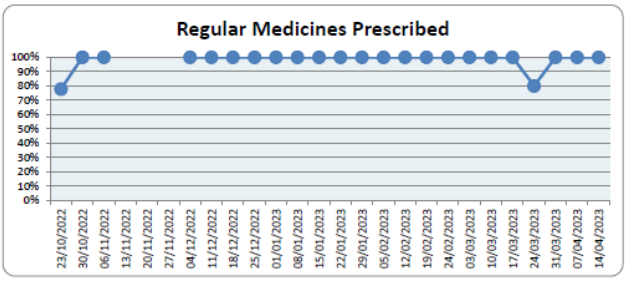


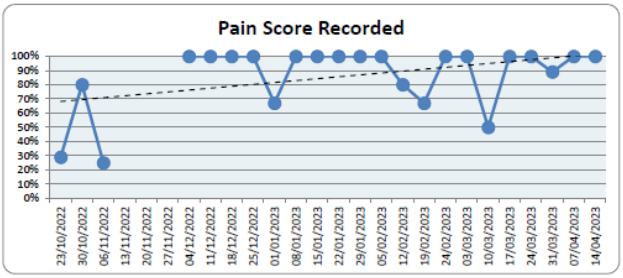


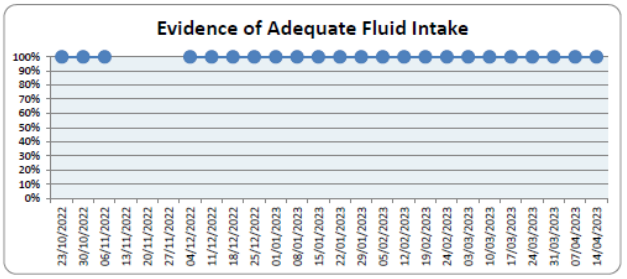


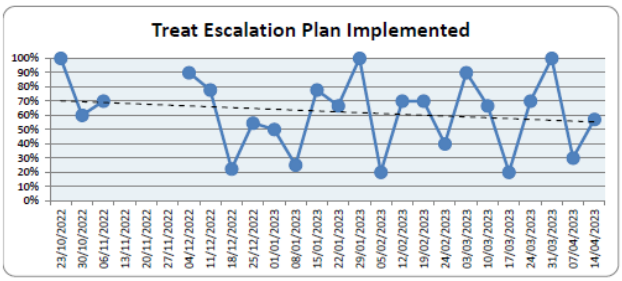


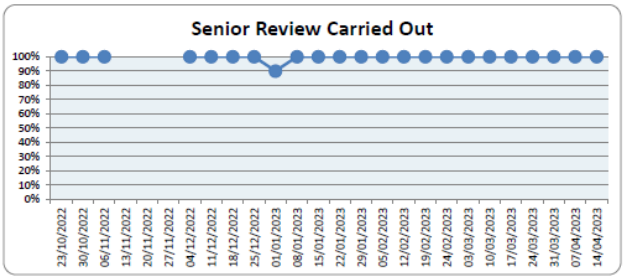


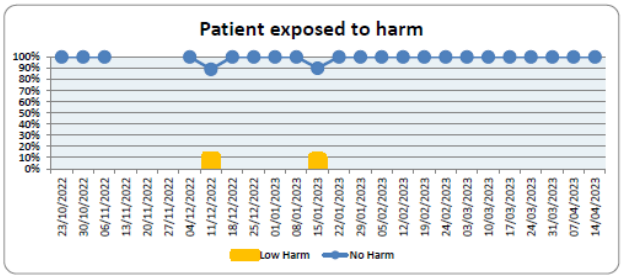












8. Recommendation

The Board of Directors are asked to consider the update within this report and the assurances for the delivery of key actions.

Date: 16 May 2023

Appendix A
Overdue Actions York Hospital Medicine Inspection (March 2022)

Recommendation	Action	Owner	May 2023		
			Due Date	Completion Date	Action Update
Recommendation 2 - S29A Risk Assessments	Review Bumpers & Crashmat Provision	Alison Bielby	30/07/2022	30/09/2023	Following a change in personnel work continues with the procurement team to ensure a specification for the crash mats required by the trust and a process for review of products and procurement. Due to a delay in the procurement process this action has been extended until September 2023 to allow the lead in time.
Recommendation 6 - Must Do: Record Keeping	Information Governance - Review Storage and Location of Medical Records on Wards	Kate Ayres	30/09/2022	30/06/2023	With the introduction of Nucleus, the number of paper nursing records will reduce. As more clinical information is recorded electronically this again will reduce the number of paper records. The IG team carry out regular walk rounds on ward areas giving advice on the security of information. Recently a visit was undertaken in York ED by the Head of Information Governance to discuss the security of records and advised on the storage of records particularly in the reception area. The clinical lead for Elderly Medicine has agreed that records will only be requested where absolutely necessary and not for all admissions. The storage of paper records on wards will continue to be monitored.
	Information Governance - Scope Requirements for Medical Records on Wards	Kate Ayres	31/08/2022	30/06/2023	With the introduction of Nucleus, the number of paper nursing records will reduce. As more clinical information is recorded electronically this again will reduce the number of paper records. The IG team carry out regular walk rounds on ward areas giving advice on the security of information. Recently a visit was undertaken in York ED by the Head of Information Governance to discuss the security of records and advised on the storage of records particularly in the reception area. The clinical lead for Elderly Medicine has agreed that records will only be requested where absolutely necessary and not for all admissions. The storage of paper records on wards will continue to be monitored.
Recommendation 7 - Must Do: Safe Staffing	Widen the scope and locations of available military support	Emma George	31/08/2022	30/09/2023	Continue to work with the military to work with us, the combat technicians and their support on the acute areas Feedback is good Work further in 2023 to consider other roles
Recommendation 9 - Overarching Trust Actions	Freedom to Speak Up - Create a Mechanism for "Anonymous" Internal Whistleblowing	Polly McMeekin	31/08/2022	31/05/2023	A button to whistleblow will be on the front page of the new intranet when it goes live. The Whistleblowing Policy is currently being redrafted by the Freedom to Speak up Guardian
	Implement "Huddle up for Safety" Coaching Project	Caroline Johnson	31/08/2023	31/08/2023	The Huddle up for safety work was commenced on ward 36, however, it was quickly determined by the Improvement Academy that they were not ready to commence the work, as the sister was new and was rather overwhelmed. Then 31 agreed to participate but there was already QI work ongoing on the ward. Currently G2 have commenced this work and it will then move to labour ward. Alice Hunter - patient Safety Specialist is being trained to deliver the improvement work as part of this process so will be able to roll the approach out to other areas.

Overdue Actions York Emergency Department Inspection (October 2022)

Recommendation	Action	Owner	May 2023		
			Due Date	Completion Date	Action Update
Deteriorating Patient	Provide additional staff to support the ambulance overflow corridor	Donna Jack	21/10/2022	not set	At present the department is unable to staff the ambulance assessment corridor to release the ambulance crews from the existing ED establishment. Bank shifts have been offered to existing staff. The ICS have supported the trust with 3 months of funding to enable CIPHER or similar agency to provide staff to cohort the ambulances on the overflow corridor. We are waiting for CIPHER to provide us the availability of the shifts that they are able to cover. We are also meeting with Mark the Clinical Services lead to discuss governance of the staff on Tuesday 8th November 22.
Medication management and controlled drugs	Bite-size medicines management fundamentals training to all registered ED staff	Sharon Sleightholm	31/01/2023	30/04/2023	Unable to complete this on target due to severe operational pressures in December and January - internal critical incident called in January 2023.
	Pharmacy monthly walk-around with senior nurse from Care Group	Caroline Dunn	19/10/2022	31/12/2022	Reports from walk-arounds will provide assurance that this action can be closed

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 May 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 Amanda Pearson Maternity Improvement Advisor NHSEI

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 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. A GAP analysis will be devised upon receipt of the year 5 Maternity Incentive Scheme (MIS) to inform the Quality and Patient Group of any risks to non-compliance.

Recommendation:

- The Board of Directors are asked to receive the report for information and assurance of continued improvement work within Maternity Services.

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History

Meeting	**Date**	**Outcome/Recommendation**
Quality and Patient Safety Group	10th May 2023	Continue to report on MEOWS
Quality and Safety Assurance Committee	23rd May 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 and the Maternity Incentive Scheme.
The Maternity services at this Trust are committed to the NHS Long Term Plan maternity focused commitments and the Safer Maternity Care NHS England progress report 2021 highlighting the national ambition for maternity services.

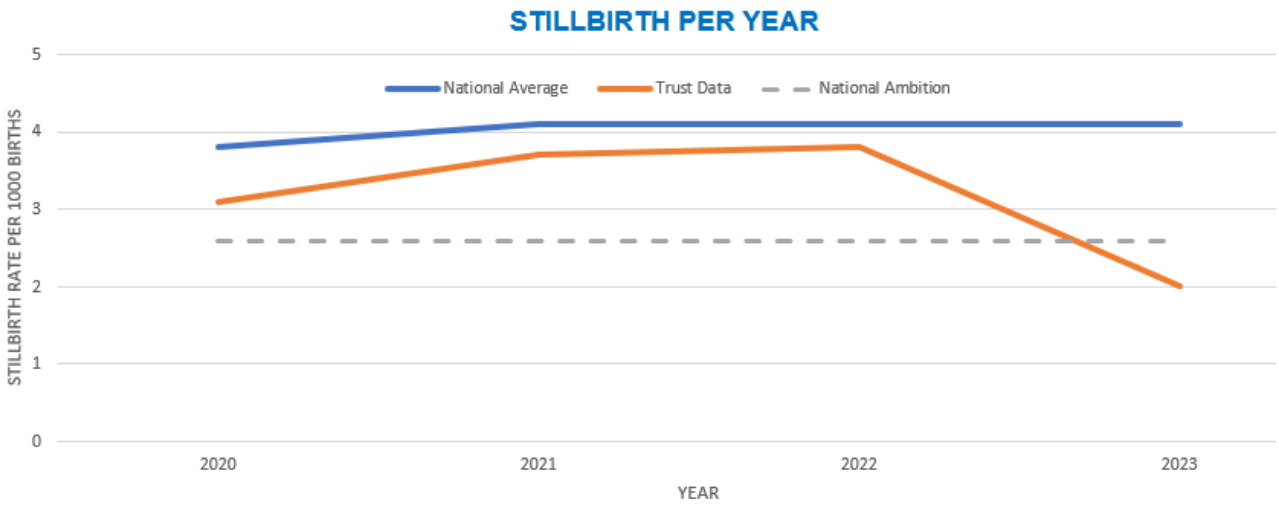
The three-year delivery plan for maternity and neonatal services was published in March 2023 which identifies four key themes in supporting safer maternity and neonatal services and will work closely as a multidisciplinary team, our external stakeholders and regulators in enacting this plan.

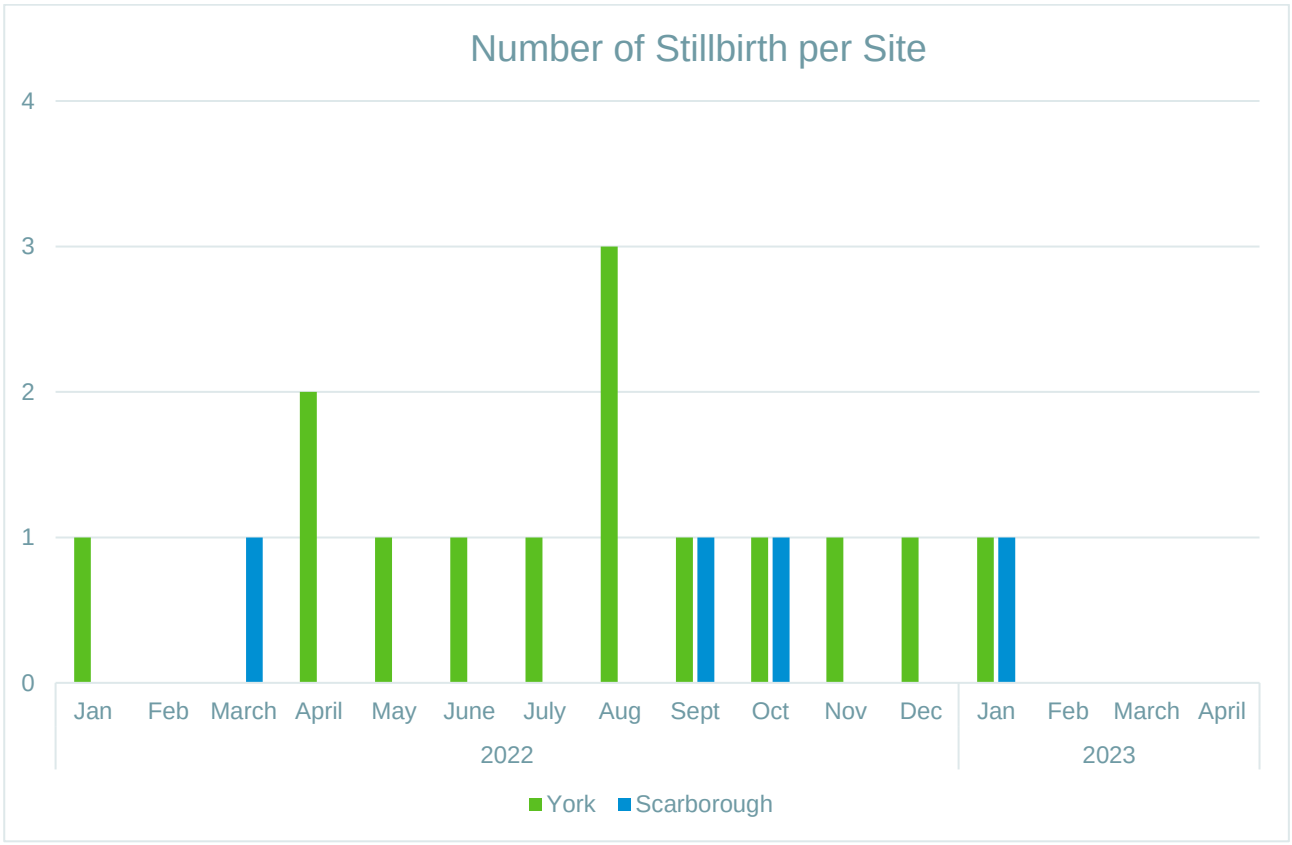
As part of the ongoing improvement work being undertaken within the care group Maternity services continue to be supported by the National and Regional Maternity Teams as part of the Maternity Safety Support Programme (MSSP) and working closely with the Local maternity and Neonatal System.

1.2 Perinatal mortality rate

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





We are pleased to report that there have been no reported stillbirths in February, March or April. The Trust are now in receipt of the MBRRACE Trust specific perinatal data for 2021 and a breakdown of this data will be provided in the next report.

1.3 Coroner Reg 28 made directly to Trust

There were no coroner Reg 28 made directly to the Trust in Q4.

1.4 NHSR referrals

There have been no referrals made to NHS Resolution in Q4.

1.5 PMRT

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 too, this is a requirement of the Maternity Incentive Scheme Safety Action 1. 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.

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. All families who have experienced a baby loss over 22 weeks gestation are provided with a named contact, they have the PMRT process explained to them and are invited to ask any questions to inform the review, should they wish. Following the review, they are offered an appointment to go through the review with a Consultant and Bereavement midwife and provided with a written summary of the findings of the review.

PMRT 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	Case needs to be discussed at PMM when quorate 19.05.23 Following initial review, it was noted the potential consideration of YAS transport of known high risk patients to the planned delivery Tertiary unit. However, the understanding is that practice is to transfer patients to the nearest Hospital in emergencies which was done in this case.	No immediate concerns requiring action based on initial review and discussion with paediatric team – care was appropriate for clinical presentation. This will be discussed further at PMM.
20.01.23	Unbooked Antenatal Stillbirth	24+0	Mother was unbooked and reports she did not know she was pregnant and delivered at home before any medical	21.04.23	No immediate concerns with management. The woman was not aware she was pregnant, and all	This will be discussed at PMM on 19.05.23 for a deeper review into the case and derive any actions via the MDT discussion.

			personnel arrived. Transferred to A+E and dealt with by midwifery team when requested. The Consultant Paed estimated gestation to be 24 weeks based on weight.		staff acted appropriately. The team involved were debriefed following the incident. There is nothing that could have been done to prevent this.	
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	No follow up of blood tests taking, no accountability of close the loop.	Escalated to an SI which is currently ongoing. Safety briefing updated to include process to follow if there are conflicting clinical opinions. This requires escalation to senior clinicians for urgent input. Work ongoing with regards to assigned responsibility of ensuring blood results are followed up in a timely manner within emergency situations.
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 advanced	24.03.23	This mother had an operative delivery but this was not conducted with appropriate urgency/grading This mother was induced but the type of fetal monitoring used during	Discussed at CTG case review with all involved for immediate learning and debrief shared with wider team Improved communication between the obstetric and paediatric teams to make it clear

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

1.6 Health Safety Investigation Branch (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.

Date Reported	Incident Details	Immediate Action Taken
12/02/2023	Baby transferred for therapeutic cooling to a tertiary unit to reduce the impact of HIE. Meets the criteria for HSIB investigation.	Review of the case by the MDT, the review team. It was identified after birth that the baby had a congenital disorder that impacted on respiratory effort, this would have not been detected antenatally. Individual outdated practice was identified as an incidental finding and addressed with the individual.

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

HSIB Notification Category	Number Investigations Open
Maternal Death	1
Intrapartum Stillbirth	2
HIE/Cooling	2
Early Neonatal Death	1

All the above HSIB referrals have been subject to a thorough Patient Safety incident review which has been share with HSIB. Any immediate actions for learning have been shared with the wider MDT and the service is working with the Maternity Improvement Advisors to review the current systems and processes in place to provide more assurance around quality improvement and the closed loop of learning to demonstrate a reduction in incident themes.

2. Moderate Harm Incidents reported March 2023

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 representative of midwifery, obstetric, anaesthetic, and neonatal team members to ensure there is a multi-professional review of the care provided and care is in line with regional and national guidance to ensure that any learning or changes to practice are clearly identified and articulated to staff. The process supports women and their families to enable them to contribute to the review and support the debrief process. All women where there has been the potential for moderate harm receive a verbal Duty of Candour and are provided with a leaflet on informing them that their care will be reviewed at the Maternity Case Review meeting.

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.
WEB180229*	Second baby, instrumental delivery as failure to progress, 3c tear	

WEB180098*	First baby, vaginal birth, 3b tear	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
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 eight 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

2.1 Postpartum Haemorrhage

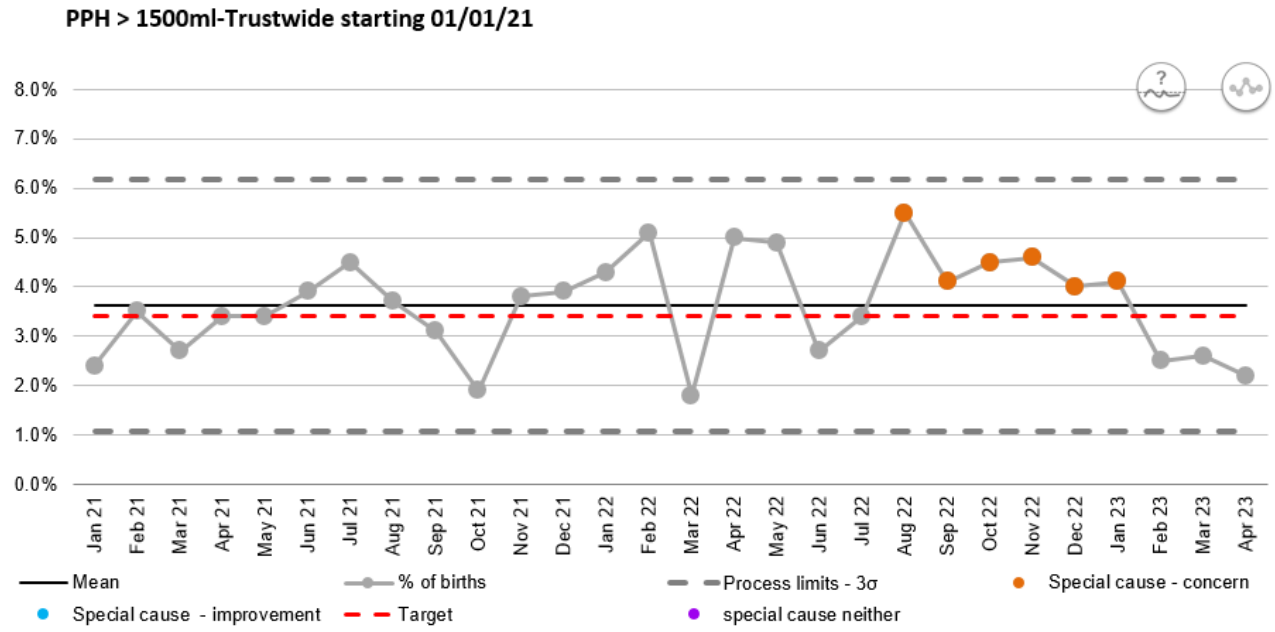
The national Maternity Services Data Set reports that the national average for PPH over 1.5 litres is 30/1000 births, the Trust average for Q4 is 40/1000 births.

In Q4% an average of 3.0% 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%.

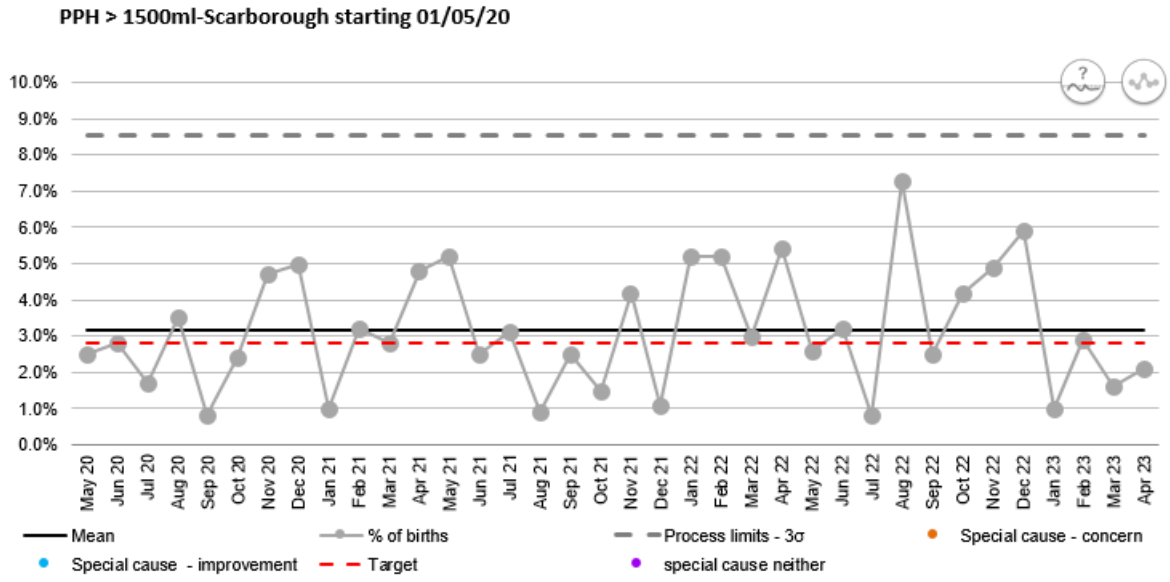
There has been a significant rise on a national level and reassuringly from the table below this demonstrates that the immediate management has been effective from time of escalation to ensure blood loss has not exceeded two litres

Blood Loss	Number in March 2023
1.5l – 1.9l	8 (range 1.5l – 1.9l)
2l – 2.4l	0
> 2l	0

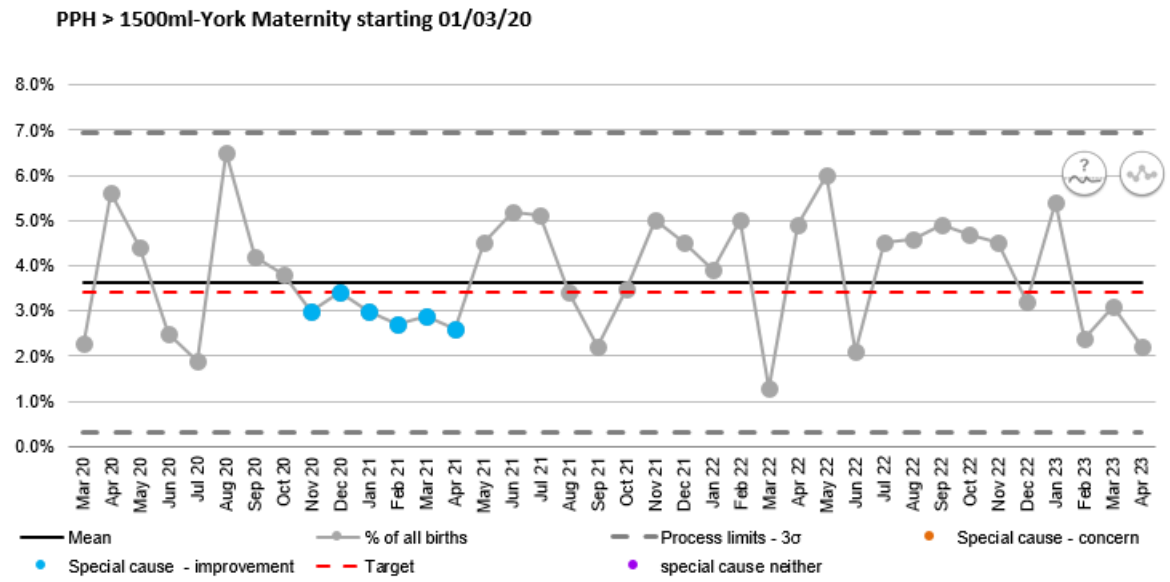
The MDT review identified that the escalation and management of all PPH in line with Trust guidelines. In five of the cases reviewed three were identified with elevated risk factors that would increase the likelihood of PPH. Three PPH occurred following trauma during birth.



There has been a downward trend in the Trust wide PPH rate however there has been no statistically significant improvement or decline during Q4.



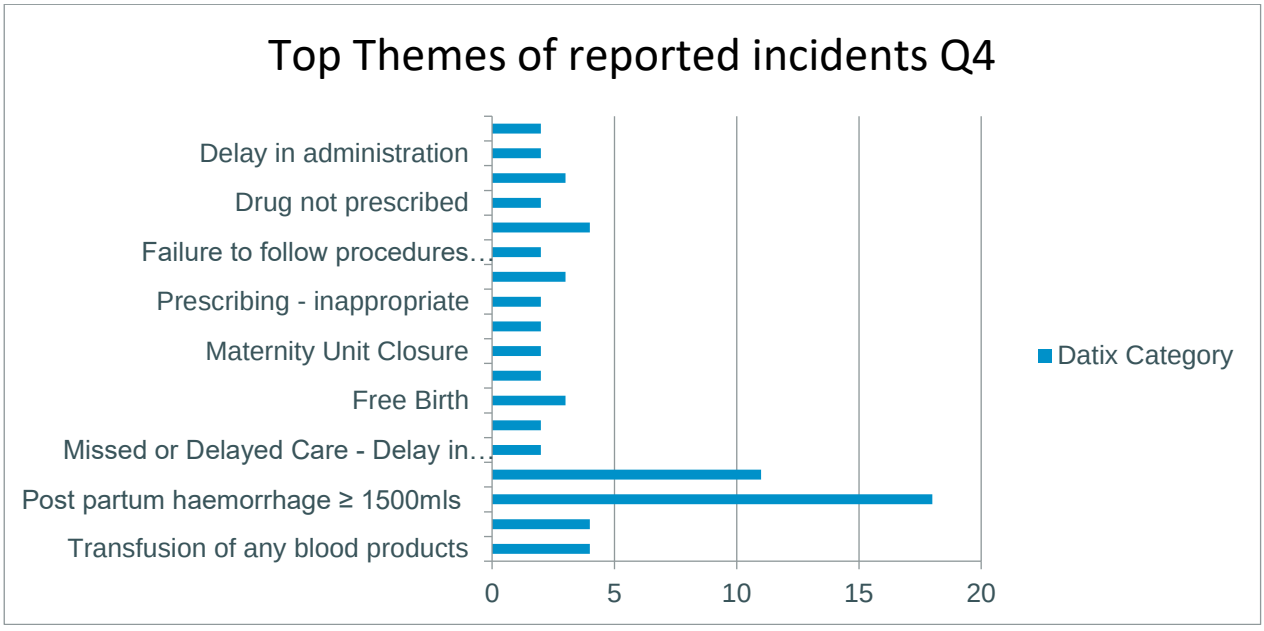
The mean rate at Scarborough remains above the national average with no improvement or decline in performance against this target.



The mitigation for this is that there are now scales in every delivery room to accurately weigh blood loss and provide a real time verbal update to the emergency team, the PPH risk assessment has been updated to ensure high risk women are identified, and therefore are proactively managed following delivery and these women are clearly identified in the handover boards on the labour ward rounds.

All PPH under 1500ml are reviewed by the cross site PPH Scrutiny Panel and the monthly snapshot audit overseen by the panel. The audit in March identified that there was inconsistency in the completion of the PPH risk assessment at 36 weeks The introduction of BadgerNet in the antenatal clinic in April 2023 has mandated the requirement for the PPH risk assessment to be completed at 36 weeks. The effectiveness of these risk assessments will form part of the ongoing audit plan in Q1 for 2023.

2.3 Themes of Incidents Reported



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 Special Care Baby Unit (SCBU).

2.4 Serious Incidents (SI's) (Q4 2023)

There have been three SI's declared in Q4 2023, these incidents are undergoing the formal investigation process with an estimated date for completion in May 2023.

Date Reported	Incident Details	Immediate Action Taken
11/01/2023	Postpartum haemorrhage following elective caesarean section. Total blood loss 3555mls SI declared. Investigation completed and to be presented at SI panel on 17.05.2023	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. Investigation completed, presented to Clinical Governance on 12.05.2023 and will be presented at SI panel on 24.05.2023	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
13/02/2023	PPH following caesarean section that resulted in a hysterectomy. SI declared. Extension request made due to availability of clinical records	Rapid improvement work undertaken around the scoring of MEWS and understanding the barriers to recognition, calculation, and escalation of the deteriorating patient

Immediate learning identified was around the prompt undertaking of maternal observations and the use of the Modified Early Obstetric Warning Score (MEOWS) in Maternity Triage and on the Labour Wards. Raising awareness about how and when to undertake MEOWS has been ongoing during April 2023 by Ward Leaders and Matrons on both sites, this has been through 1:1 support, safety briefing, updated communications to the staff and weekly monitoring of compliance by the Deputy Head of Midwifery.

There is an improvement plan in place which is being overseen by the Deputy Head of Midwifery and the Associate Chief Nurse to ensure MEOWS is completed as the Trust transition to BadgerNet, the aim is to reach the target of 90% compliance by the end of June 2023.

2.5 Compliance of consultant attendance for clinical situations

The Royal College of Obstetrics and Gynaecology (RCOG) Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (Updated 2022). The document has clear criteria for when a consultant must attend certain clinical situations. This criterion is highlighted through the maternity staffing standard operating procedure and discussed at the departmental meting for oversight.

This data should be submitted to the LMNS in preparation for MIS year 5

Compliance of consultant attendance for clinical situations	Jan 2023	Feb 2023	March 2023
In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	4	3	6
Any return to theatre for obstetric emergency	0	0	0
Team debriefs requested	-	-	-
If requested to do so	-	-	-
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary	-	-	-
Caesarean birth for major placenta praevia / abnormally invasive placenta	1	0	0
Caesarean birth for women with a BMI>50	-	-	-
Caesarean birth <28 /40	1	0	1
Premature twins <30/40	1	2	4
Fourth degree perineal tear repair	0	0	0
Unexpected intrapartum stillbirth	0	0	0
Eclampsia	-	-	-
Maternal Collapse e.g., septic shock, massive abruption	-	-	-
PPH >2l where the haemorrhage is continuing, and Massive obstetric haemorrhage protocol has been instigated	7	4	0

The required information to evidence compliance for Q4 is incomplete in several areas due to the current data collection methods. This will be addressed in May 2023 and a full data set will be presented in the next report by site.

3. Maternity Dashboard

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

3.1 York

YORK - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional Average for last Quarter	Jan-23	Feb-23	Mar-23
RESPONSIVE											
Activity	**Births**	Bookings	1st m/w visit	CPD	≤295	296-321	≥322		302	216	291
		Bookings <10 weeks	No. of mothers	CPD	≥90%	68.1%-89%	≤68%	68.20%	65.1%	76.2%	80.1%
		Bookings ≥13 weeks (exc transfers etc)	No. of mothers	CPD	< 10%	10.1%-19.9%	>20%		7.0%	6.1%	8.3%
		Births	No. of babies	CPD	≤245	246-266	≥267		216	204	223
		No. of women delivered	No. of mothers	CPD	≤242	243-263	≥264		214	200	218
		Planned homebirths	No. of mothers		≥2.1%	≤2-1.6%	≤1.5%	1.20%	0.0%	0.0%	0.0%
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3		4 or more		20	20	10
		Women affected by suspension	No. of women	Comm. Manager	0		1 or more		1	1	1
		Community midwife called in to unit	No. of times	Comm. Manager	0-3	4-5	6 or more		7	0	5
		Maternity Unit Closure	No. of closures	Matron	0		1 or more			0	
	SCBU	SCBU at capacity	No of times	SCBU					9	16	
		SCBU at capacity of intensive cots	No. of times	SCBU					19	11	
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more		0	0	
WELL LED											
Workforce	**Staffing**	M/W to birth ratio	Ratio	Matron	≤29.5	29.6 - 31	>31	DH			
		1 to 1 care in Labour	CPD	CPD	100%		≤99.9%	94.50%	99.4%	99.4%	100.0%
		L/W Co-ordinator supernumary %	Shift Handover Sheets	Risk Team	100%		≤99.9%			100.0%	
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	10	4-9	≤3		10	10	10
SAFE											
Clinical	**Neonatal/Maternal**	Normal Births	No. of svd - %	CPD	≥57%	≤56.9-54%	<54%	57%	54.8%	56.2%	47.3%
Indicators	**Morbidity**	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤12.4%	≥12.5-14%	≥14.1%	10%	13.1%	8.5%	15.1%
		C/S Births	Em & elect - %	CPD				33%	31.3%	34.0%	38.1%
		Elective caesarean	%	CPD				14%	16.8%	17.0%	18.3%
		Emergency caesarean	%	CPD				19%	14.5%	17.0%	19.7%
		Induction of labour	%	CPD				36%	44.4%	43.5%	37.2%
		HDU on L/W	No. of women	L/W Activity Sheet	5 or less	6-9	10 or more			8	
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		2	0	3
0		HSIB cases	No. of babies	SCBU Paed	0				0	0	0
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more		0	0	
		Antepartum Stillbirth	No. of babies	Risk Team	0	1		n/a	1	0	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	n/a	0	0	0
	Neonatal Indicators	Cold babies	No of babies admitted to SCBU cold (<36.5)		1 or less	2-3	4 or more		0	0	
		Preterm birth rate <37 weeks	% of babies born <37 weeks	CPD	≤6%	6-9%	≥10.1%	8.40%	8.80%	7.40%	7.60%
		Preterm birth rate <34 weeks	% of babies born <34 weeks	CPD	≤2%	2.1-3%	≥3.1%	1.50%	4.70%	2.90%	3.60%
		Preterm birth rate <28 weeks	% of babies born <28 weeks	CPD	≤0.5%	0.6-0.9%	≥1%	0.40%	0.50%	0.00%	0.00%
		Low birthweight rate at term (2.2kg)	% of babies <2.2kg at term	CPD	0%	0.1-0.4%	≥0.5%	0.80%	0.50%	0.00%	0.40%
	Public Health	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	≥75%	≤74.9-71%	≤70.9%	65%	70.7%	75.0%	77.6%
		Breastfeeding rate at discharge	% of babies breastfeeding at discharge	CPD	>65%	60.1-64.9%	<60%		56.7%	60.8%	65.5%
		Smoking at booking	% of women smoking at booking	CPD	≤6%	≥6.1-10%	≥10.1%	13%	7.6%	10.7%	
		Smoking at 36 weeks	% of women smoking at 36 weeks	CPD	≤6%	≥6.1-10%	≥10.1%	8%	2.7%	2.9%	3.5%
		Smoking at time of delivery	% of women smoking at del.	CPD	≤6%	≥6.1-10%	≥10.1%	12%	9.8%	9.0%	6.9%
		Carbon monoxide monitoring at booking	% CO completed	CPD	≥95%	80-95%	≤79.9%		85.7%	83.6%	%
		Carbon monoxide monitoring at 36 weeks	% CO completed	CPD	≥95%	80-95%	≤79.9%		6.3%	7.6%	11.9%
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more		1	2	0
		PPH > 1.5L as % of all women	% of births	CPD				0.0	4.5%	2.4%	3.10%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more		2	0	2
		3rd/4th Degree Tear - normal birth	No of women	CPD	≤2.8%	2.9- 4.5%	≥4.6%	1.90%	1.1%	1.1%	1.1%
		3rd/4th Degree Tear - Assisted birth	No of women	CPD	≤6.05%	≥6.1-8%	≥8.1%	6%	3.6%	5.9%	6.1%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more		3	4	5
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more		3	5	1

3.2 Scarborough

SCARBOROUGH - MATERNITY DASHBOARD			Measure	Data source	No Concerns (Green)	Of Concern (Amber)	Concerns (Red)	Regional average for last	Jan-23	Feb-23	Mar-23
RESPONSIVE											
Activity	**Births**	Bookings	1st m/w visit	CPD	≤169	170-184	≥185		178	113	82
		Bookings <10 weeks	No. of mothers	CPD	≥90%	68.3%-89.9%	≤68.2%	68.20%	68.50%	77.00%	64.91%
		Bookings ≥13 weeks (exc transfers etc.)	No. of mothers	CPD	< 10%	10%-20%	>20%		6.2%	3.5%	6.9%
		Births	No. of babies	CPD	≤113	114-134	≥135		97	103	121
		No. of women delivered	No. of mothers	CPD	≤112	113-133	≥134		96	103	118
		Planned homebirths	No of mothers		≥2.1%	≤2-1.5%	≤1.5%	1.20%	0.0%	0.0%	0.0%
	Closures	Homebirth service suspended	No. of suspensions	Comm. Manager	0-3		4 or more		24	18	24
		Women affected by suspension	No. of women	Comm. Manager	0		1 or more		1	0	0
		Community midwife called in to unit	No. of times	Comm. Manager	3	4-5	6 or more		3	3	1
		Maternity Unit Closure	No. of closures	Matron	0		1 or more		0	3	
	New for May2017	SCBU at capacity	No of times	SCBU					0	0	
		SCBU at capacity of intensive care cots	No. of times	SCBU					2	11	
		SCBU no of babies affected	No. of babies affected	SCBU	0	1	2 or more		0	0	
WELL LED											
Workforce	**Staffing**	M/W to birth ratio	Ratio	Matron	≤29.5	29.6-30.9	>31	DH			
		1 to 1 care in Labour	CPD	CPD	≥100%		≤99.9%	94.50%	100.0%	97.8%	98.9%
		L/W Co-ordinator supernumerary %	Shift Handover Sheets	Risk Team	≥100%		≤99.9%		95.2%	97.3%	
		Anaesthetic cover on L/W	av.sessions/week	DM / CD	≥10	4-9	≤3		5	5	5
SAFE											
Clinical	**Neonatal/Materna**	Normal Births	No. of svd - %	CPD	≥57%	56.9-54%	<53.9%	57%	51.5%	56.7%	47.5%
Indicators	**Morbidity**	Assisted Vaginal Births	No. of instr. Births - %	CPD	≤12.4%	≥12.5-14%%	≥14.1%	10%	9.4%	8.7%	9.3%
		C/S Births	Em & elect - %	CPD				33%	38.5%	33.0%	41.5%
		Elective caesarean	%	CPD				14%	17.7%	10.7%	17.8%
		Emergency caesarean	%	CPD				19%	20.8%	22.3%	23.7%
		Induction of labour	%	CPD				36%	35.4%	33.0%	39.8%
		HDU on L/W	No. of women	L/W Activity Sheet	5 or less	6-9	10 or more		3	3	
		BBA	No. of women	Risk Team - Datix	2 or less	3-4	5 or more		0	1	2
		HSIB cases	No. of babies	SCBU Paed	0	1			0	1	0
		Neonatal Death	No of babies	Risk team- EBC	0		1 or more		0	0	
		Antepartum Stillbirth	No. of babies	Risk Team	0	1	2 or more	N/A	1	0	0
		Intrapartum Stillbirths	No. of babies	Risk Team	0		1 or more	N/A	0	0	0
	Neonatal Indicator	Cold babies	No of babies admitted to SCBU cold (<36.5)		1 or less	2-3	4 or more		0	0	
		Preterm birth rate <37 weeks	% of babies born <37 weeks	CPD	≤6%	6-9%	≥10.1%	8.40%	9.4%	5.8%	11.60%
		Preterm birth rate <34 weeks	% of babies born <34 weeks	CPD	≤1%	1.1-2%	≥2.1%	1.50%	3.1%	1.0%	5.0%
		Preterm birth rate <28 weeks	% of babies born <28 weeks	CPD	≤0.5%	0.6-0.9%	≥1%	0.40%	0.00%	0.00%	0.80%
		Low birthweight rate at term (2.2kg)	% of babies <2.2kg at term	CPD	0%	0.1-0.4%	≥0.5%	0.80%	0.0%	1.9%	0.8%
	Public Health	Breastfeeding Initiation rate	% of babies feeding at birth	CPD	≥75%	71-74%	≤70%	65%	58.3%	53.4%	52.9%
		Breastfeeding rate at discharge	% of babies breastfeeding at dischar	CPD	≥65%	61-64%	≤60%		46.90%	39.80%	42.10%
		Smoking at booking	% of women smoking at booking	CPD	≤6%	≥6.1-10%	≥10.1%	13%	15.2%	15.9%	
		Smoking at 36 weeks	% of women smoking at 36 weeks	CPD	≤6%	≥6.1-10%	≥10.1%	8%	7.2%	5.8%	9.0%
		Smoking at time of delivery	% of women smoking at del.	CPD	≤6%	≥6.1-10%	≥10.1%	12%	14.6%	14.6%	14.4%
		Carbon monoxide monitoring at booking	% CO completed	CPD	≥95%	80-95%	≤79.9%		78.7%	77.0%	
		Carbon monoxide monitoring at 36 weeks	% CO completed	CPD	≥95%	80-95%	≤79.9%		24.70%	18.30%	25.40%
	Risk Management	SI's	No. of SI's declared	Risk Team	0		1 or more		0	1	
		PPH > 1.5L as % of all women	% of births	CPD				3.80%	1.00%	2.90%	1.60%
		Shoulder Dystocia	No. of women	CPD	2 or less	3-4	5 or more		2	2	0
		3rd/4th Degree Tear - normal births	No of women	CPD	≤2.8%	2.9- 4.5%	≥4.6%	1.90%	1.1%	0.0%	0.0%
		3rd/4th Degree Tear - assisted birth	No of women		≤6.05%	≥6.1-8%	≥8.1%	6%	0.0%	0.0%	0.0%
	New Complaints	Informal	No. of Informal complaints	Risk Matrix	0	1-4	5 or more		0	0	
		Formal	No. of Formal complaints	Risk Matrix	0	1-4	5 or more		1	3	

3.3 Summary of Exceptions – Performance Data:

The introduction of BadgerNet in the antenatal setting in March 2023 has impacted the data collection for March therefore some of the data is not available for that month. This will be rectified in the next report as the data will be available on BadgerNet.

The number of booking appointments < 10 weeks is consistently below the target of 95%, a full review will be undertaken to understand if this is due to women presenting for booking appointments later or if is a data quality issue, this will be presented in Julys paper.

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, there has been a timeout with staff and the MVP with opportunities to explore new models, these discussions are ongoing, and the department continue to engage the services of Independent Midwives to facilitate choice for our women and birthing individuals. The MIAs are undertaking a full workforce review to understand the funded establishment, vacancy shortfalls, on call provision and escalation policy. A further birth-rate plus exercise has been commissioned to support this to ensure that women and families in York and Scarborough have equitable and safe services.

The number of births remains consistent across both sites however, the data indicated that mode of birth across both sites has noticed a decrease in vaginal birth and an increase in elective caesarean sections and inductions of labour. An audit will take place to review the cases to demonstrate whether this is an ongoing theme.

A business case was written to increase the number of elective caesarean section theatre lists from half day to full day to manage the capacity in York, this was not approved. Within any new business case there will need to be evidence that the current lists are used up to at least 85% which is challenging due to maternity not using the element of CPD that the rest of theatres use. At York, the department are working through a back-to-basics demand and capacity planning and utilisation review at York with a planned completion.

There is evidence of extra ad hoc lists and the efforts undertaken to book the lists more efficiently.

The Department need to understand the theatre capacity in Scarborough with a proposed plan for an options appraisal for elective LSCS taking place in main theatre to ensure there are no delays in emergency LSCS.

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, oversight of inductions of labour occurs at the daily staffing huddles and MDT ward rounds to enable prioritisation of risk.

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.

3.4 Summary of Exceptions - Public Health Data

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

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.

The dashboards 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 than one format and stored in more than one location is on the Obstetric Risk Register.

3.5 Saving babies lives V2

Saving Babies Lives version 3 was due to be published on the 30th march this has been delayed ensuring that this is published with the updated core competency framework. There has been a sixth element within the standards which relates to the management of diabetes in pregnancy and additional audits will be commenced on receipt of the report.

The trust remains non-compliant with SBLv2, this not only poses a safety risk to both the mother and baby but noncompliance with standard six of the Maternity Incentive Scheme

Element		**Compliance**
Element 1 Reducing Smoking in Pregnancy	Target eighty% compliance	Unable to demonstrate compliance
Element 2 Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction	Target eighty% compliance	Unable to demonstrate compliance
Element 3 Raising awareness of reduced fetal movements	Target eighty% compliance	Unable to demonstrate compliance
Element 4 Effective fetal monitoring during labour	Target ninety% compliance	Unable to demonstrate compliance

Element		Compliance
Element 5 Reducing preterm birth	Target eighty-five% compliance	Unable to demonstrate compliance

The Maternity Improvement Advisors will be supporting the oversight of compliance, mitigations and any resource required to achieve compliance of the national safety standard. The committee are asked to note this safety concern fir escalation to the trust board.

A highlighted risk for escalation has been identified.
Following a snapshot audit of Ultrasound in maternity, it has been identified that there are several areas of concern. The audit benchmarked against national standards for scan within 72 hours of referral as outlined by the Perinatal institute and within our own trust guidance. The audit shows significant delays of longer than 10 days of time from referral to scan in some cases. Fifty-two percent waited nine -13 days from referral in April. Even with the extra scan capacity of WLI as shown below, the time delays remain significant enough to potentially result in stillbirth due to the delay. In Feb 2023, a 15-day delay was identified as part of a still birth SI. There is no assurance currently that this will not recur. A full review of demand and capacity are being undertaken and increase in scan requirements has increase exponentially within the last 3 years with service provision not meeting the demand. Immediate mitigations will be to review scan capacity cross site to maximise availability and review seven-day service, explore regional outsourcing for scan availability review current risk score for further escalation and executive oversight,

4. Training Compliance

4.1 York Midwives/MSW/HCA

Maternity Specific Training	Projected % April	Actual %April
PROMPT - Midwives	95	85
PROMPT - HCAs	92	81
NLS	95	89
Fetal Monitoring including K2 competencies	72	60
Personalised Care - Year 2 (2023)	29	30
SBLBC - Supporting a smoke free pregnancy	N/A	53
SBLCB - Detection and surveillance of growth restrictions	N/A	42
SBLBC - Reduced Fetal Movements	N/A	45
SBLCB - Effective continuous fetal monitoring	N/A	44
SBLCB - Reducing pre-term birth	N/A	48
Perinatal Mental Health	N/A	96
Professional Midwifery Advocate	N/A	89

Antenatal and New-born screening	N/A	62
Learning from incidents, complaints and claims	N/A	83
Substance misuse	N/A	87
Student Midwife support and supervision	N/A	65
Bereavement	N/A	87
Bereavement - HCAs	N/A	54
Infant Feeding	N/A	87
2 Day BFI - Midwives/MSW/HCA	N/A	79

4.2 York Medical Staff

Maternity Specific Training	Projected % April	Actual% April
PROMPT - Consultants	80	64
PROMPT - Other medical staff	84	78
Fetal Monitoring inc. K2 competencies - Consultants	80	64
Fetal Monitoring inc. K2 competencies - Other medical staff	47	39
Risk assessments and Personalised care - Consultants	N/A	36
Risk assessments and Personalised care - Other medical staff	N/A	39
SBLBC - Supporting a smoke free pregnancy - Consultants	N/A	64
SBLBC - Supporting a smoke free pregnancy - Other medical staff	N/A	50
SBLCB - Detection and surveillance of growth restrictions - Consultants	N/A	64
SBLCB - Detection and surveillance of growth restrictions - Other medical staff	N/A	61
SBLBC - Reduced Fetal Movements - Consultants	N/A	64
SBLBC - Reduced Fetal Movements - Other medical staff	N/A	61
SBLCB - Effective continuous fetal monitoring - Consultants	N/A	71
SBLCB - Effective continuous fetal monitoring - Other Medical staff	N/A	39
SBLCB - Reducing pre-term birth - Consultants	N/A	64
SBLCB - Reducing pre-term birth - Other medical staff	N/A	56
Perinatal Mental Health - Consultants	N/A	93
Perinatal Mental Health - Other medical staff	N/A	56
Antenatal and New-born screening - Consultants	N/A	86
Antenatal and New-born screening - Other medical staff	N/A	50
Learning from incidents, complaints and claims - Consultants	N/A	36
Learning from incidents, complaints and claims - Other medical staff	N/A	33

Maternity Specific Training data for Scarborough was not available for this report and will be included in June's report. This is a trust wide reporting issue and therefore does not

provide assurance on the accuracy of data. There needs to be a targeted and structured approach to the delivery of mandatory training within the maternity services and will require adequate resources to undertake this. It is currently unclear what the uplift is for the maternity services and the percentage of training that is allocated within this uplift. The national requirements are that there will be four to five full days per year for midwives and obstetricians to undertake all of the required maternity specific and trust wide mandatory training

The committee need to note that the updated NICE guidance December 2022 in relation to fetal wellbeing has not been implemented by the trust and therefore the trust is currently working outside of guidance. The Maternity Improvement Advisors have provided updated guidance, study day tools and a competency assessment that can be completed on the day. This will provide immediate assurance that staff have the relevant skills and knowledge to provide evidenced based care. SBLv2 recommends that staff who are not competent and have passed their competency assessment should not be providing intrapartum care in the labour ward environment. The MIA will be working with the fetal wellbeing leads to implement a new process that provides greater assurance and therefore safer care.

5. Staffing

5.1 Medical and Midwifery Staffing

Scarborough current medical vacancy is one consultant and two registrars. York medical vacancy is one consultant on long term sick and one consultant vacancy. The establishment gaps impact the rotas and requires the service to rely on locums, with demonstrated fill rates. From a safety perspective, relying on locums' services poses its own challenges not only in a financial impact but on the capacity for clinics across maternity pathways, particularly scanning and antenatal. The Departments are providing some mitigation by having additional registrar clinics and requesting consultants to undertake extra clinics where able.

Recruitment
All vacant posts are out to advert and have the best establishment in medical staffing since the beginning of 2022 and in addition the recovery of Scarborough medical staffing from a 1:2 to a present 1:8 acute rota. The Scarborough medical team support York with their deficit of capacity and there isa rotating Consultant from York now as part of the Scarborough non-resident on call rota and cross-site oversight for maternal and foetal medicine clinical leads.

Sick leave:
One person on sick leave out of 24 Consultants across the two sites – phased return is being discussed, Locum cover in the meantime.

Clinical leadership:
Proposals discussed with MIA and Medical Director for expanding dedicated maternity transformation leadership and finding a replacement for the current Clinical Governance lead role.

Culture:
Good numbers of medical staff booked onto the MDT workshops scheduled (x8) during May and June. Survey of juniors through college tutor to support whether there are concerns around culture from our junior staff.

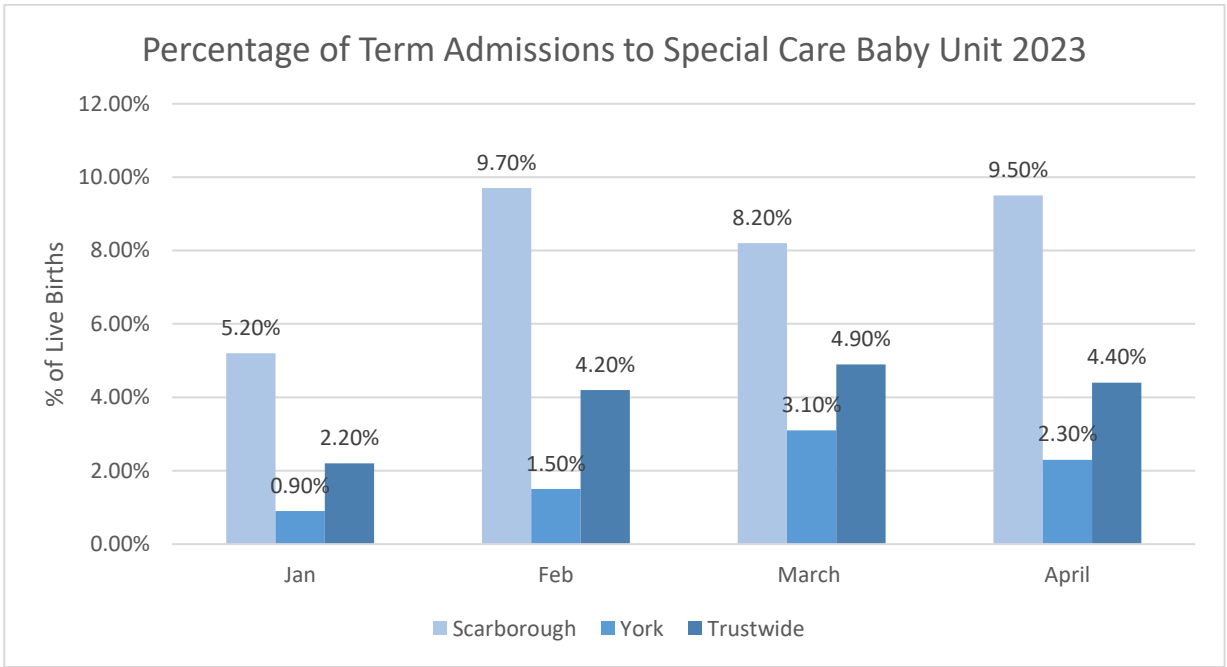
Dedicated obstetrics service triumvirate for all medical staff to join to engage with all aspects of maternity transformation – meets monthly. Further expanding this dedicated time from June to support the maternity improvement programme work.

5.2 Scrub Nurses

- A 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.
- An electronic roster for maternity theatres is in development.
- Recruitment for 27 WTE Theatre Scrub Practitioners has been approved by the Trust Board.
- A continuous advert for band 5 Theatre Practitioners / ODP's in Maternity was published on Trac on the 12 April 2023.
- As of the week commencing 24 April 2023,17 applications had been submitted.
- International recruitment is being considered to fill these vacant posts as the Trust will shortly be recruiting in India.
- The Maternity Theatre Manager has developed a Maternity Theatre Staffing Plan

6. Unexpected admissions to SCBU

The national maternity and neonatal transformation programme have 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.



Date source: Si

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 combined Trust rate is consistently below 5% however the data indicates an increased percentage of admissions at the Scarborough site. The disproportionate numbers of term admissions to Scarborough are understood to be due to outdated practice form some of the departments mature long term locums' paediatricians

who tend to be cautious and “just admit” rather than wait and see. There probably is not anything in nursing practice other than direct challenge to the medical teams in respect of admission to SCBU and the Head of Children’s Nursing will take this forward

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.

ATAIN in York is in place, there is a registrar for Paediatrics who has engaged in the process with Obstetric input to form a meaningful ATAIN process with the support of the Deputy Head of Midwifery.

In Scarborough there is no neonatal lead and there is a barrier to these meetings happening from all areas. The Interim Associate Chief Nurse and Deputy Head of Midwifery will be working together to improve this situation and a cross site ATAIN meeting is under consideration. There is a disproportionate number of term admissions to Scarborough SCBU as opposed to York and a process is in development to review these term admissions. The Care Group Director and Clinical Director for Paediatrics are arranging to review the ATAIN cases with the Maternity Improvement Advisor in May to understand where improvements in the pathway can be made and will discuss directly with the Consultants, but without a neonatal lead embedding modern practice this will be a challenge. The cross-site Neonatal Lead Consultant is out to advert with several enquiries leading the service to be confident to recruit, ATAIN improvement will be a key objective for this new Consultant.

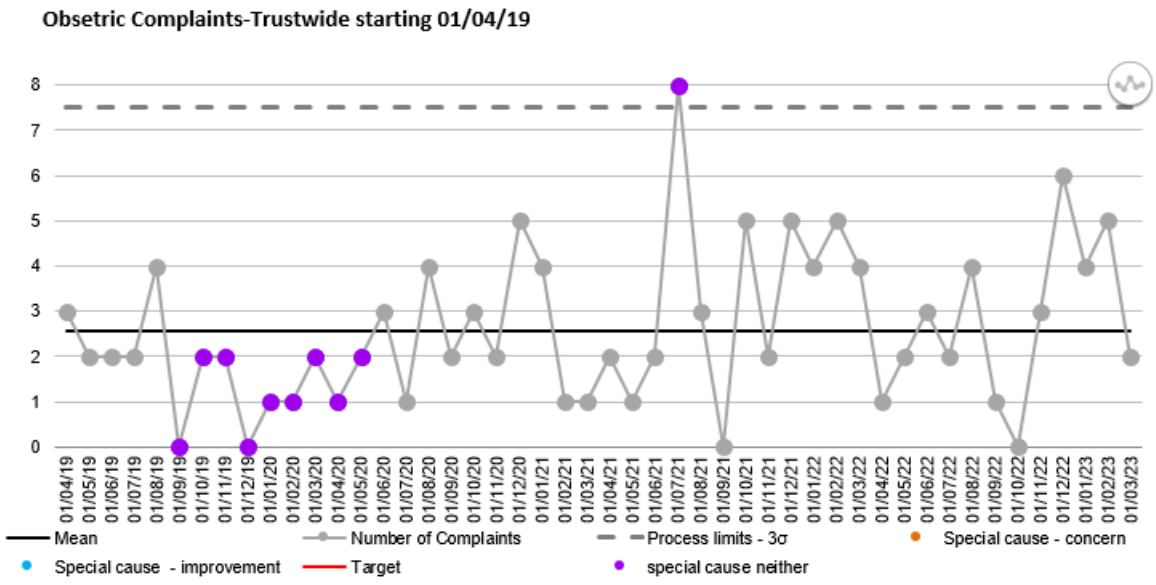
6.1 Transitional care

The transitional care bay at York was suspended in January 2023 and moved into another area of the ward. There has been a delay in re-opening due to the required estates works. This has now been completed with the estimated date for reopening on w/c 22 May 2023. Noncompliance with transitional care will therefore be non-complaint with MIS year 5 so therefore the committee are asked to support the expedition of works required to complete the Transitional care works at York. A full review of transitional care and ATAIN will be undertaken by the Mia's to provide further assurance

7. Service User Feedback

7.1 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.

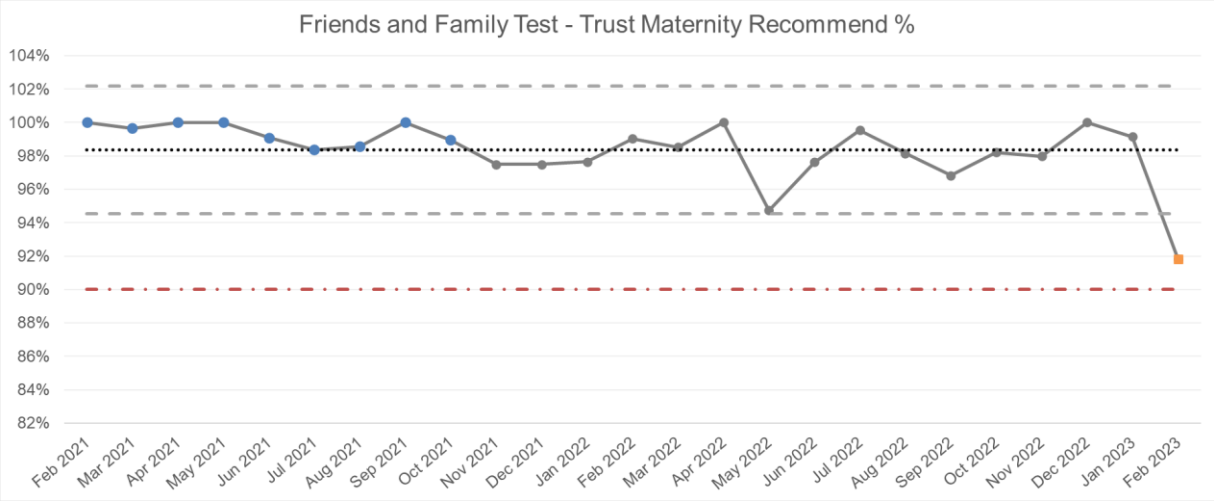
Examples of completed complaint responses and actions are below:

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.

7.2 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. The Deputy Head of Midwifery has a planned meeting with the Patient Engagement Lead in May to review maternity's position. It is apparent that many staff consider we do not collect Family and Friends Test anymore and have reported receiving no information for many years about this metric. The Department plan to relaunch Family and Friends Test but prior to this we wish to understand how Badgernet can be used, and how we will collate our results.

7.3 Maternity Voices Partnership

The first '15 moments' visit took place on the 25th of April in York visiting Labour Ward, Antenatal Day Services and G2 with plans to undertake in Scarborough in June. The meeting was incredibly positive and leads us forward on our journey of co-production. 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.

7.4 Safety Champions

The MAT Neo Maternity Safety Champions Meetings have been refreshed with new Terms of Reference and agenda and met on 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 Non-Executive Director (NED). The last walkaround with the Chief Nurse and NED on the 27th of April raised the following themes highlighted below and will be discussed at the Senior Maternity Meetings with plans for improvement and fed back at the next Safety Champions meeting in June.

Communication remains an issue and this is variable. A request made for mask wearing to cease, compliance was poor at the time of the visit, The DoM is working with the Lead Nurse for IPC to understand the Trust and LMNS to understand their positions. A concern was made by a coordinator that there had been poor communication about the labour ward manager post, after showing interest there was no feedback. The Manager of the day role was raised as an issue in the lack of consistency with how the role was conducted, some were more visible than others , and some more able to be of assistance particularly on labour ward. It was not clear what value the role was adding. Issues on G2 re inductions link into the issues raised at the previous month re capacity and demand and staffing ratios which is all part of ongoing discussions within the service. Some staff did not like the mix of antenatal/postnatal work and felt they could not deliver the postnatal care as they would wish. Lack of visibility of senior team continues to be raised.

8. Recommendations

The Trust Board is asked to.

i) Receive and discuss the report
ii) Recognise the significance of this report for the Maternity Service and that further detailed work is required to ensure full compliance
iii) Escalate the associated risks highlighted

Report to:	Board of Directors
Date of Meeting:	24 May 2023
Subject:	CQC Section 31 Update
Director Sponsor:	Heather McNair, Chief Nurse
Author:	Sue Glendenning, Interim Director of Midwifery

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

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

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

On the 25 November 2022, the CQC decided under Section 31 of the Health and Social Care Act 2008 to impose conditions on the Trust registration in respect of maternity and midwifery services. The structure of the update papers aligns with the CQC themes.

Recommendation:

- To approve the submission of the Section 31 update to the CQC on Tuesday 23 May 2023.

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

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

CQC Section 31 Progress Update

Maternity Services at York and Scarborough NHS Foundation Trust have embarked on a programme of service and quality improvements.

This report provides assurance on the progress to date in delivering against the improvement plan for the purpose of the monthly submission to CQC following the section 31 notice.

A. Assessing and Responding to Patient Risk

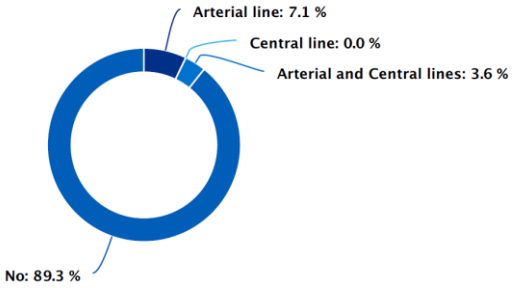
A.1 Arterial Line

The Care Quality Commission (CQC) found that a patient with an arterial line was being managed on the labour ward.

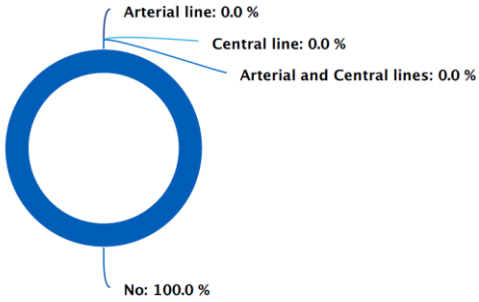
There have been no reported incidents within the maternity department in relation to the management of obstetric patients requiring an arterial line since the CQC reported their concerns in November 2022.

All women requiring enhanced maternity care are entered into the Yorkshire and Humber Maternity Clinical Network's Maternal Enhanced and Critical Care (MEaCC) Audit tool.

Invasive Monitoring York:



Invasive Monitoring Scarborough:



The practice development midwives complete the audits and review and monitor all women who receive enhanced care before, during or after delivery. The audit confirmed that all women at the York site who had an arterial line sited were cared for in the obstetric theatre and had the line removed before leaving theatre.

The Trust have thirteen midwives who have undertaken the Maternal Aims and PROMPT Care of the Critically Ill Pregnant or Postpartum Woman course providing them with the skills to provide enhanced care which include the care of women with arterial lines. Further training sessions will take place with sessions on both sites in July and further sessions arranged until the services can safely provide the 5.2 WTE midwives on each site required to provide enhanced maternity critical care on both sites. The aim is that this is completed by the end of 2023.

A.2 Fetal Monitoring and CTG

A.2.1 CTG Machines

Following the inspection in October 2022, the CQC were concerned about the lack of availability of cardiotocography machines (CTG).

Availability of CTG Machines (April 2023)

- Seventy percent increase in the availability of CTG machines at York Hospital since the CQC inspected (six to 20)
- Sixty-seven percent increase in the availability of CTG machines at Scarborough Hospital since the CQC inspected (five to 15)
- There have been no incidents escalated where a CTG monitor has been needed but one has not been available.
- The addition of the availability of CTG machines (in line with the Trust SOP) has been requested to be added to the Tendable Ward Audit Programme with the aim to have this in place during May 2023
- CTG machine availability remains as a prompt on the twice daily MDT Staffing Huddle .

No incidents have been reported relating to the availability of CTG machines since the delivery of the additional machines commenced in December 2023.

York Hospital Area	No of CTG Machines (SOP Requirement)	Actual (27 April 2023)
Labour Ward	10	10
Triage	3	4
G2	6	4
Antenatal Day Unit	2	2
Floating	2	One under repair Two loaned to Scarborough

Scarborough Hospital Area	No of CTG Machines (SOP Requirement)	Actual (27 April 2023)
Labour Ward	11	10
Hawthorn Ward	4	3
Antenatal Day Unit	2	2
		Four under repair

- Immediate action was taken and a CTG machine was transferred from Triage to G2 at York to align the CTG location with the SOP
- Based the needs of the service at the time of the audit, the distribution of CTG machines was deemed sufficient.

- A complaint has been raised with Huntleigh (manufacturer) by the Medical Engineering Team due to the delays in getting replacement parts

A.2.2 CTG Training

Low compliance rates were found for CTG training for medical and midwifery staff.

It has been identified that compliance with the fetal monitoring training is significantly impacted by staff not completing the online K2 assessment. As of 30 April 2023, compliance levels for the face-to-face element of the training are shown below:

Staff Group	Numbers	% Compliance
York Midwives	**162/176**	**92%**
Consultants	**12/15**	**80%**
York Med staff	**10/17**	**59%**
SGH Midwives	**59/70**	**84%**
SGH Consultants	**6/8**	**75%**
SGH Med staff	**10/14**	**71%**

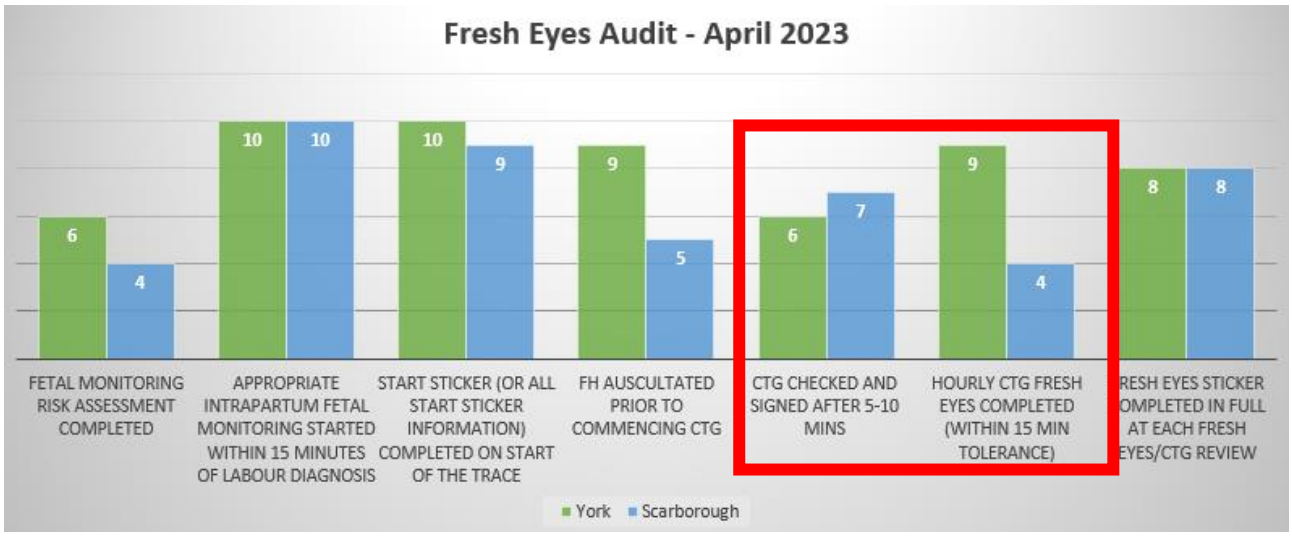
The Maternity Improvement Advisor has recommended the Trust develops its own assessment. This is in progress and should improve compliance, as the content will be easier to access, and allow better oversight of the assessment process.

In the meantime, non-compliance has been escalated within the Care Group and K2 assessments will be completed until the Trust assessment has been developed. All staff who are non-compliant with the K2 assessment have been identified and have been given the deadline of 26 May 2023 to complete the assessment.

A.2.3 Fresh Eyes Audit

In the November CQC inspection review of eleven patient records, evidence to support the completion of hourly fresh eyes was found in only one record. It was also noted that staff were not interpreting, classifying, or escalating CTG's appropriately. Documentation on CTG was poor and not in line with NICE guidelines.

A monthly record audit (10 x York and 10 x Scarborough) is undertaken. The April 2023 data can be seen below:



There has been improvement in compliance with the hourly CTG check at the York site and improvement in Scarborough for signing at checking the CTG after 5 – 10 minutes.

In addition to the monthly audit, a deeper dive audit has been undertaken in May 2023 using April's records by the Quality and Governance Team. This audit reviewed twenty-eight sets of records at York and fifteen at Scarborough where fetal monitoring had been used in April 2023. This audit looked beyond the completion of fresh eyes and reviewed the categorisation of the CTG and the care plan that was then put in place. The audit results are currently being analysed and the action plan developed. Early findings from the audit are.

- Full completion of the sticker and timeliness of fresh eyes at York is not consistent however the auditor agreed with the classification of the CTG in 27/28 records audited
- The care plans at York were audited as being appropriate and safe
- The stickers and fresh eyes are being completed fully at Scarborough however, the auditor disagreed with the classification of the CTG in 4/15 records audited. This was immediately escalated with the Fetal Monitoring Lead Midwife to address with the staff involved in the care and feedback learning

The full audit results and action plan will be share following approval through the speciality governance meeting on 8 June 2023.

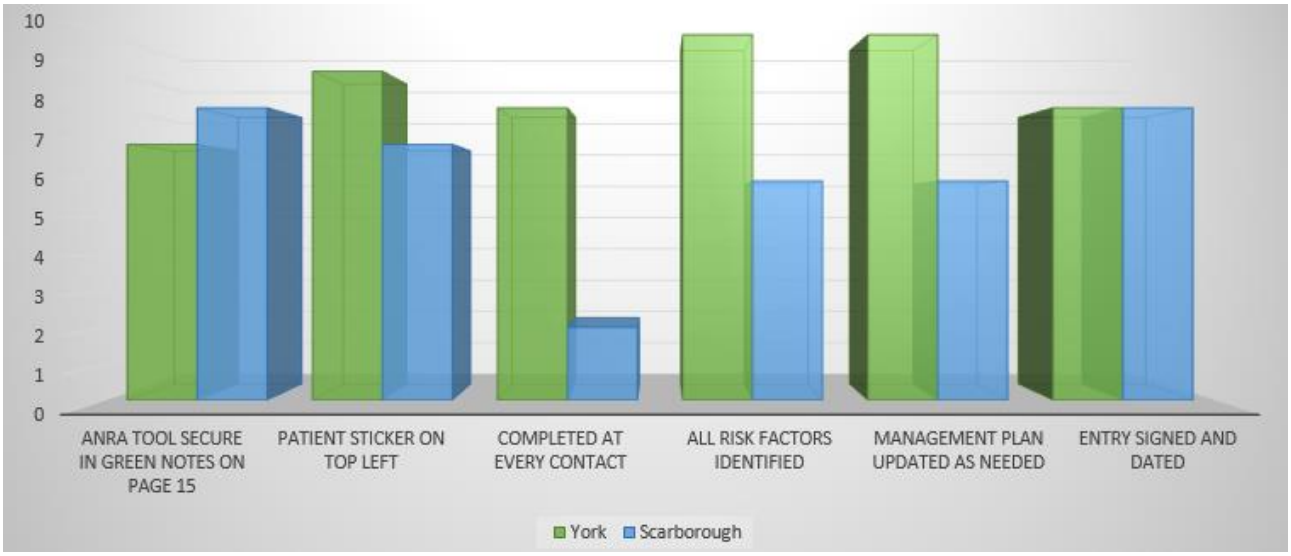
The following audits feature on the 2023/24 Clinical Audit Plan for Care Group Five (Family Health):

- Intrapartum Fetal Monitoring Audit
- CTG Classification and Documentation Audit

A.3 Risk Assessments

The CQC found evidence in patient records which showed incomplete assessments of risk and plans of care to mitigate such risks.

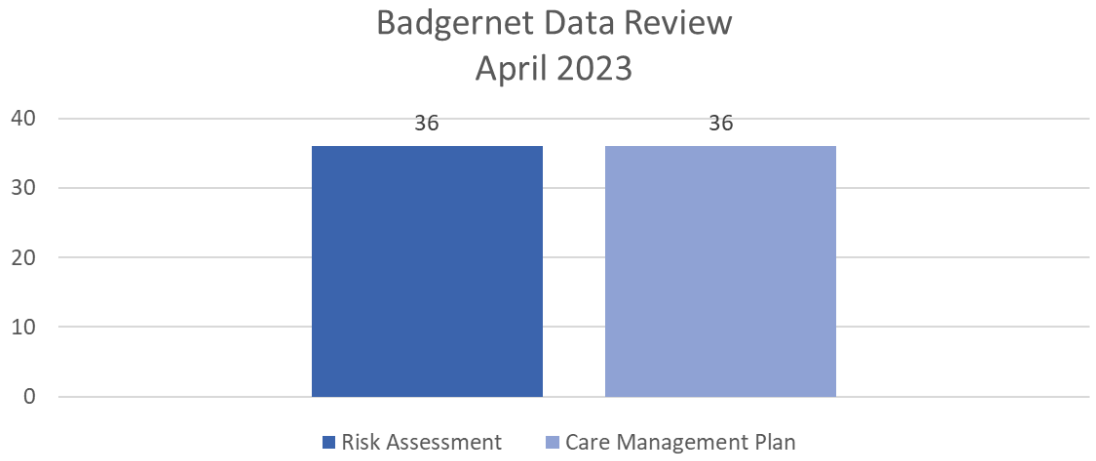
A monthly antenatal risk assessment audit is completed. The data for April 2023 is presented below:



The audit highlighted low compliance in relation to the completion of the risk assessments at every contact.

BadgerNet was rolled out to the antenatal teams in April 2023. The software mandates that an antenatal risk assessment is completed at every contact.

A snapshot audit of all appointments between 26 April 2023 to 28 April 2023 (36 records) evidenced that all women had a risk assessment completed and that there was an appropriate care management plan produced and documented in response to any risks identified.



A.3.1 High Risk Category Audit

Following the CQC findings the MDT, under the lead of the Clinical Director for the department, reviewed the process for high-risk women with complex medical conditions.

The data from April 2023 has provided positive assurance as high-risk patient pathways were followed in 100% of medical notes reviewed from York and 100% from Scarborough.

York Hospital

High Risk Category	Care Pathway followed correctly
PREVIOUS PPH	YES
PREVIOUS UTERINE SURGERY	YES
HYPOTHYROID, PREV PET, HERPES, PREV GDM	YES
SMOKER	YES
UTERINE DIDELPHYS, GROWTH RESTRICTION	YES
IVF, INTERMEDIATE VTE	YES
CROHNS, LOW PAPP-A	YES
SMOKER	YES
HYPERTHYROID	YES
BMI >35	YES

Scarborough Hospital

High Risk Category	Care Pathway followed correctly
BMI>35	YES
PREV LSCS, BMI>30, PREV PPH	YES
COELIAC DISEASE	YES
SMOKER, PREV PPH, HIGH VTE	YES
BMI>30	YES
BMI >30, PREV PRE-ECLAMPSIA, PREV PUNCH BIOPSY	YES
PREV GBS	YES
GDM	YES
ESSENTIAL HYPERTENSION	YES
PREV LSCS	YES

The Trust have received the HSIB final report following a maternal death of a woman who was on a high-risk pathway due to epilepsy and was being cared for by two NHS Hospital Trusts. The report was presented and discussed at the LMNS Perinatal Quality, Safety and Assurance Group meeting on 25 April 2023. A system wide approach to addressing the safety recommendations has been undertaken which will include the maternal medicine network, the LMNS, obstetric and neurology leads at both sites and the MVP.

A snapshot audit on the categorisation of caesarean sections had been planned for May 2023 however this has been delayed allowing BadgerNet to be rolled out on the Labour Wards as BadgerNet will support the data collection for this audit. The Consultant Obstetrician working with the Trust alongside the Maternity Improvement Advisor has been approached to undertake this audit.

A.4 Assessment and Triage

It was highlighted that recommendations from the Trust HSIB review from May 2022 had not been implemented which included written guidance to support the telephone triage process.

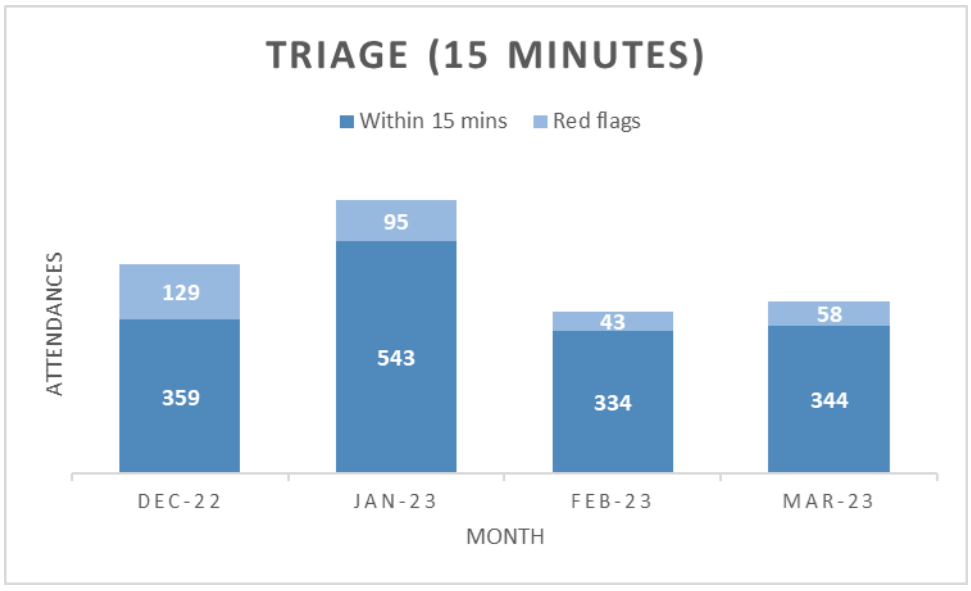
On the 12 May 2023, the BSOTS Triage system went live at the York Hospital site. The triage system is part of the Badgernet software, the system facilitates the prioritisation of women based on needs.

A BSOTS triage SOP has been developed by the Midwifery Ward Manager and has been circulated to all staff with a supporting you tube video.

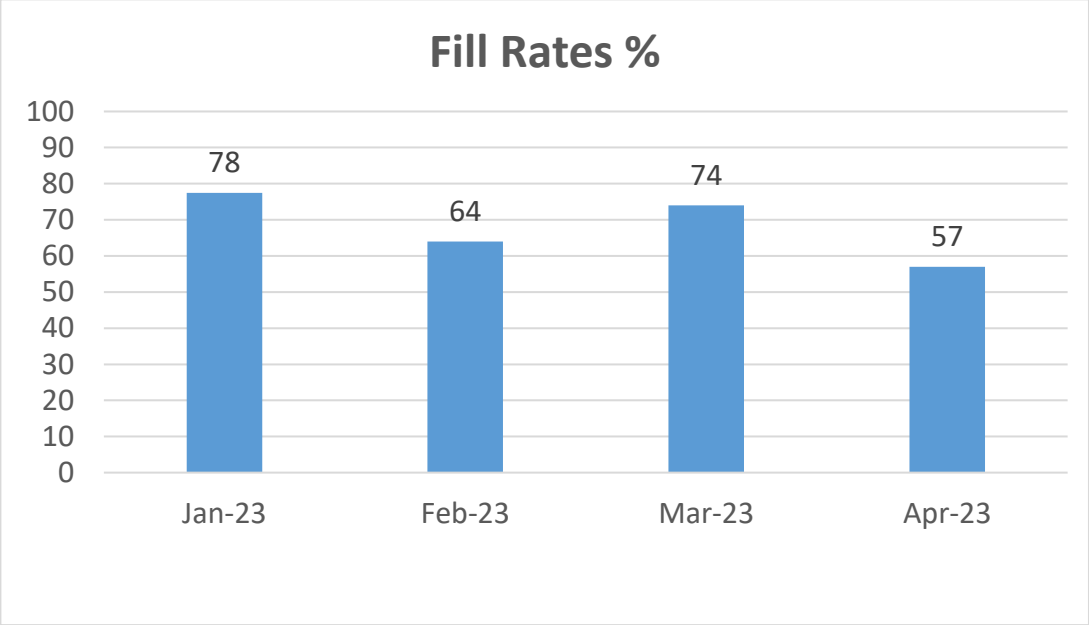
The core triage team are attending the clinical skills drop-in sessions to answer any queries.

A screen shot of the system being used to record telephone contact is shown below:

The introduction of a dedicated telephone triage midwife shift and the soft launch of the BSOTS framework in January 2023 saw the instance of delayed assessment within the 15 minutes for red flags fall from 26% (129/488) in December 2022 to 15% (58/344) in March 2023. The Maternity Triage Manager in York continues to monitor the length of time women wait for initial assessment



The fill rates for the dedicated telephone triage midwife shift until 30 April 2023 are shown below (double time incentive ceased 16.04.2023 which has had an impact on the uptake of shifts.)



B. Governance and Oversight of Maternity Services

B.1 Post-Partum Haemorrhage
B.2 Incident Reporting

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 representative of midwifery, obstetric, anaesthetic, and neonatal team members to ensure there is a multi-professional review of the care provided and care is in line with regional and national guidance to ensure that any learning or changes to practice are clearly identified and articulated to staff. The process supports women and their families to enable them to contribute to the review and support the debrief process. All women where there has been the potential for moderate harm receive a verbal Duty of Candour and are provided with a leaflet on informing them that their care will be reviewed at the Maternity Case Review meeting

The moderate harm incidents are also escalated weekly to the Triumvirate by the Quality and Governance Lead and are shared with the Trust Board as part of this Perinatal Clinical Quality Surveillance Report.

Moderate Harm (potential) April 2023		
Incident Category	**No**	**Outcome / Learning / Actions**
PPH>1500ml	8	See below
Born Before Arrival	3 Two downgraded	One born before arrival and two freebirths
3rd and 4th degree tears	6 5 downgraded	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

Moderate Harm (potential) April 2023		
Incident Category	**No**	**Outcome / Learning / Actions**
		One fourth degree tear in April 2023.
Term admissions to the Special Care Baby Unit (SCBU)	6 Four downgraded	All term admissions to the special care baby unit (SCBU) are discussed at weekly Maternity Case Review attended by paediatricians. These will be reviewed at ATAIN meetings in April for themes.
Postnatal readmission	1	Admission triggered the sepsis six

- Two Serious Incidents were reported relating to hysterectomy following Massive Obstetric Haemorrhage in 2023 (January at Scarborough and February at York).
- Investigations are in progress and expected to complete May 2023.
- Immediate learning identified was around the prompt undertaking of maternal observations and the use of the Modified Early Obstetric Warning Score (MEOWS) in Maternity Triage and on the Labour Wards.
- Raising Awareness on how and when to undertake MEOWS has been ongoing during March and April 2023 by ward leaders and Matrons on both sites through 1:1 support, safety briefings and updated communications to the staff.
- Weekly monitoring of compliance by the Deputy Head of Midwifery has found week on week improvement toward the compliance target of 90% on the York labour ward.

There were eight PPH > 1500ml incidents reported as having the potential for moderate harm in April 2023:

Blood Loss	Number and Range April 2023
1.5l – 1.9l	2 (1.5l – 1.6l)
2l – 2.4l	3 (2.1l – 2.3l)
> 2l	3 (2.9l – 3.1l)

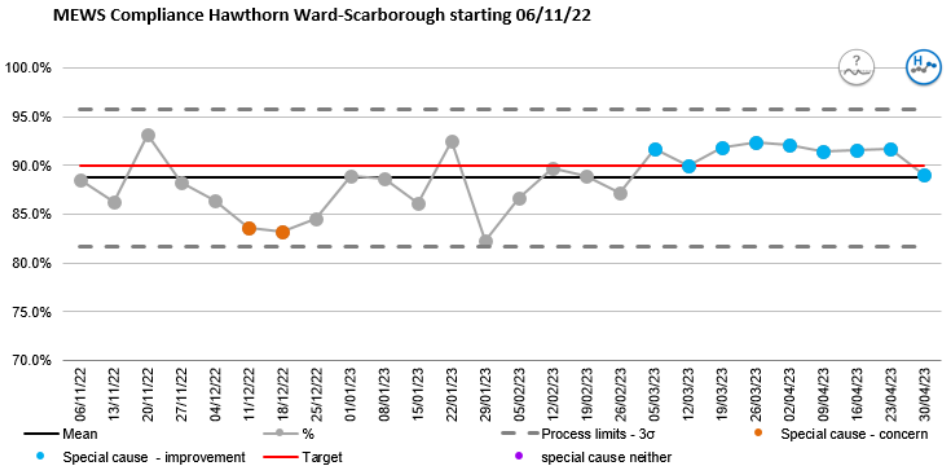
MDT reviews PPH > 1.5l identified that the escalation and management of the PPH was good and in line with Trust guidelines.

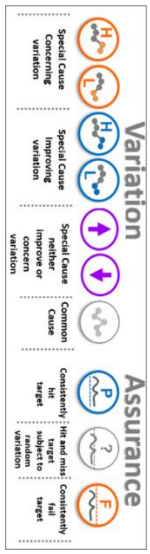
One of the PPH over two litres was as a result of a planned homebirth and BBA, another PPH over two litres was following an emergency caesarean section for a cord prolapse, Patient Safety Incident Review's are being undertaken for these PPH's.

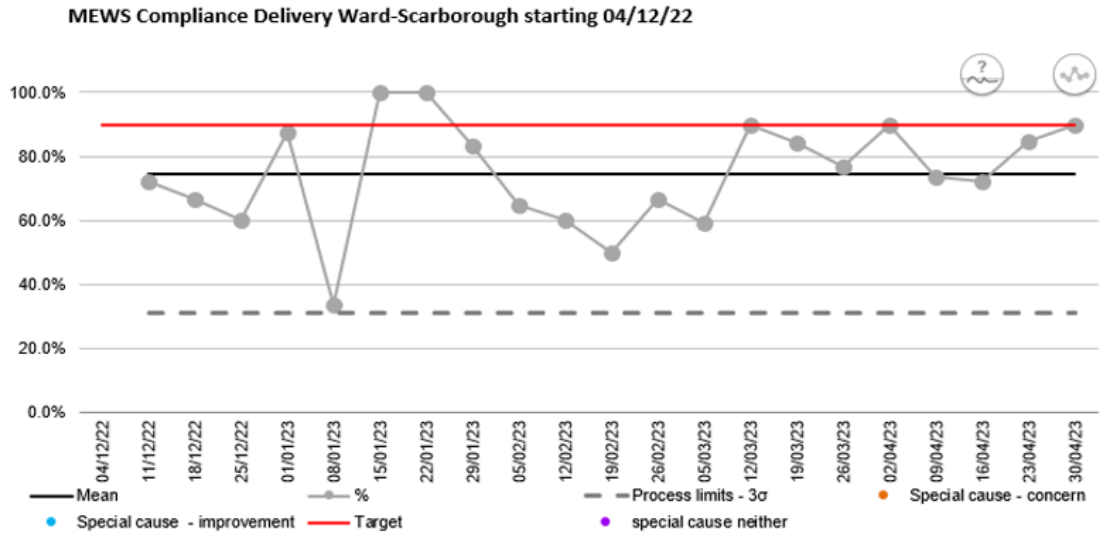
PPH < 1.5l are reviewed by the PPH Scrutiny Panel. See B.1.1

MEOWS Compliance:

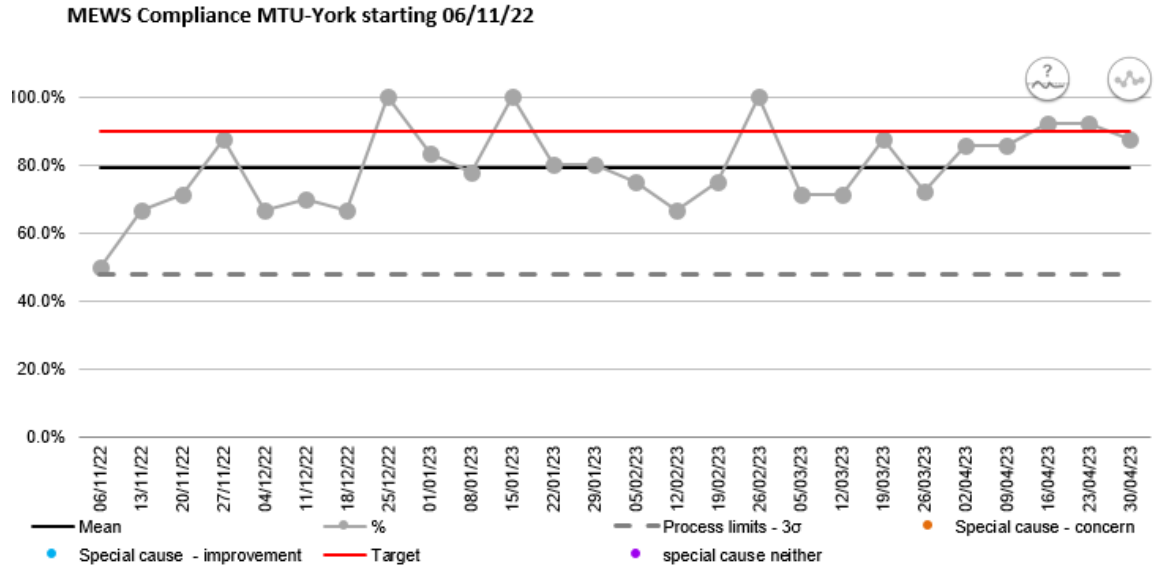
Scarborough Hospital:

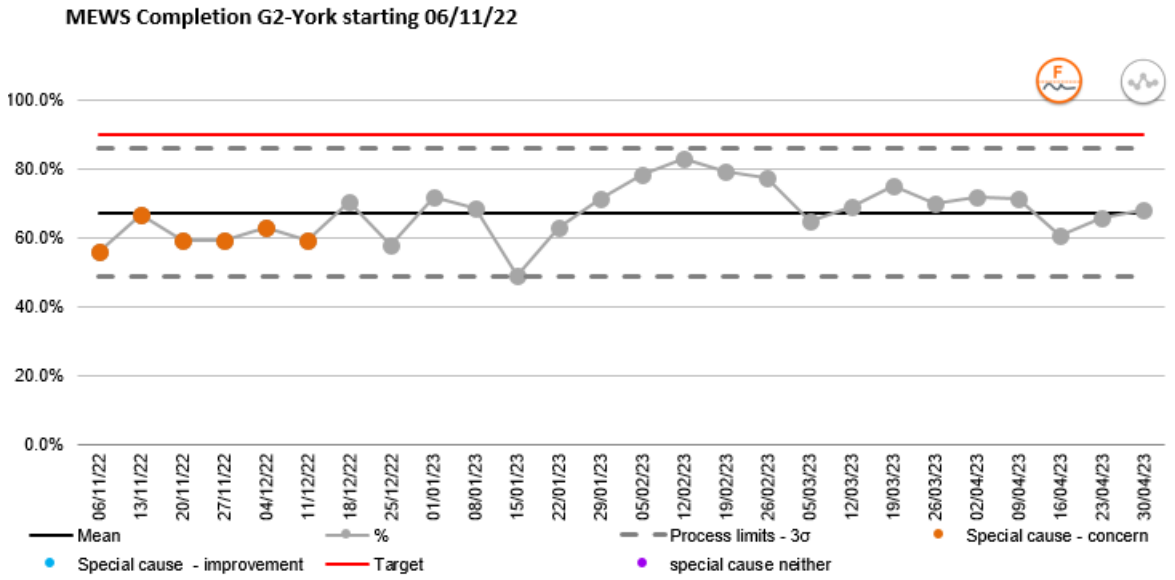


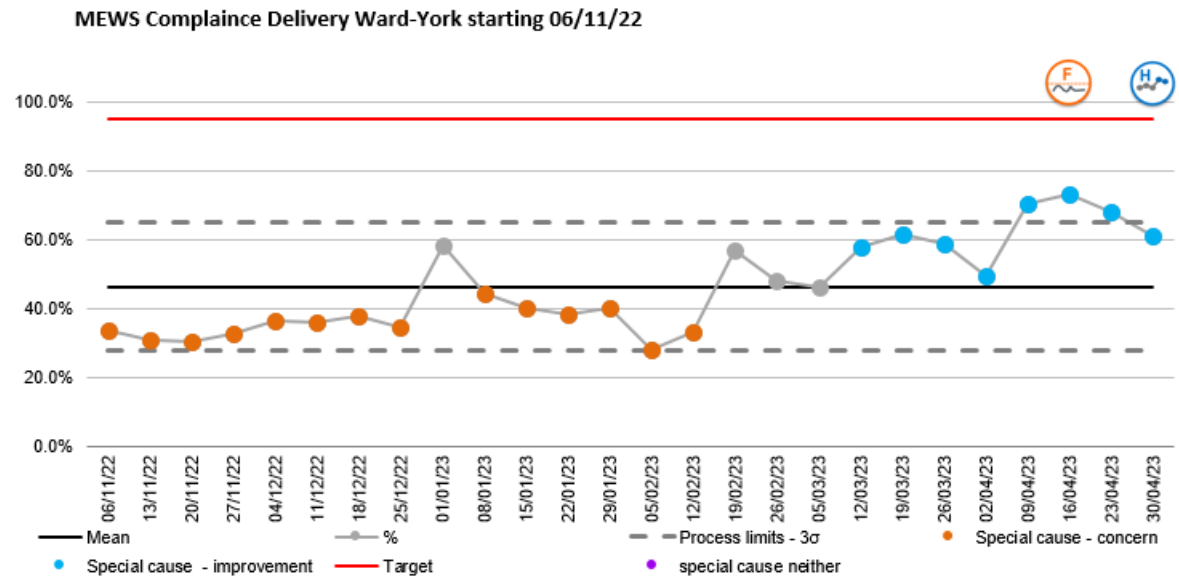




York Hospital:







The higher rates of compliance with MEOWS at Scarborough Hospital is attributed to the recording of observations on the electronic patient record being embedded in practice.

B.1.1 PPH Data

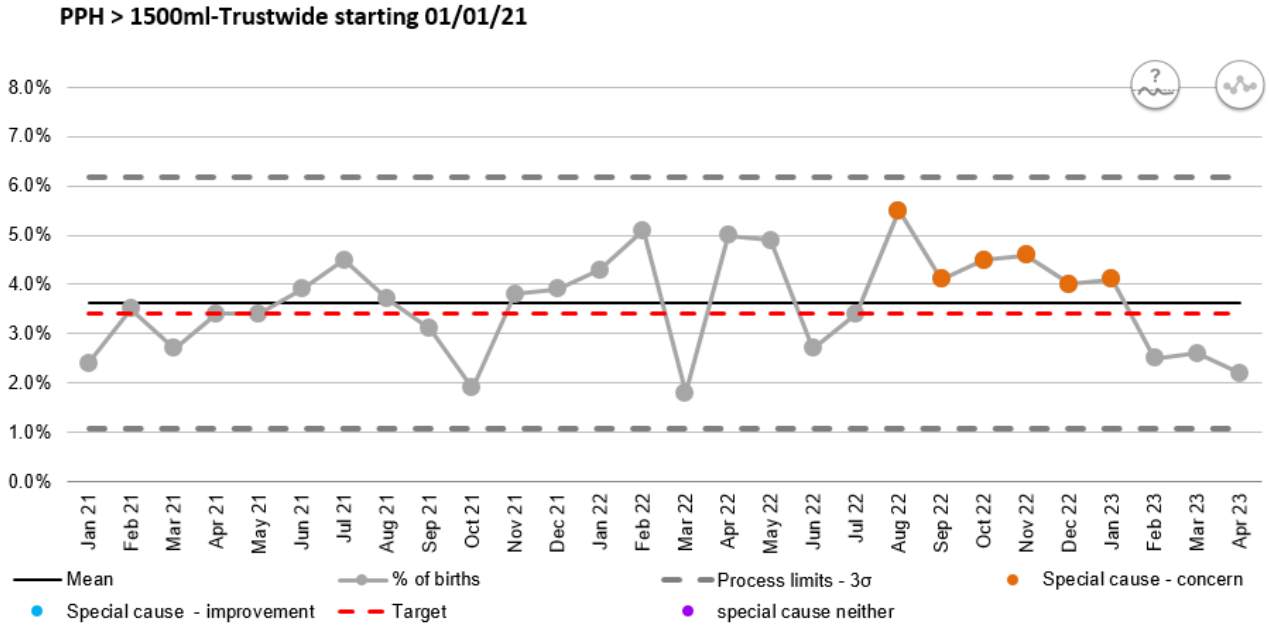
PPH over 1.5 litres

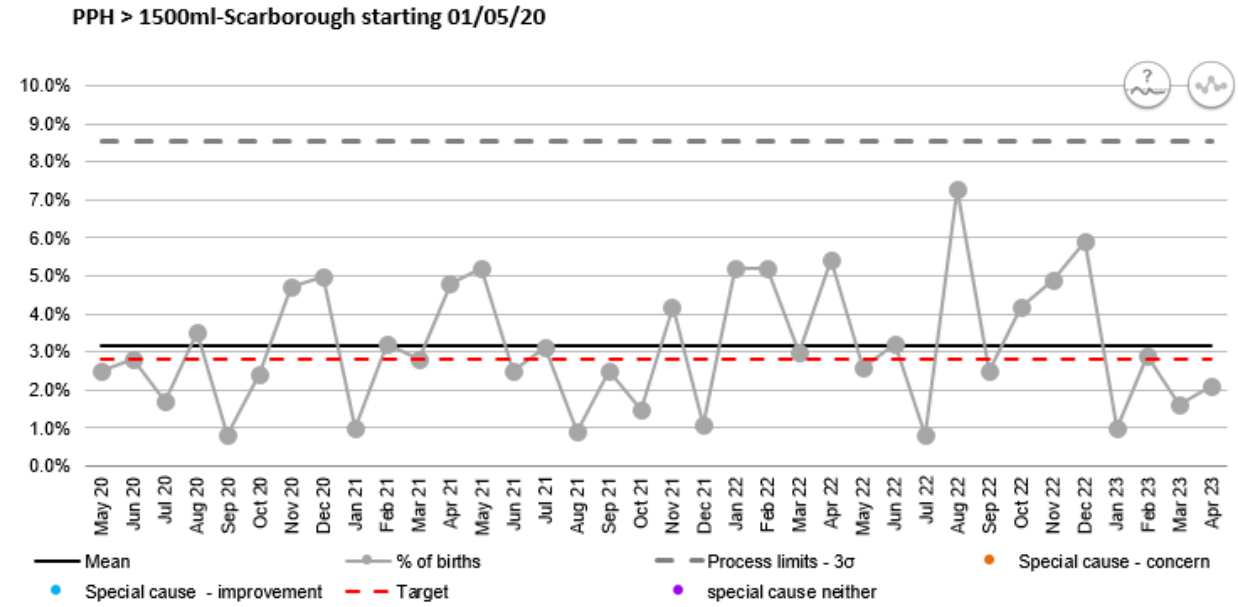
Maternity Data Set

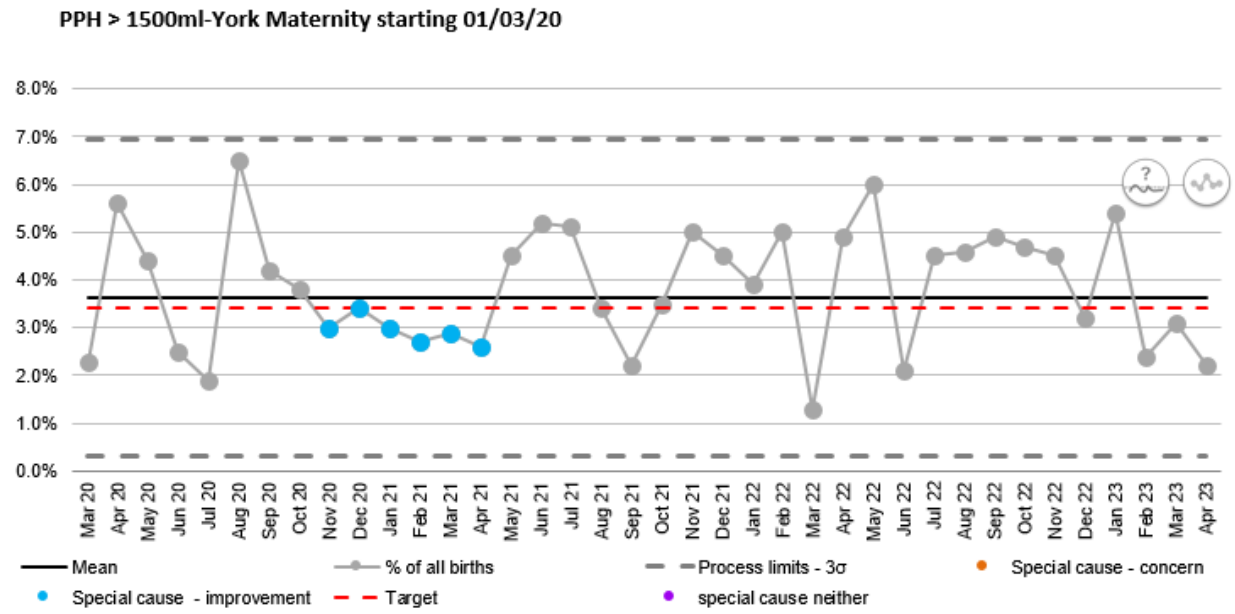
National Average	Trust Average
30/1000	40/1000

- It is a key priority of the maternity department to reduce and maintain the postpartum haemorrhage rate to below the national average.
- The last three data points are now below the national average. The Trust will continue to monitor to determine that early signals are sustained and can be then seen as improvements.

- In April 2023, **2.2%** 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 chart (see next slide).
- 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%.**



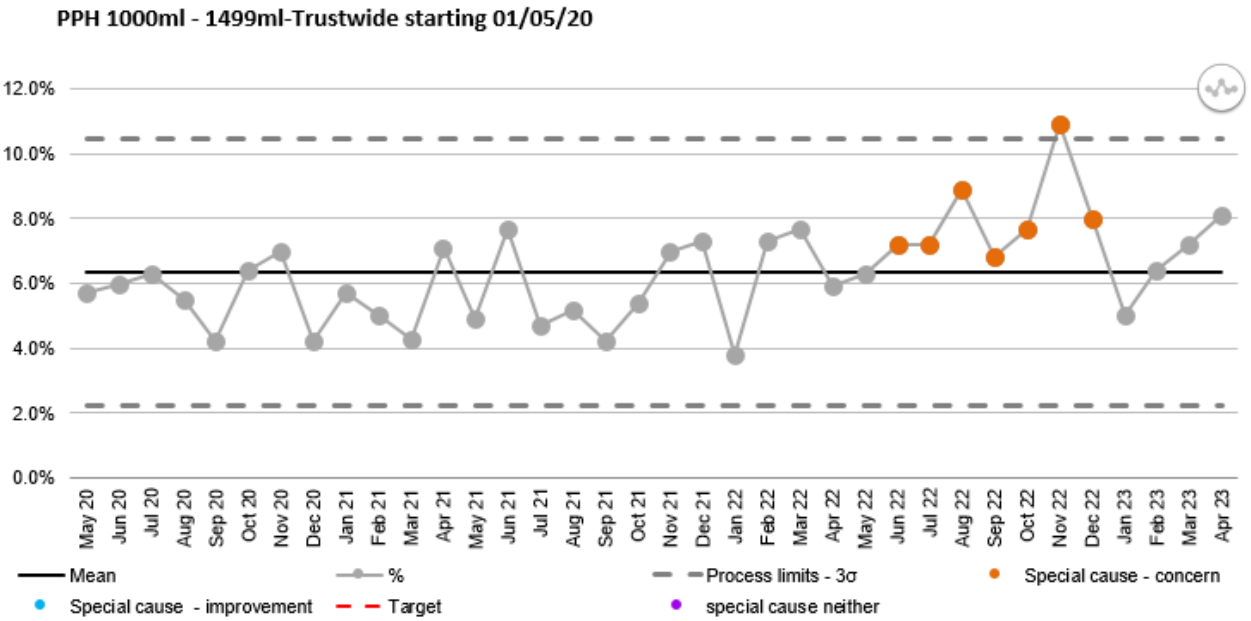




PPH Below 1500ml

All PPH under 1500ml are reviewed by the cross site PPH Scrutiny Panel and the monthly snapshot audit overseen by the panel. The audit in March identified that there was inconsistency in the completion of the PPH risk assessment at 36 weeks The introduction of BadgerNet in the antenatal clinic in April 2023 has mandated the requirement for the PPH risk assessment to be completed at 36 weeks. The effectiveness of these risk assessments will form part of the ongoing audit plan in Q1 for 2023.

The mitigation for this is that there are now scales in every delivery room to accurately weigh blood loss, the PPH risk assessment has been updated to ensure high risk women are identified, and these women are clearly identified in the handover boards on the labour wards.



B.3 Management of Risks

B.3.1 Fire Safety and Security

B.3.1.1 Trust wide

- The Strategic Security Lead and Associate Chief Operating Officer meet daily with Estates for immediate concerns and escalations, as well as progress reports on works being undertaken.
- The Security and Estates Task and Finish Group meets monthly to oversee the delivery of actions and escalate any delays.

B.3.1.2 York

- Fully functioning baby tagging system in place.
- All power and data works completed in April 2023 to support the upgrade which will link access control, fire and baby tagging systems.
- Systems will be installed by mid-May 2023.

B.3.1.3 Scarborough

- Fully functioning baby tagging system in place.
- The door between Oak and Hawthorn wards has full fire interface added, meaning that the door automatically releases on activation of the fire alarm.
- The connecting doors between Labour Ward and Hawthorn Ward are being replaced. The contractors are due to attend in the first week of May 2023. Swipe access is being added to make these doors for emergency use only.

B.3.1.4 Snapshot Audit – Use of Baby Tags (27 April 2023)

All wards were found to have an adequate stock of tags.

York Hospital

- There were fifteen babies on the antenatal ward, fourteen had tags on and one baby had just arrived on the award from the labour ward without a tag. This was addressed immediately.
- Two babies were on the labour ward and only one had been registered on the X-tag system. This was addressed immediately.
- A communication on baby tagging was included in the safety brief on 28 April 2023.
-

Scarborough

- Five babies were on the antenatal ward, four had tags on.
- One baby was having a newborn infant physical examination and therefore the tag had been removed for the examination. This was observed as being replaced immediately once the examination was complete.
- An audit on the correct tagging of babies have been added to Tendable and will be reported in June 2023.

To ensure that all ward managers and matrons have oversight of baby tagging, a mandatory check has been requested to be added to the weekly and monthly Tendable ward audits at the beginning of May 2023.

B.3.2 Scrub and Recovery Roles

The ability to identify shift fill rates for scrub practitioners has been escalated to the Director of Workforce as a priority.

The CQC were concerned that midwives were undertaking both the scrub and recovery roles for caesarean sections on the Labour Wards.

- A dedicated Maternity Theatre Manager started in post in February 2023. This is a new position to oversee the running of maternity theatres to support the standardisation of practice in line with National Guidelines.
- An electronic roster for maternity theatres is in development.
- Recruitment for twenty-seven wte Theatre Scrub Practitioners has been approved by the Trust Board. 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.
- A continuous advert for band 5 Theatre Practitioners / ODP's in Maternity was published on Trac on the 12 April 2023.
- As of the week commencing 24 April 2023,17 applications had been submitted.
- International recruitment is being considered to fill these vacant posts as the Trust will shortly be recruiting in India.
- The Maternity Theatre Manager have developed a Maternity Theatre Staffing Plan.

Phase 1 Training
Block four weeks for theatre staff to double scrub during elective sections.
Weeks 15.05.23, 22.05.23, 29.05.23 and 05.06.23
*(Monday, Wednesday and Friday unless bank holiday)

Phase 2
From 12.06.23 extra band five in theatre during elective lists during the day shift (8-6 / 8-8)

Phase 3
Introduction of two times band five on days with no elective lists (Tuesdays and Thursdays).
No timeframes as dependent on recruitment and staff availability. Update in June 2023.

Phase 4
Introduction of two times band 5 (experienced) on nights (8-8)
No timeframes as dependent on recruitment and staff availability. Update in June 2023.

Minutes

Quality and Safety Assurance Committee
24 April 2023

Members in Attendance:

Stephen Holmberg (SH) (Chair), Karen Stone (KS), Heather McNair (HM), Caroline Johnson (CJ), Mike Taylor (MT), Lorraine Boyd (LB), Jenny McAleese (JM)

Attendees:

Sue Glendenning (SG) (Item 08 23/24 only), Ben Adekanmi (BA) (Item 08-23/24 only), Jamie Todd (JT) (Item 13-23/24 only) and Gary Kitching (GK) (Item 13-23/24 only), Liz Hill (LH) (Item 14 23/24 only), Allison Pollard (Item 14 23/24 only), Amanda Vipond (Item 14 23/24 only) and Sally Light (Governor observer).

01-23/24 Apologies for Absence

There were no apologies.

02-23/24 Declaration of Interests

There were no declarations provided.

03-23/24 Minutes of the meeting held on 21 March 2023

Minutes of the meeting were accepted as an accurate record of the meeting subject to amends received from Lorraine Boyd.

04-23/24 Matters arising from the minutes and outstanding actions

JM enquired about the increased reports of violence and aggression and asked if de-escalation training was available. CJ stated that this was available online and is provided face to face on targeted areas and attendance has been an issue with ongoing staff resourcing pressures. HM noted that with the training staff have been encouraged to report further as tolerance levels have increased in recent times particularly in ED.

Action 144 – An update was asked for by the Chair and provided by HM on the upcoming strike action for nursing in being different as there will be less staff available to cover around the bank holiday with no derogations. Some staff are choosing not to state whether they intend to strike or not. Planning is ongoing with nights at York a particular area of concern. The skill mix on site is a further concern with some staff including ICU and chemotherapy still delivering patient care it is planned.

Regarding the junior doctors strike further news is expected on upcoming planned action with large numbers of elective activity having to be cancelled at the last strike.

All other actions that referred to the escalation report had been escalated to the Board or the remaining actions were on today's agenda and were to be closed.

05-23/24 Escalated Items

There were no escalated items.

06-23/24 Risk Management Report

MT presented the report which detailed the full Board Assurance Framework (BAF) for Q4 and the full Corporate Risk Register (CRR) from previous feedback at the Committee. Those risks that were under the Committee's responsibilities were outlined and the amends over the reporting period in the BAF and CRR were provided in the red text. These would be reported to the April Board of Directors meeting.

JM enquired around the no gaps in assurance identified as a common issue on the BAF risks compared with the digital risk which has gaps identified. SH concurred and used PR2 has an example with KS commenting that the risk is incorrect, and work is ongoing to re-draft to state 'failure to provide expected outcomes' with this not a waiting list issue which is included in PR3. The new risk will be reported to the Committee next month.

SH commented that the people risk in being picked up by the People and Culture Committee was unclear which parts are relevant for the Quality and Safety Assurance Committee. The full BAF had been all provided to look across the risks to see if there were any areas to identify for the Committee and LB commented specifically as an example the workforce plan of the AHP review scheduled for April 2024 and can the Committee tolerate that level of risk for that length of time under its responsibilities.

The process was agreed if there are areas of concern such as this it would be best discussed with the Executive concerned attending the relevant Committee. This principle was in progress with the review work of quality governance with NHSE and reviews of terms of reference which were now due as scheduled.

LB commented on the lack of outcomes of assurance rather than the methods of where the assurance comes from which was agreed by the members. The assurances may be in place but do we actually know that they are working which is what needs to be recorded in the gaps in assurance.

In summary SH asked that all the points raised were considered in the development of the BAF and it was agreed that MT take this forward to be considered as a Board development session in the future.

Action:

- **The Associate Director of Corporate Governance to raise the requirement of a Board development session on the BAF at a future Board meeting.**

07-23/24 Quality and Patient Safety Escalation Report

KS commented that QPaS wasn't held in the reporting period because of industrial action though the papers were produced, and KS and CJ went through these to summarise the important points for the Quality and Safety Assurance Committee paper.

An issues was raised different to the paper with over 1000 patients affected regarding echo reports been reported by a non-accredited reporter not having been verified across a mix of inpatients and outpatients. Subsequently 15% of these reports have been reviewed with no harm found and inpatient reports have consultant overview. A trajectory to review all reports

is in place with a plan to ensure this doesn't occur again, which will delay new reports with the Quality and Safety group having oversight. This was agreed to be escalated to Board.

There is a further concern at the York and Bridlington Care Unit raised by the Chief Pharmacist on safety of medication with patients not recorded on the CPD electronic prescribing system with paper-based recording instead. Subsequently pharmacy support has been put in place to review to prevent and review errors as a potential patient safety issue. EPMA cannot be used when discharged on CPD with work ongoing on electronic prescribing solutions by the DIS team.

Next month the change of the clinical governance takes effect with amends to QPaS terms of reference and the groups beneath with some subsequent reporting through to Quality and Safety Assurance Committee.

JH raised a concern following a learning from deaths review of an outlier patient who hadn't had care reviewed and subsequently didn't die in their choice of setting. KS responded that the outlier patients process was for Care Group 1 and 2 to answer that KS would lead on seeking a response.

Action:

- **Echo reports been reported by a non-accredited reporter not having been verified across approximately 1000 inpatients and outpatients to be escalated to Board by the Chair.**
- **Outlier patient processes from care groups 1 and 2 to be reassured by the Medical Director.**

08-23/24 Maternity Update Report

Perinatal Clinical Quality Surveillance Report

The report was presented by SG and stated that in future the report would to be known as the Quality Report amended from the work ongoing with the maternity team. This month's report was for January, February, and March with as from June the report would then go back to monthly data reporting.

It was agreed by members that the report was too lengthy for reporting to the Committee and that in discussion this should be reported to the Maternity Assurance Group with the summary being brought to the Committee. The report doesn't currently give the quantitative view of what is the ambition and where are the Trust in its achievement and new Maternity Assurance Group is in diaries with a new escalation report to be provided to the Quality and Safety Committee next week.

JM asked on the Postpartum Haemorrhage (PPH) that the Trust was an outlier in comparison with other Trusts. BA queried being an outlier as we were above the average, but this was now coming down to the average level. HSIB was also discussed with SG outlining that the maternity team have been working closely with the HSIB team which had resulted in positive meetings with no specific concerns raised not already known. LB added that it was important assurance to recognise that HSIB were not just looking at past incidents but also that could have been a problem had the incident occurred differently.

SH noted that he believed there was still a way to go until confidence was in place that the Trust was a learning organisation and an organisation that gets better as a result of specific events that have taken place in being driven from a QI process. It was discussed by CJ around the thematic analysis of reducing incidents and where learning has been shared and the impact that this has happened and is demonstrated that the learning is in practice. KS

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stated that a different look at data is required that enables informed quality of improvement. The Patient Safety Incident Response Framework (PSIRF) thematic analysis as the new national standard is being worked through in the coming months.

It was further discussed that the anti-natal risk assessments were high on the priority list as part of the national audit standards and the team were working with the Patient Safety & Quality Governance team. Training wasn't included in the report because of the learning hub data incident with data to be provided in future reports.

HM noted the external support in the team is as a national advisor who will be with the Trust for some time which develops the continuity of support with the Trust wishing to appoint a Director of Midwifery longer term.

LB enquired on the maternity dashboard with just January and February data points provided which didn't enable a trend to be identified compared with other information from Healthwatch for example. SG agreed and noted that this would be worked on further in the future.

Maternity CQC Update Report

The report had now been redesigned to meet the needs to the section 31 CQC notification rather than the maternity department update as a whole. HM noted that the report needs to state what the ambition is and how much have we achieved on an ongoing basis. It was agreed that this report in future should go to the Maternity Assurance Group on route to the Committee.

09-23/24 CQC Compliance Update Report

HM commented that the report was required to demonstrate what was the impact from the action that had been included in feedback from the CQC. There had been requests for data of the fundamentals addressed which is underway.

As an example, Nucleus having an ambition of 95% of patients needing a risk assessment and presenting the data on the position now and when it will be achieved in the future. This required to be presented in SPC charts in showing an improvement in trajectories.

10-23/24 Q4 Infection, Prevention and Control Update Report

There were no further comments on the report that weren't discussed elsewhere in on the agenda.

11-23/24 Serious Incident Report (Including Maternity and Never Events) - Monthly

There were no comments on the report which would be taken to the April Board of Directors meeting.

12-23/24 Quality and Safety Assurance Metrics (TPR)

There were no comments on the report.

13-23/24 Care Group 1 Assurance Report

JT and GK presented the report of the summary of key risks and assurances reported on a day-to-day basis across the Care Group. Key issues raised were:

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- ED environment during the extension works in its interim design
- Overcrowding of ED as a result of the works
- Nursing workforce

The performance standards of the care group were outlined including 12-hour patient waits with reassurance provided to a degree on the conclusion of the new build but overcrowding could remain dependent upon the new model of care that was aimed to be implemented making a difference to patient pathways. The build will be concluded by 15 May with a process to then commission the department to work effectively within 6-8 weeks to be fully operational. It is identified that there is needed a change of culture of staff to implement the new care model completely.

HM noted that NHSE had been in the Trust last week to look at establishment of the Trust's nursing in the Trust's ask in the plans submitted. In particular e-roster was picked up as an area of improvement in the team been under resourced and not being able to produce a roster template to move with the moving rostering needs. Approximately 9000hrs over 2 months has been lost in not being productive. It was noted therefore that it would be a false economy to not subsequently invest in e-roster. This has been brought in a business case previously in investment in the e-rostering team.

Further discussion continued on the emergency care capacity and the onboarding in managing risk across the Trust, ED staff and inpatient staff joint working with reassurance taken on the progress underway. It was agreed by members that the ED build was an enabler to improve overall patient care and the culture change that needed to take place.

The revised ED clinical model business case was underway and was noted in its intention in changing ways of working to improve the situation for staff and patients at the Trust

It was agreed that the e-roster issues would be escalated further following discussion by the Committee.

Action:

- **E-roster improvement resourcing issues to be escalated to the Board of Directors.**

14-23/24 Care Group 3 Assurance Report

LH presented the report of the summary of key risks and assurances of the care group with the majority of surgery in the Trust across the two sites. The Care Group have worked hard to improve governance and timeliness of response and duty of candour have particularly been developed further.

CJ commented on being asked around how effective care group quality and safety governance meetings were, in that the care groups have different processes and a workshop with the care groups is planned with support from NHSE facilitating to standardise. QPaS for example has been worked on in having too large an agenda and this is being worked on and in the subsequent ask of the care group reporting. The cross-care group work is considered at for example Quality and Safety group dependent upon the issues presented.

LH noted concerns around the 6-day training required in delivery of the PSIRF in losing the good engagement with staff and the care group are working with CJ on this to achieve by the deadline required planned for the Autumn. KS commented that the team need to determine what the team needs to then progress quickly on the training rather than further training needs analysis.

The elective recovery achievements were presented, and clarity sought by SH on the improvements reported in August 2022 from the Trust wide figures with 5671 patients having breached a 78 week wait in having been treated as at 31 March. This could have been up to a cohort of 30,000 for all patients across the Trust without intervention. Concerns were escalated around the harms that could occur in being on the waiting lists and the complaints received from patients as a result and with cohort P4 patients which hadn't been prioritised at that time. KS noted the data that had been looked through and commented on at the Digital, Performance and Finance Assurance Committee and the Tier 1 meetings.

There was clear reliance on the workforce of the care group in retaining staff and how this has been focussed on successfully recruiting anaesthetists for example in development of the role, the flexibility of patient facing roles working hours and changing language in job descriptions. In response to how assured the group is in using their workforce effectively, only nursing is currently on e-roster with job plans not documented fully to understand skills mix across all staff.

Further discussion centred on further improvements needs including central processes across sites, technology use and efficiency of theatres. Securing beds for complex elective care to ensure procedures can commence on time was identified as an issue and environmental concerns in refurbishment of wards needed of backlog maintenance. This was agreed to be escalated with the healthcare acquired infections implications.

It was agreed that SH should escalate outpatient utilisation data availability from the DIS team with the Digital, Performance and Finance Assurance Committee to understand further detail.

Action:

- **The healthcare acquired infection potential in not refurbishing surgical wards to be escalated to the Board of Directors**
- **Outpatient utilisation data availability from the DIS team to be escalated to the Digital, Performance and Finance Assurance Committee**

15-23/24 Issues to escalate to the Board and/or other Committees

- Echo reports been reported by a non-accredited reporter not having been verified across approximately 1000 inpatients and outpatients to be escalated to the Board of Directors
- E-roster improvement issues to be escalated to the Board of Directors
- The healthcare acquired infection potential in not refurbishing surgical wards escalated to the Board of Directors
- Outpatient utilisation data availability from the DIS team to be escalated to the Digital, Performance and Finance Assurance Committee

16-23/24 Issues to escalate for BAF and CRR consideration

No further issues to be escalated for the BAF or CRR.

17-23/24 Any other business

There was no any other business.

18-23/24 Date and Time of next meeting

The next meeting will be held on 23 May 2023 2.00pm-5.00pm (extended following member feedback).

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York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	24 May 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 April position for 78-week RTT waiters of 187 compared to the trajectory of 192. This progress is monitored on a fortnightly basis by the Chief Executive and national team.

The Trust is above trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 196 against a target of 194 for April.

The April Emergency Care Standard position was 73%, achieving the trajectory of 70.1%.

Recommendation:

That the Board notes 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 Digital, Performance and Finance Assurance Committee oversight. The operational performance position is provided in the Trust Priorities Report.

2. Considerations

The Digital, Performance and Finance Assurance Committee notes the updated position and associated actions.

3. Current Position/Issues

At the time of writing the report, the COVID-19 inpatient numbers have decreased across the Trust to 99 from 143 on the 8th of April.

The Trust cancelled 1,013 outpatients and 217 elective procedures during the industrial action by the British Medical Association Junior Doctors on the 11th to 15th of April.

RCN industrial action took place between the 30th of April and 1st May resulting in a further 74 outpatients and 12 elective procedures being cancelled.

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 17% of ambulances having a handover time of over 60 minutes against the <10% target (down from 27% in March 2023).

Advise (2): The total number of patients waiting over 12 hours in ED decreased to 16% from 20% in March 2023 (target <8%), with those waiting more than 12 hours after a Decision to Admit also decreasing (800 against zero target, March 2023: 1,070).

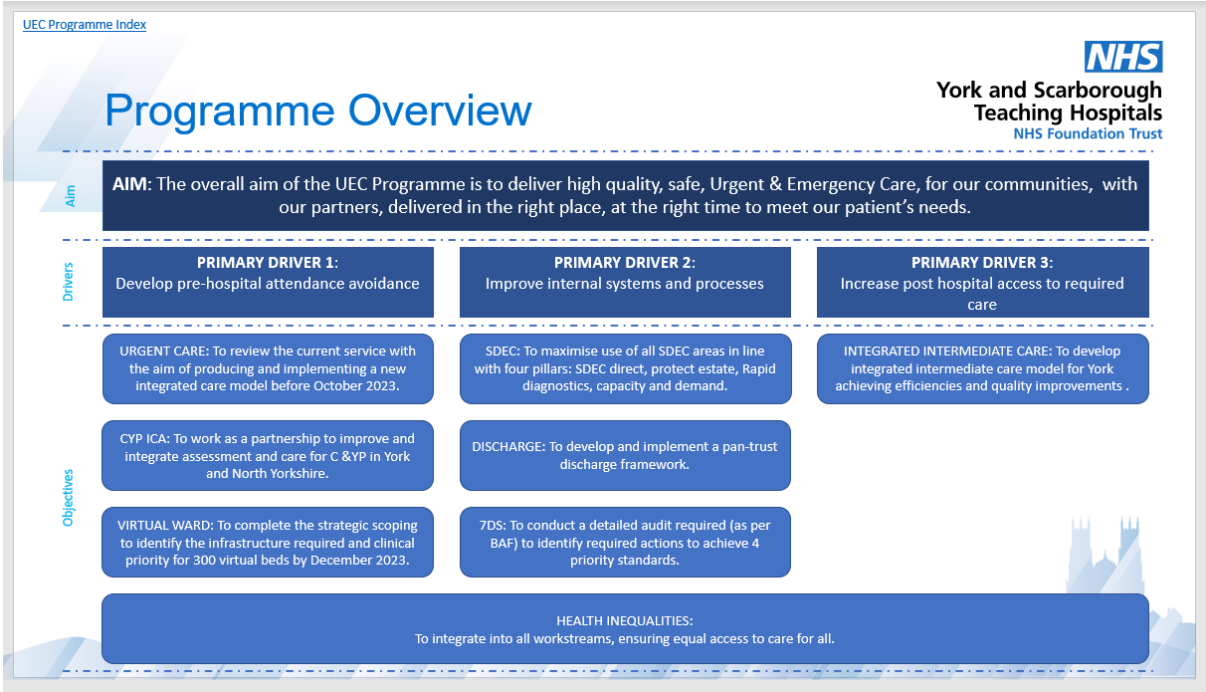
Assure (1): The Trust achieved to Emergency Care Standard improvement trajectory with performance of 73% against the end of April ambition to achieve above 70.1%.

Programme Team:
Recruitment to the Programme Team has been completed with two Programme Managers, Deputy Programme Manager and two Project Managers all in post. The Programme Team will be working across the four priority programmes for the organisation: Urgent & Emergency Care (UEC), Elective Recovery, Maternity and People & Culture. In addition, work continues with the Quality Improvement team and Corporate Efficiency team to explore joint working opportunities and avoidance of duplication whilst progressing shared approaches. ECIST are working with the programme team and specifically an Improvement Manager for two days a week as well as the required clinical leadership from the ECIST Clinical Leaders team. One of the National NHSE Directors is also working with the Programme team specifically on the Urgent Care Project.

4.1.1 The Urgent and Emergency Care Programme

The UEC 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.



- The programme was refreshed in late 2021 to develop three areas of focus and 7 priority workstreams.
- This was then reviewed in February 2023 against the national UEC recovery plan to confirm the priority areas were in line with the national ask.
- As part of the planning work for 23/24 the milestones for the programme have been set in line with the national expectations for achievement of the Emergency Care Standard, Ambulance response times and bed occupancy levels.
- The plan indicates key delivery points in the summer and in October ahead of the winter.
- 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.

Whilst establishing the refreshed programme from August 2022 to March 2023 the following key achievements were recognised:

- Revised programme, with detailed metrics, linked to system measures and national targets.
- System relationship development.
- Scoping provision of a domiciliary care service and agreed direction for integrated intermediate care.
- Development of an integrated urgent care specification and initial workshops with all stakeholders for the new model of care.

- Establishing the trust strategy on virtual wards, i.e., the development of a virtual hospital infrastructure. As now recognised nationally as the most effective approach.
- York Frailty virtual ward beds on trajectory of 5 patients, with 157 bed days saved and excellent patient feedback scores.
- Significant analysis of understanding behaviour and populations in relation to children and young people. Identifying factors which drive family presentation and choice of location.
- Testing Integrated models of care for children and young people such as the CAT hub.
- SDEC benchmarking regionally and nationally identifying the areas which will have the most impact and identifying SDEC direct pathways to be implemented this year.
- Development of internal professional standards to address two of the priority seven-day standards and address the requirement for a pan trust discharge framework.

UEC Performance: The April ECS position was 73% achieving the trajectory (70.1%). The ECS is a system target and our work with system partners will continue. Both the York and North Yorkshire Place UEC plans are aligned with the Trust internal plan to cover Integrated Urgent Care and Transfer of Care projects. Regular meetings take place with partners in relation to the joint plans.

Each project within the UEC Programme contributes towards this and has its own detailed metrics to indicate progress with the project specifically. Each of the project's objectives have been highlighted below in terms of how they will contribute to ECS performance. The impact is mainly in terms of reducing attendances in ED and thus reducing overcrowding and associated delays or in terms of reducing bed days (admissions and LOS) which will reduce bed occupancy and improve flow out of the Emergency Department, for those who need to be admitted. It will also improve capacity available in the department for those who need to attend ED. Nationally there is also a focus on Category 2 Ambulance response times which the Trust will support through delivery of these projects which will each contribute to ambulance handover times, enabling improved response times.

Project	Impact	April	May plan
Urgent Care	To develop the Integrated Urgent Care Model to reduce unnecessary attendances in ED.	Contracting and procurement process developed. Review of risks and opportunities identified from initial workshops. *	ICB proposal submitted to Board for approval. Design process for clinical and workforce models of the new Integrated Urgent Care Model.
Children and Young people Integrated Care and Assessment	To develop integrated models of care for C&YP to reduce paediatric ED attendances	Stock take, following confirmation of lack of continued investment in CAT hub.	Planning for public health summit in June which will bring together all system partners to discuss and agree the next steps for integrated care.
Virtual Ward	To develop pan trust strategy on VW to enable a reduction in	Plan for increasing capacity on the virtual ward by	Develop surgery, paediatrics and respiratory pathways understanding resource

Project	Impact	April	May plan
	admissions & ED attendances and reduction in LOS across specialties.	including heart failure patients.	available to support these patients. Test the concept with diagnostic virtual pathway.
SDEC	To maximise the potential of SDEC pan trust to reduce ED attendances and LOS.	Developing the surgery SDEC pathways from the ED new build to ensure patients receive timely treatment.	Implement YAS direct pathways for all SDEC units and agree implementation plan for 111 direct pathway and enhanced GP Direct.
Internal discharge processes	To reduce admissions and LOS.	Review of internal audit with CGDs, review of ECIST findings from Criteria to Admit audit to further inform internal professional standards work.	Approval of internal professional standards and implementation plan.
7day standards	Reduce LOS	Review of internal audit with CGDs, review of ECIST findings from Criteria to Admit audit to further inform internal professional standards work.	Approval of internal professional standards and implementation plan.
Transfer of Care	Reduce LOS	Agreement with York place team on ambition and commitment to work ahead of winter.	Preparation work for workshop to document ambition to be signed up to by all partners including one team approach.

*The Trust has received a formal request from the Integrated Care Board to be the Prime Provider for Integrated Urgent Care services across the Trust's geographical footprint commencing 1st October 2023, subject to due diligence from both parties. The Trust is working through the due diligence and identifying risks and opportunities, an initial paper will be presented in May Trust Board with a detailed business case to be presented at July Board.

The new metrics, by project, will be reported from next month once April data is available and routinely included in this report going forward.

Community Response Team: In relation to Transfer of Care, one key area of focus is the expansion of the Community response team for York. The Community Response Teams are a multi-disciplinary service of health care professionals providing assessment, intervention, rehabilitation and reablement for patients within their own homes, supporting

admission avoidance and facilitating timely hospital discharges from Acute Hospital. The service is provided 8am – 8pm, 365 days per year, across the geographical localities of York, Selby and South Hambleton and Ryedale.

Over time, the service has grown incrementally, with additional investment supporting the expansion of the clinical model in line with the Trusts Home First Strategy, to improve acute hospital flow and to deliver patient care closer to home.

The service originated in the development of the York Intermediate Care Team, twelve years ago, providing rehabilitation and reablement for early supportive discharge, soon after amalgamating with the Community Fast Response Service to include an integrated admission avoidance function.

No. of funded patients on York CRT caseload	Funding streams
45	York Intermediate Care and Fast Response historical capacity
22	Investment following closure of Archways Intermediate Care Unit
15	Winter monies – now substituted by £373k additional investment into Intermediate Care business case
27	40% increase in CRT clinical capacity, via UCR business case
Total 109	

Although the service has been expanded through specific funding streams, ongoing service improvement and economies of the scale have enabled efficiencies and the flexibility to support increasing demand. The service now regularly manages a caseload of between 130 patients and above, up to 171 patients during winter/COVID pressures and national strike action. The service has also responded to the growing needs of acuity, dependency, and complexity of patients on the caseload.

The response to growing demand, has however relied heavily upon the good will and dedication of staff, regularly stepping down all non-essential work and the deployment of staff from other services to support patient flow. The current capacity of 109 is short of the demand of 145 patients who could use the service at any one time. Demand also continues to grow for the service and is in line with the strategic direction of the organisation in relation to caring for patients in their own homes. Further investment opportunities continue to be explored but is challenging in the current financial climate.

4.2 Board Priorities: Elective Recovery

Whilst remaining a challenged position, April 2023 has seen an improvement on a range of elective and cancer performance metrics in comparison to March 2023.

Advise (1): Reduction seen in elective RTT long waiters over 78 weeks; Trust achieved 187 at the end of March 2023, this included nine 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 April (192).

Advise (2): Patients waiting 63 days or more on the Cancer PTL has increased from 162 to 196 at the end of April 2023. This is above the trajectory of 194 submitted as part of the national planning programme for 2023/24.

The latest validated position at 11 May 2023 shows a further improvement to 185, which is below the current trajectory of 192.

Assure (1): There were zero 104-week RTT waits at the end of April 2023.

2023/24 Operational Guidance Requirement	Mar-23	Apr-23	
Eliminate 104 week RTT waits	0	0 ⇔	National target - 0
Reduce 78 week RTT waits to zero	192	187 ▼	Trajectory 0 by end June 2023
Reduce 65 week RTT waits to zero	1,034	1,053 ▲	National ask 0 by end Mar 2024
Return the number of people waiting for longer than 62 days to the level in February 2020	162	196 ▲	National ask - maximum of 143 at end of April 2023

4.2.1 RTT position

The Trust has, despite the challenges of the Easter holiday and BMA industrial action, continued to see improvements in the long wait position in April, with the number of 78-week RTT patients reduced to 187 (March: 192). The 187 included nine 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 delivered on the trajectory of 192 submitted to NHSE for the end of April 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 April 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 April 2023 the Trust had 1,053 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. At the end of April, the Trust was 272 below the end of month trajectory of 1,325.

The Trust has seen an increase in the total RTT waiting list position, rising to 51,059 at the end of April (March 2023, 49,717). 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 was forecasted to deliver a 3% reduction by March 2024. Further capacity would be required to deliver significant improvement in waiting times.

The ICB “Revitalising HNY” elective programme has been established, chaired by the HDFT Chief Operating Officer currently focusing on improving theatre workforce provision, mutual aid for long waiting RTT patients and reduction in Outpatient follow up activity.

4.2.2 Cancer Position

Due to continued improvements, the Trust has been moved to Tier 2 for the Cancer 62-day backlog. The Trust remained off trajectory to meet the target 143 for the end of March 2024, with 196 patients waiting over 63 days at the end of April against the improvement trajectory of 194.

However, the latest validated position at 11 May 2023 shows a further improvement to 185, which is below the current trajectory of 192.

The Cancer performance figures for March maintained the improvement in the 28-day Faster Diagnosis standard seen in February (68% compared to 69%) and 62-day wait for first treatment (from urgent GP referral) position improved, 63.5% compared to 60% in February.

The 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 27th of February 2023. The impact of this change has been analysed and KPIs have been agreed between the Cancer Alliance and the Trust's Business Intelligence Team, it is planned that reporting of these KPIs will be available by July 2023.

4.2.3 Diagnostic Position

Diagnostic performance data for April showed a decline to 56.9% from 58.5% at the end of March for patients waiting less than 6 weeks.

The focus for quarter one is development of the Diagnostic Recovery Plan in conjunction with the NHSE Intensive Support Team. This project will embed good practice diagnostic pathway management, including refresh on DM01 rules, and accounting for diagnostic pathways in elective governance, development of a diagnostic PTL and support operationally led Demand and Capacity modelling for MRI, Colonoscopy and Echocardiography for key constraints on the clinical pathway, including scenario planning to compare pathway options.

The National Community Diagnostic Centre (CDC) programme has approved the CDC equipment for the Askham Bar and Selby sites which will increase capacity for physiological measurement, DEXA, Ultrasound and Phlebotomy. Askham Bar will be delivered in partnership with Nimbuscare.

4.2.4 Clinical Risk

Following the escalation regarding patients that had their referral to treat (RTT) Clocks Stopped erroneously resulting in patients not receiving treatment a Serious Incident Task and Finish Group has been established and has met. This includes clinical and technical expert stakeholders.

The following cohorts have been reviewed, the causes have been identified and mitigations to prevent reoccurrence have been put into place:

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

A process for clinical review for those patients has been agreed and is ongoing.

4.2.5 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/Current position
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 and Demand & Capacity	Action plan template approved at ERB and H&N ongoing, additional support objective agreed to support Gynaecology commenced 10.5.23.
Training	Launch of mandatory RTT training	Completed
	C&D and Recovery Planning Training	Back to basics workshop completed. Additional support objective agreed for 'drop in' sessions for Operational Managers and Clinicians ongoing.
KPI's and Reporting	Review of operational reports	Completed
	Development of elective KPI's	Completed, due to go live May 2023.
	Implement clock stop audit	Completed.
Diagnostics	Develop operational reports and PTL	Commenced and ongoing.
OP pathway booking process	Process mapping of booking process	Original support objective stood down. New objective agreed to critically review Ophthalmology and H&N OP booking processes

The progress against the EY Consultancy workstreams have now been completed is detailed below:

Governance

- Development of the elective governance book –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
- Report of summary findings and recommendations discussed and provided to Trust's BI Team.

Imaging

- Development of dashboard and insights report.

Histopathology

- Review of high-level histopathology service to identify opportunities for performance improvement report provided.

4.2.5 Delivery of the 2023/24 Activity Plan

The Trust experienced industrial action during April, which affected outpatients and elective procedures.

April 2023 Activity

Point of Delivery	Planned	Actual	% Plan	% 19-20 outturn
Outpatient 1st	14,603	11,379	78%	84%
Outpatient FU	34,713	30,269	87%	98%
Day Case	5,783	5,980	103%	100%
Ordinary Elective	700	461	66%	74%

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

Recommendation

That the Board notes the report and associated actions.

Date: 11th May 2023

Challenges & Risks	Actions & Mitigations

Acute Flow Priority Metrics – Narrative Page 1

Challenges:	Actions:
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 delivery of building materials. High number of patients without a 'Right to Reside' (228 on 9th of May 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 (14 patients on 12th April 2023) and community response teams. High number of patients with COVID-19 in inpatient beds, 99 on 9th of May. 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).	1. 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. 2. 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. • The programme was refreshed in late 2021 to develop three areas of focus and 7 priority workstreams. • This was then reviewed in February 2023 against the national UEC recovery plan to confirm the priority areas were in line with the national ask. • As part of the planning work for 23/24 the milestones for the programme have been set in line with the national expectations for achievement of the Emergency Care Standard, Ambulance response times and bed occupancy levels. • The plan indicates key delivery points in the summer and in October ahead of the winter. • 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. Recruitment to the Programme Team has been completed with two Programme Managers, Deputy Programme Manager and two Project Managers all in post. The Programme Team will be working across the four priority programmes for the organisation: UEC, Elective Recovery, Maternity and People & Culture. In addition, work continues with the Quality Improvement team and Corporate Efficiency team to explore joint working opportunities and avoidance of duplication whilst progressing shared approaches. ECIST are working with the programme team and specifically an Improvement Manager for two days a week as well as the required clinical leadership from the ECIST Clinical Leaders team. One of the National NHSE Directors is also working with the Programme team specifically on the Urgent Care Project. Whilst establishing the refreshed programme from August 2022 to March 2023 the following were key achievements: • Revised programme, with detailed metrics, linked to system measures and national targets.

Challenges & Risks	Actions & Mitigations

Acute Flow Priority Metrics – Narrative Page 2

	• System relationship development. • Scoping provision of a domiciliary care service and agreed direction for integrated intermediate care. • Development of an integrated urgent care specification and initial workshops with all stakeholders for the new model of care. • Establishing the trust strategy on virtual wards, i.e., the development of a virtual hospital infrastructure. As now recognised nationally as the most effective approach. • York Frailty virtual ward beds on trajectory of 5 patients, with 157 bed days saved and excellent patient feedback scores. • Significant analysis of understanding behaviour and populations in relation to children and young people. Identifying factors which drive family presentation and choice of location. • Testing Integrated models of care for children and young people such as the CAT hub. • SDEC benchmarking regionally and nationally identifying the areas which will have the most impact and identifying SDEC direct pathways to be implemented this year. • Development of internal professional standards to address two of the priority seven-day standards and address the requirement for a pan trust discharge framework. The April ECS position was 73% therefore achieving the trajectory (70.1%). The ECS is a system target and our work with system partners will continue. Both the York and North Yorkshire Place UEC plans are aligned with the Trust internal plan to cover Integrated Urgent Care and Transfer of Care projects. Regular meetings take place with partners in relation to the joint plans. Each project within the UEC Programme contributes towards this and has its own detailed metrics to indicate progress with the project specifically. Each of the project's objectives have been highlighted below in terms of how they will contribute to ECS performance. The impact is mainly in terms of reducing attendances in ED and thus reducing overcrowding and associated delays or in terms of reducing bed days (admissions and LOS) which will reduce bed occupancy and improve flow out of the Emergency Department, for those who need to be admitted. It will also improve capacity available in the department for those who need to attend ED. Nationally there is also a focus on Category 2 Ambulance response times which the Trust will support through delivery of these projects which will each contribute to ambulance handover times, enabling improved response times. The Trust has received a formal request from the Integrated Care Board to be the Prime Provider for Integrated Urgent Care services across the Trust's geographical footprint commencing 1st October 2023, subject to due diligence from both parties. The Trust is working through the due diligence and identifying risks and opportunities, an initial paper will be presented in May Trust Board with a detailed business case to be presented at July Board.

Challenges & Risks	Actions & Mitigations

Acute Flow Priority Metrics – Narrative Page 3

	The new metrics, by project, will be reported from next month once April data is available and routinely included in this report going forward. Community Response Team In relation to Transfer of Care, one key area of focus is the expansion of the Community response team for York. The Community Response Teams are a multi-disciplinary service of health care professionals providing assessment, intervention, rehabilitation and reablement for patients within their own homes, supporting admission avoidance and facilitating timely hospital discharges from Acute Hospital. The service is provided 8am – 8pm, 365 days per year, across the geographical localities of York, Selby and South Hambleton and Ryedale. Over time, the service has grown incrementally, with additional investment supporting the expansion of the clinical model in line with the Trusts Home First Strategy, to improve acute hospital flow and to deliver patient care closer to home. The service originated in the development of the York Intermediate Care Team, twelve years ago, providing rehabilitation and reablement for early supportive discharge, soon after amalgamating with the Community Fast Response Service to include an integrated admission avoidance function. Although the service has been expanded through specific funding streams, ongoing service improvement and economies of the scale have enabled efficiencies and the flexibility to support increasing demand. The service now regularly manages a caseload of between 130 patients and above, up to 171 patients during winter/COVID pressures and national strike action. The service has also responded to the growing needs of acuity, dependency, and complexity of patients on the caseload. The response to growing demand, has however relied heavily upon the good will and dedication of staff, regularly stepping down all non-essential work and the deployment of staff from other services to support patient flow. The current capacity of 109 is short of the demand of 145 patients who could use the service at any one time. Demand also continues to grow for the service and is in line with the strategic direction of the organisation in relation to caring for patients in their own homes. 3. 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.

Challenges & Risks	Actions & Mitigations

Risks:	Mitigations:
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. Further industrial action by BMA Junior Doctors and/or Royal College of Nurses.	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.

Challenges & Risks	Actions & Mitigations

Elective Recovery Priority Metrics – Narrative Page 1

Challenges:	Actions:
The Trust is in Tier 1 Elective Recovery support (National intervention) for RTT and Tier 2 for Cancer (Regional intervention). The Trust is off trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 196 against a target of 194 for April. 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.	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. The Trust had 187 RTT 78-week waiters remaining at the end of April below the planned trajectory of 192. 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 mid-June 2023. 5. Waiting List Harms Task and Finish Group established. 6. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with patient specific information ongoing.

Challenges & Risks	Actions & Mitigations

Elective Recovery Priority Metrics – Narrative Page 2

Risks:	Mitigations:
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. Further industrial action by BMA Junior Doctors and/or Royal College of Nurses.	Tier 1 fortnightly 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 live for non-admitted and diagnostic patients, the Trust continues to explore the opportunities this presents. 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.

Challenges & Risks	Actions & Mitigations

Acute Flow Exception (i) – Narrative Page 1

The ED Capital Build at York which commenced at the beginning of November 2021 has meant that York Emergency Department continues to operate out of a smaller footprint. The development has been delayed with a completion date of June 2023.	Work continues support direct admission from ambulance to assessment units by extending the range of clinical criteria for Paediatrics and Surgery by Summer 2023. Medicine is now in place. Protected beds for predictable admissions implemented for Stroke at York Hospital. Ambulance Handover Plan in place and updated SOP for escalations, cohorting and diversion requests. CIPHER cohorting contract in place since December 2022 funded by NY and York place for Scarborough (ambulance clinical handover and PTS discharge) and York (ambulance clinical handover working with VCS-PTS) has now been extended to March 2024 with confirmed ongoing funding. Plan agreed with Primary Care, the Humber and North Yorkshire Interim Locality Director and YAS for a QI approach around conveyancing and primary care to be undertaken across Scarborough (Rapid Quality Review took place early March) then York when the new build has been completed. As planned Dr Matthew Cooke (the former Clinical Chair of the Royal College of Emergency Medicine) visited the York ED in December and provided a comprehensive report which has been reviewed by the Care Group and incorporated into their transformation programme. To summarise he identified the following key actions: • Professional standards with other specialties and wards in terms of referrals and associated behaviours as well as improving communication with the site management office. • Clear plans for maintaining patient flow out of the front door services (UCC, ED, SDEC) – to be done by considering earlier transfers to the discharge lounge or reducing the number of ward moves for patients. • Capacity and demand analysis to ensure adequate and responsive staffing in all acute areas. As well as full hospital escalation to implemented when appropriate and boarding. • Agreed clinical pathways including externally to improve non conveyance and GP referrals to ED. • Clarity over the five-year vision for front door urgent and emergency care and the milestones on the way.

Challenges & Risks	Actions & Mitigations

Acute Flow Exception (i) – Narrative Page 2

	Work continues with the new ED build at Scarborough, which is due for completion in 2024, project resource has been identified to support the development of the revised clinical model.
Staffing constraints (sickness, fatigue, vacancies, use of agency and bank staff) coupled with future industrial action.	The Trust continues to collaborate with Vocare and continues, when possible, to backfill their staffing gaps. Weekly planning meetings are in place between Vocare and the Trust on the Scarborough site to maximise resilience with escalations relating to workforce gaps made to the ICS. Plans are in place to mitigate the impact of industrial action.

Challenges & Risks	Actions & Mitigations

Acute Flow Exception (ii) – Narrative Page 1

High number of patients without a 'Right to Reside' (228 on the 9th of May 2023) in inpatient beds affecting flow and ability to admit patients from ED in a timely manner.	Weekly meeting in place to progress the Rapid Quality Review Action Plan and individual patient escalations to local amenities and Place Directors.
The number of COVID-19 cases in the bed base remains high, increasing across the Trust to 99 from 143 on the 8th of April. Most COVID-19 positive patients are not being treated for COVID-19 as their primary complaint, however the need to manage high risk patients separately and cohort COVID-19 positive patients due to Infection Prevention Control (IPC) requirements creates flow (bed) issues and impacts on the Trust's ability to admit some elective patients. The Trust continues to be mindful of the risk of new COVID-19 variants.	COVID surge plan in place. Daily review of medical and nursing staffing to ensure appropriate skill mix – ongoing.

Challenges & Risks	Actions & Mitigations

Elective Recovery Exception (i) – Narrative Page 1 (Cancer)

Delays in the diagnostic pathway, affecting the 62-day pathway target and the number and percentage of patients on the Cancer Tracking List over 62 days.	The IST has reviewed the Cancer Recovery Plan as part of their support offer. Weekly Cancer PTL meeting with increased focus on breach avoidance in addition to backlog clearance in place. Significant reduction seen in the 63+ PTL numbers. The Trust has six Cancer Pathway Navigators in post covering the Lung, Scarborough Gynaecology, Upper GI, Lower GI, Urology and RDC services.
Absence of FIT testing in primary care when submitting colorectal fast track referrals.	Letter was sent to primary care in January 2023 advising that to make the transition to having >80% of colorectal referrals include a FIT result, referrals submitted to RSS on and after 27th February 2023 without a FIT result, for those pathways requiring a result, will not be accepted. The impact of this change has been analysed and KPIs have been agreed between the Cancer Alliance and the Trust's Business Intelligence Team, it is planned that reporting of these KPIs will be available by July 2023.
The current IT system does not enable clinicians to identify fast track diagnostic results, increasing time to report benign diagnosis of patients on the cancer PTL.	Somerset Cancer Register system to track our cancer patients: phase 1 live. Live PTL now being utilised as part of weekly cancer PTL meeting with increased focus on breach avoidance in addition to backlog clearance.

Challenges & Risks	Actions & Mitigations

Elective Recovery Exception (ii) – Narrative Page 1 (Outpatients)

Further industrial action by BMA Junior Doctors and/or Royal College of Nurses.	COVID surge plan in place. Plans in place to mitigate industrial action.

Elective Recovery Exception (iii) – Narrative Page 1 (RTT)

Theatre capacity affected by short notice sickness, vacancies and an influx of acute activity reducing the number of available theatre lists across the Trust during the month. Theatre staffing vacancy, retention, and high sickness rates. Anaesthetist vacancies: national position shows over one thousand vacancies across the country.	The Trust continues to review the theatre productivity approach and data quality. Improvements are being seen across most specialties with targeted work on those specialities that have not yet improved. DMAS being utilised to seek alternative providers for long waiting patients who are willing to travel.

Challenges & Risks	Actions & Mitigations
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. Potential further COVID-19 variants and/or waves. Ongoing management of high levels of acute activity impacting elective work.	Tier 1 fortnightly meetings with National and Regional Team on Elective Recovery. Waiting List Harms Task and Finish Group established. The NHS Intensive Support Team work continues with the EY Consultancy workstreams now completed, details below: Governance • Development of the elective governance book – 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 • Report of summary findings and recommendations discussed and provided to Trust's BI Team. Imaging • Development of dashboard and insights report. Histopathology • Review of high-level histopathology service to identify opportunities for performance improvement report provided. Electronic platform for patients to access guidance on keeping 'fit for surgery'; 'My Planned Care' platform live. "Back to Basics" Programme for operational managers launched early April at an event at the Community Stadium. Weekly Elective Recovery Meetings in place for long wait RTT patients.
Lower uptake of additional Waiting List Initiative sessions due to staff fatigue and pension arrangements than previously seen however it is that hoped the changes to pension provision will have a positive impact.	Use of IS capacity to support delivery of diagnostic activity (currently MRI and CT). Additional mobile capacity to be supported by the ICS.

Challenges & Risks	Actions & Mitigations

Elective Recovery Exception (iv) – Narrative Page 1 (Diagnostics)

Experiencing significant radiographic and sonographer workforce challenges in the Trust, impacting upon ultrasound and MRI delivery. There is a national shortage of trained imaging staff, and the number of radiographers which have retired recently or have left to undertake work as an agency or independent sector radiographer has increased creating further challenge for recruitment and retention. Significant increase in acute scanning compared to pre-pandemic levels continues for MRI (+360 scans per month), CT (+1,300 scans per month) and NOUS (+400 scans per month). Not only does this displace elective activity but acute scanning is more intensive, takes longer, and is exacerbated by workforce challenges on the inpatient wards.	Trust has secured an increased allocation of the ICS funded mobile MRI and CT scanners during 2023/24. Second CT scanner at Scarborough Hospital will be operational at the end of May 2023. Campaigns are ongoing to support workforce resilience, including: 1. International recruitment programme developed. 2. Development of a recruitment and retention premium for CT. 3. Introduction of Higher Support Worker roles in CT and USS. 4. Increased number of Radiographic apprenticeships and associated Clinical Educator roles to be funded to start growing a new workforce to meet the demands of the growing service. ICS CDC hub and spoke model: • Scarborough CDC hub proposal has been supported by the national team and is now with the Secretary of State for approval • The National Community Diagnostic Centre (CDC) programme has approved the CDC equipment for the Askham Bar and Selby sites which will increase capacity for physiological measurement, DEXA, Ultrasound and Phlebotomy. Askham Bar will be delivered in partnership with Nimbuscare. • Additional Diagnostic sessions being undertaken where possible.

Challenges & Risks	Actions & Mitigations

Children and YP Exception (i) – Narrative Page 1

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 reduced footprint.	Children and Young people Integrated Care and Assessment: The initial focus has been on understanding children and their family's behaviour around accessing healthcare. The partnership group will be reviewing this in February and starting to discuss options for integrated models of care which can be tested ahead of next winter. The CAT hub continues as the initial test of an integrated model of care with recurrent funding options being discussed with the Place team this month. PEM Consultant and CAT service in place at Scarborough.

Challenges & Risks	Actions & Mitigations

Community (i) – Narrative Page 1

Persistently increased length of stay in community inpatient units (IPU) in recent months has been driven by an increased deconditioning of inpatients in acute setting (driven by workforce shortfalls) which requires additional time for rehabilitation, workforce shortfalls in inpatient units slows rehabilitation progress and delays for patients who have additional care needs on discharge due to constraints in social care sector. Increase in referrals to York Community Response Team (CRT) driven by the implementation of Urgent Community Response pathway with funding and associated capacity in place to manage, additional demand for non-2 hour referrals for additional support for patients in the community and additional demand for patients leaving hospital (as with the IPU length of stay likely driven by increased hospital related deconditioning and AHP workforce shortfalls). We are seeing an increased number of step-up referrals to CRT which is putting pressure on step down referrals which in turn is impacting on delays in hospital. The growth not related to Urgent Community Response is not resourced and therefore capacity is not available to meet this increased demand leading to increasing delays for patients to start with the service and routinely running at OPEL4 due to demand on the service.	Paper presented to Executive Committee with proposed nursing workforce model for inpatient units. Proposal being developed for therapist establishment to provide 7-day therapy provision (actual delivery model will be an integrated nursing and therapy workforce). Care of Elderly team on acute site working with medical and therapy teams to understand increased referrals to CRT and IPU.
Increased demand for intermediate care without investment in additional capacity (as this is workforce delivered the investment needs to be over the longer term to allow recruitment of staff) will continue to build queues of patients in hospital awaiting discharge. It will also mean that people in the community experiencing a health crisis are less likely to be able to be supported in their own home and therefore present at the hospital front door for support. Workforce pressures in the Inpatient Units – through a combination of historical insufficient establishments, staff being redeployed to support acute ward workforce shortfalls and vacancy/sickness rates – lead to risk of sub-optimal care delivery and further pressure on the remaining staff on duty.	Continue to support additional bank staff utilisation for CRT to maximise available capacity to meet increased referrals. Daily IPU staffing review by community matrons to mitigate shortfalls.

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: 16 May 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 also welcomed Nik Coventry (DIS) and Sarah Barrow (Finance)			
Digital			
i)	- The Committee discussed the Digital KPIs. It sought further assurance on FOIs and the risks including not meeting statutory responsibilities. It requested again, for assurance, an update on the planned policy submission for the next meeting. - The Committee reviewed and discussed in detail the EPR Outline Business Case. Key milestones include the Trust moving towards the EPR digital maturity of HIMSS Electronic Medical Record Adoption Model level 5 by December 2024. Four options were considered and discussed including the 'do nothing' current CPD model. - The Committee requested that for assurance consideration be given to: o reviewing options appraisal including system impacts (ICB level: enterprise and hybrid system-wide interoperability). o Investigation ways to accelerate the benefit realisation from start at year 3 and reviewing more potential cashable incremental benefits from the business such potential savings of on premise infrastructure from moving to Cloud, patient pathway/process improvements, as well as wider non-cashable benefits e.g., sustainability. o cost review including gaps e.g., performance, and given the scale of the transformation is current workforce profile sufficient? Are patient forums to be included? - The Committee noted the EPR risks including the wider system risks with developing mitigation plans. - The Committee discussed the significance of this case: its impact on the strategy and the huge potential of enabling transformation for the Trust**. Board Action:** The Board to review the EPR case alongside its strategy review. To discuss as a priority, the level of Trust ambition, the strategic fit and impact of transformation on current requirements and thus case options.	BOARD BOARD	INFORMATION ACTION
Performance			
i)	- The Committee noted the downward trajectory of Covid patients presenting at the Trust from 122 last Committee Day to the current day of 78 patients. - The Committee noted that the Trust is still not meeting targets for ambulance handover (17% against a target of 10%) and the total number of patients waiting in ED over 12 hours (16% against a target of 8%).	BOARD	INFORMATION

	- The Committee noted the ICB ask for the Trust to become Prime Provider for IUC services, and sought assurance as plans develop. It welcomed the new programme structure for the Acute/UEC programmes.		
ii)	- For Elective Backlogs: The Committee noted 78 week waits position continues to improve with a planned trajectory of 192 and currently at 187, however is concerned about hitting the Tier 1 plan of zero by the end of June 2023). The Committee has consistently raised concern over the overall total RTT waiting list position which is unsustainably high and has risen again, now over 51k – a sustainable waiting list for open clocks is 26k. **Board Action: The Board to discuss as part of its strategy its Elective Backlog position particularly improving the RTT waiting list,** given in year plans are forecast only to do a 3% improvement. - Cancer position – the Committee noted the Trust had moved to a Tier 2 regime for the Cancer 62-day backlog, but the Trust remains off trajectory, with 196 patients waiting. - The Committee discussed and noted issues still with Diagnostics and Outpatients and is looking forward to gaining assurance from the forthcoming deep dives planned.	BOARD BOARD	ACTION INFORMATION
Finance			
i)	- The Committee noted the Trust has an adjusted deficit of £3.6M against a planned deficit of £2.6M for the period to April 2023 (mth1) i.e., the Trust is £1.0M adrift of plan. - Core CIP delivery is in month 1 £1.6m behind plan. - ICB reduction in spend ask is £17.5M 44% of this has been identified to date. - Target deficit position is £15.4M. - The Committee discussed the significant target deficit position and what can help short and longer term to improve the Trust finances, and return to 19/20 Trust-wide levels of productivity, taking into account quality, safe patient care. **BOARD Action:** As part of the Trust Strategy sessions to include how can the Trust overcome its current productivity challenges?	BOARD BOARD	INFORMATION ACTION
YTHFT			
i)	- The Committee noted the EPAM report with no items to escalate.	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 awaiting update from scheduled review i.e.LLP/Trust 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 for Trust targets 23/4. Deficit forecast is very concerning with risk of significant deficit.	Draft plans still to be approved, and monitoring/control of the deficit risk.