York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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

On: Wednesday 26th July 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**	Mark Chamberlain	Verbal	-	9:00
2.	**Apologies for Absence** To receive any apologies for absence.	Mark Chamberlain	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.	Mark Chamberlain	Verbal	-	
4.	**Minutes of the meeting held on 24 May 2023** To be agreed as an accurate record.	Mark Chamberlain	Report	07	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Mark Chamberlain	Report	15	
6.	**Organ Donation Presentation** To receive the patient story.	Rob Ferguson (Clinical Lead in Organ Donation)	Verbal	-	

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	Simon Morritt	 Report Report	 18 22	9:45
8.	**Risk Management Update Corporate Risk Register** To receive the latest Corporate Risk Register.	Mike Taylor	Report	57	9:55
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).	Polly McMeekin	Item 7.2	-	10:00
10. 10.1 10.2	**People and Culture Assurance Committee** To receive the: • May meeting minutes • July meeting exception report	Jim Dillon	 Report Report	 67 72	10:05
Trust Priority: Quality and Safety					
11.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 7.2).	Karen Stone & Dawn Parkes	Item 7.2	-	10:15
12.	**CQC Compliance Update Report** To receive an update on the CQC actions.	Dawn Parkes	Report	74	10:20

Item	Subject	Lead	Report/ Verbal	Page No	Time
13.	**Ockenden Report Update** To receive the report including:	Sue Glendenning			10:35
13.1	• Maternity & Neonatal Quality and Safety Report		Report	79	
13.2	• CQC Section 31 Update		Report	191	
14.	**Q1 Guardian of Safe Working Hours**	Karen Stone	Report	204	10:50
	11:00 Break				
15.	**Quality and Safety Assurance Committee** To receive the:	Steve Holmberg			11:15
15.1	• May meeting Minutes		Report	216	
15.2	• June Meeting Minutes		Report	223	
15.3	• June/July meeting exception report to include Action BoD Pub 14, report of significant concerns from the committee		Report	231	
Trust Priority: Elective Recovery & Acute Flow					
16.	**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).	Claire Hansen	Report	234	11:30
17.	**Digital, Performance and Finance Assurance Committee** To receive the:	Lynne Mellor			11:35
17.1	• May meeting minutes		Report	244	
17.2	• June Meeting Minutes		Report	248	
17.3	• June meeting exception report		Report	252	
17.4	• July meeting exception report		Report	256	

Item	Subject	Lead	Report/ Verbal	Page No	Time
Governance					
18.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 7.2).	Andrew Bertram	Item 7.2	-	11:45
19. 19.1 19.2 19.3 19.4	**Items for Information** • Collaboration of Acute Providers Governance (Blue Box) • Executive Committee Action notes (Blue Box) • Star Award nominations (Blue Box) • TPR Mandatory Reporting (Blue Box)	All		-	-
20.	**Any other business**	Chair	Verbal	-	
21.	**Time and Date of next meeting** The next meeting held in public will be on 27 September 2023 9:00am.				
22.	**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.				
23.	**Close**				12.00

Minutes
Board of Directors Meeting (Public)
24 May 2023

Minutes of the Public Board of Directors meeting held on Wednesday 24 May 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
- Mark Chamberlain (Interim Chair)
- Lynne Mellor
- Jim Dillon
- Denise McConnell
- Lorraine Boyd
- Steve Holmberg
- Jenny McAleese

Stakeholder Non-Executive Director
- Matt Morgan, Stakeholder Non-executive Director

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, Director of Communications

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

Observers:
- Emma Hardy – Member of the Public
- Maria Di Sciascio, Chief of Quality Control and Risk Management, Chieti, Italy
- Zaid Alnakeeb, Deputy Medical Director, Mallorca, Spain

This was the first meeting for Mark Chamberlain as the Interim Chair. Mark gave an overview of his background and his role as Member of Humber and North Yorkshire Integrated Care Board (a role in which he will be stepping down from during his Interim role with the Trust). Mark went on to share that patient care was his number one priority and the delivery of this coming from having excellent engaged staff who have the right

skills and tools to deliver this. Getting the culture and approach right from the Board in setting the tone and influencing the rest of the organisation.

The Chair welcomed everyone to the meeting.

20 23/24 Apologies for absence

No apologies received.

21 23/24 Declaration of Interests

There were no declarations of interest to note.

22 23/24 Minutes of the meeting held on 26 April 2023

The Board approved the minutes of the meeting held on 26 April 2023 as an accurate record of the meeting following an addition to minute 15 23/24 to be agreed outside the meeting.

23 23/24 Matters arising from the minutes

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

BoD Pub 02 - 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. Polly McMeekin updated that a reasonable adjustment report had been presented to the Executive Committee with specific recommendations around implementing reasonable adjustment approaches such as a policy, training for staff and also an equipment log/library for the digital team to expedite requests when related to reasonable adjustments. This action was now closed.

BoD Pub 03 - Ellen Armistead to attend and present at an upcoming meeting of the Board of Directors. The Board noted the Ellen was scheduled to attend the private meeting but for personal reasons she was no longer available to attend. This would need to be rescheduled.

24 23/24 Patient Story

The Board welcomed Dr Jemimah Clarke to the meeting to present her son's (Jamie Clarke) experience whilst a patient at York Hospital. Jamie was admitted on Sunday 19 February with sepsis and was then transferred to ward 17. Dr Clarke described the care they had received from across all professions they had interacted with including doctors, nurses, surgeons, healthcare support workers, radiographers and imaging assistants, critical care outreach team to name but a few. Dr Clarke described that everyone had been amazing, caring, professional and helpful and without doubt worked above and beyond to ensure the best outcome for Jamie. Dr Clarke shared that she was aware of staff shortages in the Trusts but wanted to ensure that the Board heard that this was not evident throughout their stay. Jamie was since recovering well at home.

The Board took the time to thank Dr Clarke for attending the meeting and sharing her families experience, appreciating how challenging this will have been.

25 23/24 Chief Executive's Update

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

- BMA industrial action – Junior Doctor members of both the BMA and HCSA unions will walk out from 7:00am on Wednesday 14 June until 7:00am on Saturday 17 June 2023. Understand action will be taken every month until there is an agreement. Significant impact previously in particular on elective recovery. Hope to find a way forward
- Agenda for change pay award/settlement has been agreed
- Stepping down from NHS Level 3 incident
- Deescalating around mask wearing for visitors, patients and staff. Some exceptions, notably in areas with patients identified as being at high risk of severe Covid infection. People were welcome to continue to wear if they chose to do so
- Leadership changes within the North Yorkshire and Humber ICS:
    - Jonathan Lofthouse has been appointed Joint Chief Executive for Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust.
    - Peter Reading will be joining Yorkshire Ambulance as Interim Chief Executive.
    - Jonathan Coulter has been appointed Chief Executive of Harrogate and District NHS Foundation Trust.
- Changes at Trust Board:
    - Interim Chair - Mark Chamberlain
    - Claire Hansen joins in July 2023 as Chief Operating Officer
    - Melanie Liley as Interim Chief Operating Officer will continue to support the leadership team in her capacity as Chief Allied Health Professional

26 23/24 Risk Management update – Corporate Risk Register

The Board received and noted the current Corporate Risk Register that were risks rated 15 or greater following a formal risk assessment process and consideration at the Risk Committee.

The Board noted three new risks that had been added following the May Risk Committee:

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

27 23/24 Trust Priorities Report: Our People

Polly McMeekin described conversations previously at the People and Culture Assurance Committee around retention in general but particular in healthcare support workers. Polly went on to describe that during 2022 70 full time equivalents had left and when tracked, the reason being the pay differentials with bank incentives and flexibility which consequently really supported the Trust's priority to drive the agile and flexible working agenda, in particular within the nursing workforce.

Mark Chamberlain shared an experience with a logistics company who operate multiple shift patterns to accommodate different people as a result of struggling to recruit. He questioned whether it would be worth investigating something like this.

The Board concluded that the staff survey revealed that the flexible and agile working agenda was generally acceptable, but struggled in clinical areas. Staff shortages had led to anxiety among rota workers. Self-rostering had been successful, but staff shortages had

hindered progress. Exploring creative ways to work and exploring alternative Trusts was needed. Agile working was driving progress, but addressing pay and banding needed to consider the competitive market. The Board acknowledged that Strategic discussions were needed to address these issues and ensure a more equitable work environment.

Action: Strategic Discussion for Board to include agile and flexible working

28 23/24 Workforce Race Equality Standard (WRES) Annual Report

The Board received and noted the WRES Annual Report. Polly McMeekin discussed the national submission from August to the end of May, working with staff networks to co-develop the action plan. They identified a struggle in WRES, with 6 out of 9 metrics deteriorating. Metric 5 showed staff believe bullying was felt to be race related. Work was ongoing with the Head of Health and Safety to call out inappropriate behaviours from patient and service users.

Jenny McAleese asked about assurance for White non-British employees, but there is no national comparative. Matt Morgan discussed the timeline for actioning and the need to close the recruitment gap by next reporting. Lynne asked about PLACE support and connections for bullying and harassment, while Simon suggested a discussion with Jane Hazelgrave at ICB. Mark Chamberlain emphasised the importance of supporting staff and ensuring appropriate action.

29 23/24 Workforce Disability Equality Standard (WDES) Annual Report

The Board received and noted the WDES Annual Report. Polly McMeekin described an improving picture with ten metrics, six of which shoring improvement. A staff network did exist but needed to develop some momentum.

30 23/24 Nurse Staffing Report

The Board received the report describing how the Trust had responded to provide the safest and effective nurse staffing levels during February and March 2023 and provided assurance that nursing establishments had been reviewed utilising best practice guidance and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce were in place. Heather McNair described that little had changed from the previous month. She highlighted a gap between temporary staffing and fill rates, advising that a monthly report will be presented on the impact of this gap.

Jenny McAleese suggested that night figures were better due to enhancements, but late shifts were not appealing. Heather suggested ensuring full establishments at night to fill deficits, as other workforce filled them in the day. Denise McConnell questioned the establishment figures based on the plan, as they were consistent in March, April and May. Heather described that the report included the March figures and the plan was not signed off, once it was, the vacancy gap would become bigger and the establishment figures would then reflect the capital plan.

31 23/24 People & Culture Assurance Committee

Chair of People and Culture Assurance Committee Jim Dillon raised the Committee issue of electronic rostering for ward-based staff, which was part of the NHS's approved process. An imminent report from NHS England would support discussions on this issue. Jim highlighted that the costs of having an appropriate system may require significant investment, and the Board should take these concerns seriously. The lack of resources in

the new rostering team and the difficulty of fully rolling out eRostering across the entire workforce were challenges. The NHS England report should be revisited through the Executive Committee to identify necessary changes to the Board. Andrew Bertram emphasised the importance of benefits realisation and costing in this process.

Action: Delegation to the Executive Committee - Workforce planning and resource management in relation to an effective e-rostering facility and consideration given to the acquisition and implementation of suitable e-rostering system. An outcome report to return to the Board.

32 23/24 Trust Priorities Report: Quality & Safety

The Board received and noted the quality and safety update.

33 23/24 CQC Update

The Board received and noted the updated position to the action being taken to address the CQC regulatory conditions.

The Board noted on 21 April 2023 the Maternity action plan, in response to the section 31 warning notice, was submitted in line with CQC requirements.

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

Mark Chamberlain emphasised the importance of discussing outcomes, while Steve Holmberg described the struggle for the Quality and Safety Assurance committee to obtain any assurance up to now. Melanie Liley acknowledged the wider NHS system recognition and input of their contribution of the impact and outcomes of this.

34 23/24 Ockenden Report Update

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

Steve Holmberg discussed the new report format and positive steps taken to provide assurance however, the saving babies lives results were disturbing and the Quality and Safety Assurance Committee had asked the team to go back and look into that in detail.

Denise McConnell discussed the summary of maternity services and the need for a report on progress and training targets. Steve mentioned that similar training compliance figures were seen across the Trust. Karen Stone mentioned the need for more training for maternity, as there was a mix of issues such as time to take the training. Andrew Bertram mentioned the sustaining training section and resource issues, stating that funding cannot be the barrier. Polly McMeekin discussed the care groups' prioritisations in relation to their resources and noted that the learning hub system being unavailable for a period of time. Mark Chamberlain emphasised the importance of training for maternity and the Board-level message of training. Each care group received their training KPI's, and Managers were able to link into the learning hub to see where their staff are. Steve suggested a "mandatory training month" or something similar, which Simon Morritt agreed to look into. Simon Morritt acknowledged longstanding issues with clinical staff and suggested a timescale for improvement would be helpful. Karen suggested engagement with clinicians and mandatory training should be included in appraisals, with progress visible over the next year.

Mark highlighted the importance of accreditation and the risks associated with delays in scanning. Lorraine suggested emphasis on professionalism and training being a requirement of professional status. Lorraine also highlighted the importance of risk and that the Board were sighted on compliance with saving babies' lives (improvement team were now working on and supporting that) and the delays in scanning too, noting the risks associated with that. The Board needed to be aware of this being outside of the national standard.

The Board were clear that training and compliance was really important and wanted to support the staff in working on this and doing the right thing by professionalism. The Board requested that Sue reports back on progress to a future meeting of the Board.

Action:

- **Staff Training - supporting to improve the training and compliance in particular in maternity, the Board suggested a 'mandatory training month' initiative or similar and a key message from the Executive Team around professional responsibility in compliance. The Chief Executive agreed to follow up and consider an approach.**
- **Saving Babies' Lives V2 - To report back to the Board on progress**
- **Ultrasound in Maternity - Report back to the Board on progress**

35 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 raised concerns about the fragility of some services and the need to improve delivery across all sites. Hospital Associated Infections - there were still concerns and not assurance. Heather McNair highlighted the need for significant improvement in investments this year in particular around IPC.

Mark Chamberlain requested Steve to provide a written list of key priorities of the Board in understanding where they are around quality and Safety.

Steve also suggested that risks were held by the lead executives and that the Board should tease out risks that don't necessarily come directly to the Quality and Safety Assurance Committee. The Board agreed that siloing risks into specific sub committees was not sensible.

There were no further challenges or comments of note.

Action:

- **Steve Holmberg - Provide a written report of significant concerns discussed at the Committee to raise for discussion and action with the Board**
- **All committees to be sighted on all risks that are reported including those outside of Executive Lead relevant to the committee portfolio**

36 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 that the Covid-19 position had seen a downward trend with 78 patients, reflecting the national position. Acute flow had seen improvements, such as ambulance turnaround. The Emergency Care System (ECS) trajectory had been achieved at 76%. New metrics for each project within the UEC Programme, will be reported from next month once April data was available and routinely included in this report going forward.

The Board noted that the Trust had 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 was working through the due diligence and identifying risks and opportunities, a detailed business case was to be presented at July Board.

The Board also noted the work of the 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 were 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 Board recognised the importance of understanding the population in the Trust's community around learning difficulties. The Data Quality Committee had discussed steps to address disability data groups, and Melanie agreed to evaluate how the data would be applied to other working groups.

The Board noted the update report.

37 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 such as the key implementation of the EPR system, performance, and financial challenges. The Committee discussed the benefits and associated costs of the system, which will be a transformative change enabler. The Board was asked to consider the EPR case at its private meeting to then consider the case and all that surrounds it and as part of the strategy session, specifically talking about transformative change of which this EPR will support.

Lynne discussed the performance of the Trust in addressing the elective backlog and RTT waiting list. She emphasised previous committee discussions on strategic actions to overcome these challenges. Melanie Liley acknowledged the growth of the RTT backlog and the pandemic's impact on the position. Trust programs aimed to improve this position. Committees were discussing strategic approaches with system partners to balance the Trust's priorities of acute flow, elective recovery, and its financial challenges. Lynne assured the Board that the Committee was overseeing a number of deep dives planned.

38 23/24 Finance Update

The Board received and noted the income and expenditure Trust position, Andrew Bertram highlighted that the Trust

The plan for 2023-24 aimed to deliver a £15.4m deficit, with a £3.6m deficit driven by staffing and the efficiency program. The organisation was £1m adrift at the end of month 1, but this was likely to change. The CIP ask was over £21m (£21.4), and the gap position would close in the plan. The ICB had a total of £17.5m cost saving requests, with £7.4m identified. A significant contribution was made by elective work and switching follow-up resources to invest elsewhere. There were no cash issues to raise with the Board. Denise McConnell suggested putting together a key variances table to see the difference in productivity. Mark Chamberlain enquired about staff awareness of financials and was subsequently assured that key messages were delivered through staff briefs with a focus on working within the resource envelope.

39 23/24 Any Other Business

Research and Development

Lynne Mellor raised reporting of Research and Development to the Board and suggested that this be reinstated as a regular update. This was subsequently agreed.

Action: Associate Director of Corporate Governance - Return research and development reporting into the Board agenda

Question from Member of the Public

Emma Hardy attended the Board meeting to ask the Board about the Trust's Eliminating Mixed Sex Accommodation (EMSA) Policy and why the Trust had adopted gender self-identification instead of the protected characteristic of biological sex to provide single-sex spaces. Emma asked for the Board to explain how this policy had balanced the needs of other protected groups. Heather McNair responded acknowledging that the Trust has a duty to safeguard its staff and patients and national guidance is followed. The Trust's Head of Equality, Diversity and Inclusion had already invited Emma to be part of the review of the Trust Policy. Mark Chamberlain confirmed that by virtue the Board would respond and involve Emma in the process and acknowledged that the Board needed to consider the issues.

Action: Review of Eliminating Mixed Sex Accommodation (EMSA) Policy

40 23/24 Time and Date of next meeting

The next public meeting of the Board of Directors will be held on 26 July 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 (Section under which the item was discussed)	Action (from Minute)	Executive Lead/Owner	Notes / 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 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	Update 26.04.23 - Scheduled to attend 26.04.23 but Ellen unable to attend, will require rescheduling 13.07.23 - moved due date to September to provide a 'look back' report to the Board	Sep-23	Green
BoD Pub 05	**155**	21 March 2023			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.	Trust Chair	Escalation from Digital, Performance & Finance Assurance Committee to Board of Directors	Sep-23	Green
BoD Pub 06	-	29 March 2023	165 22/23	Chief Executive's Update	Associate Director or Corporate Governance to arrange a further TPR session for the Board.	Associate Director of Corporate Governance	MT - Update 06.06.23 chasing up with James Hawkins and Nikki Slater	Sep-23	Green

BoD Pub 09	-	24 May 2023	27 23/24	TPR: Our People	Priority discussion for Board on agile and flexible working	Director of Workforce and Organisational Development	Merge 09 & 10	Sep-23	Green
BoD Pub 10	-	24 May 2023	31 23/24	People and Culture assurance Committee Report	Delegation to the Executive Committee - Workforce planning and resource management in relation to an effective e-rostering facility and consideration given to the acquisition and implementation of suitable e-rostering system. An outcome report to return to the Board.	Director of Workforce and Organisational Development	The discussion was to include benefits realisation as well as any costing Merge 09 & 10		
BoD Pub 11	-	24 May 2023	34 23/24	Ockenden Report Update	Staff Training - supporting to improve the training and compliance in particular in maternity, the Board suggested a 'mandatory training month' initiative or similar and a key message from the Executive Team around professional responsibility in compliance. The Chief Executive agreed to follow up and consider an approach.	Chief Executive	09.06.23 - Director of Workforce and OD to share a plan with Board.	Jul-23	Green
BoD Pub 12	-	24 May 2023	34 23/24	Ockenden Report Update	Saving Babies Lives V2 - To report back to the Board on progress	Chief Nurse	Trust remains non-compliant, this not only poses a safety risk to both the mother and baby but non-compliance with standard six of the Maternity Incentive Scheme.	Jul-23	Green

BoD Pub 13	-	24 May 2023	34 23/24	Ockenden Report Update	Ultrasound in Maternity - Report back to the Board on progress	Chief Nurse	It had been identified that there were several areas of concern in ultrasound in maternity. The audit benchmarked against national standards for scan within 72 hours of referral as outlined by the Perinatal institute and within Trust guidance. The audit showed significant delays of longer than 10 days of time from referral to scan in some cases.	Jul-23	Green
BoD Pub 14	-	24 May 2023	35 23/24	Quality and Safety Assurance Committee Report	Provide a written report of significant concerns discussed at the Committee to raise for discussion and action with the Board	Chair of Quality and Safety Assurance Committee (Steve Holmberg)		Jul-23	Green
BoD Pub 16	-	24 May 2023	39 23/24	AOB - Research and Development	Return research and development reporting into the Board agenda	Director of Workforce and Organisational Development & Associate Director of Corporate Governance	Included on Board work programme quarterly from November.	Nov-23	Green

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

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

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

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

Summary of Report and Key Points to highlight:

To provide an update to the Board of Directors from the Chief Executive in relation to the Trust priorities. Key areas include: Industrial action, Care Quality Commission (CQC) report published, opening of new emergency department at York Hospital, care group structure review, Board changes.

Recommendation:

For the Board of Directors to note the report.

Report Exempt from Public Disclosure

No ☒ Yes ☐

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

Report History

Board of Directors only

Meeting	Date	Outcome/Recommendation
Board of Directors	26 July 2023	

Chief Executive's Report

1. Industrial action

We continue to experience the impact on ongoing industrial action. At the time of writing junior doctors have just completed their longest period of action lasting five days, and consultants are due to take action on 20 and 21 July. The BMA has also recently confirmed that consultants will take further action on 24 and 25 August.

Our staff are to be commended for working differently and supporting colleagues to provide a safe level of service throughout the action, however there are inevitably consequences for our elective recovery, with a number of planned operations and appointments postponed.

The BMA's mandate for junior doctors' industrial action runs out on 19 August, and they are holding an additional ballot to seek a further mandate to enable action to continue.

Meanwhile, the outcome of the RCN's ballot for further strike action concluded with no mandate for further strikes.

2. Care Quality Commission (CQC) report published

As Board members will be aware, the CQC's report was published at the end of June, covering inspections which took place between October 2022 and March 2023. During this inspection period the CQC inspected Emergency and Urgent Care, Medicine and Maternity in both York and Scarborough hospitals, and looked at the 'well-led' key question for the Trust overall.

It is important that we accept the report as a reflection of a particular point in time, and focus on using the recommendations to prioritise where we need to take action.

I am encouraged that the CQC found positive improvements against some of the areas of concern that were identified in their previous visit in March 2022. This includes improvements in systems related to nutrition and hydration for patients on medical wards on both sites.

They also talked positively about the systems in place to manage demand within the emergency department in Scarborough, and it is fantastic to see that the overall rating for urgent and emergency care at Scarborough has been lifted to requires improvement.

Their feedback also highlights some significant concerns and areas for improvement, some of which we were asked to respond to quickly.

The feedback in the well-led review also makes it clear that we need to go further, faster in our action to foster an open and inclusive culture for all our staff. Improving the experience of all staff who work here, and making the trust an exceptional place to work, remains our priority and we must commit to doing everything we can to see this improve.

In response to the report we are required to produce an action plan for submission to the CQC. As is normal practice we can expect a follow-up inspection in a few months' time to

look at progress against this action plan. We are therefore providing focused support, not just to the areas inspected this time but across all our key quality and safety priorities, to ensure that collectively we can demonstrate ongoing, positive progress and that we are ultimately improving patient care, which is at the heart of all we do.

3. York's new emergency department opening celebration

I was delighted to be joined by colleagues from across the trust to celebrate the official opening of York Hospital's expanded and redesigned emergency department earlier this month.

The two-storey expansion, which took just 20 months to complete, includes a vital new eight-bedded resuscitation area and twelve new assessment and treatment cubicles. There is also a newly remodelled waiting area which contains a separate children's area and supporting facilities.

Upstairs in the extension there is a spacious area for same-day emergency care where patients will be treated in the department and then discharged without the need to be admitted as an inpatient.

The environment for care is much better and we are hoping to reduce the time patients must wait - as well as improving the quality and timeliness of urgent treatment and reducing ambulance handovers.

This expansion is long overdue, so it is with great satisfaction and pride that we were finally able to officially mark the occasion in the week the NHS celebrated its 75th birthday.

4. Care group structure review

Over the past few months the executive committee and wider care group leadership teams have been looking at our current care group structure as part of a planned review of clinical structures that was due to take place after the introduction of care groups, but was postponed whilst we were at the height of managing the pandemic. It is now the right time to consider how we can evolve this structure to ensure that we are configured in the most effective way to tackle the significant challenges we are facing.

These discussions have resulted in an agreement to move from six care groups to four, as follows:

- Medicine Care Group
- Surgery Care Group
- Family Health Care Group
- Cancer, Specialist and Clinical Support Services Care Group

There will also be some changes for specialities who will be moving between care groups to further develop clinical alignment.

The new structure will help to strengthen how we deliver the principle of being a clinically-led organisation, which remains fundamental to how we manage our services. This is alongside the need to have effective senior leadership teams, cross-site integration and a 'one service delivered on multiple sites' ethos.

To support the revised structure we are also reviewing and streamlining our governance arrangements to ensure we are better able to manage risk and performance in relation to our key challenges and priorities without increasing the burden for teams within each care group. This reflects the work that was done with EY, and will ensure that our governance processes support our capability and capacity to deliver the improvements that are required.

We are currently seeking expressions of interest from clinicians for the care group director roles. These opportunities are open to substantive consultants, with four posts available across the new care group areas.

5. Board changes

Since the last public meeting of the Board of Directors Dawn Parkes has joined us as Interim Chief Nurse, following Heather McNair's secondment to North Yorkshire and Humber Integrated Care Partnership.

Dawn joins us from Mid Yorkshire Teaching NHS Trust, where she held the role of Director of Nursing and Quality.

Claire Hansen has also now joined us as Chief Operating Officer. Claire has extensive operational experience across all specialties, most recently as Deputy Chief Operating Officer at Northern Lincolnshire and Goole NHS Foundation Trust, where she has also acted up into the Chief Operating Officer role. Most recently Claire was Director of the Humber Acute Services Review, which involves four of the places and two of the secondary care providers in our ICS.

Claire's arrival means that Melanie Liley, who has been Interim Chief Operating Officer since July 2022, has handed over the baton. I am pleased to say that she will continue to play a pivotal part in our senior leadership team in her capacity as Chief Allied Health Professional.

Date: 26 July 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

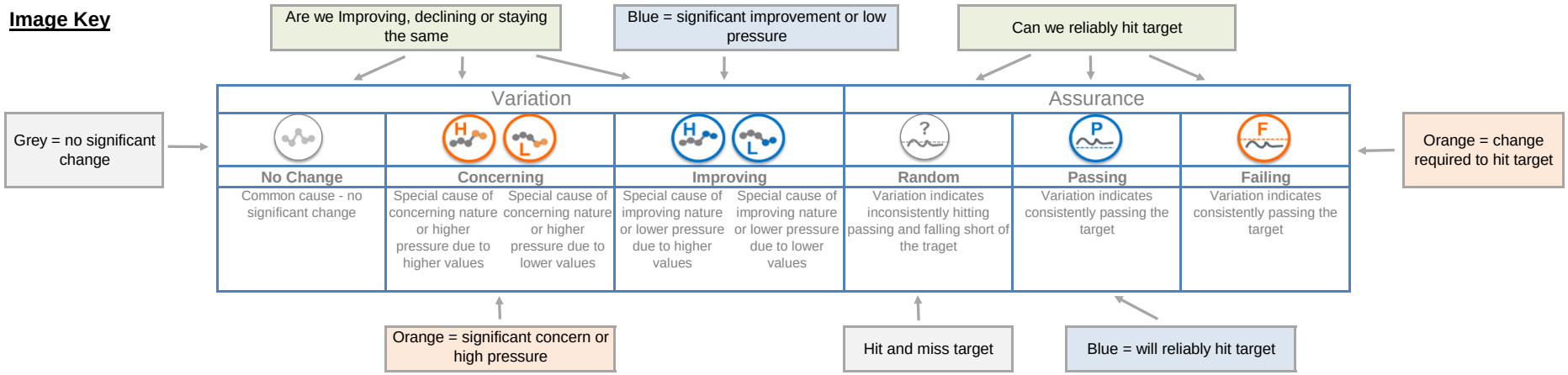
July 2023

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

KEYS

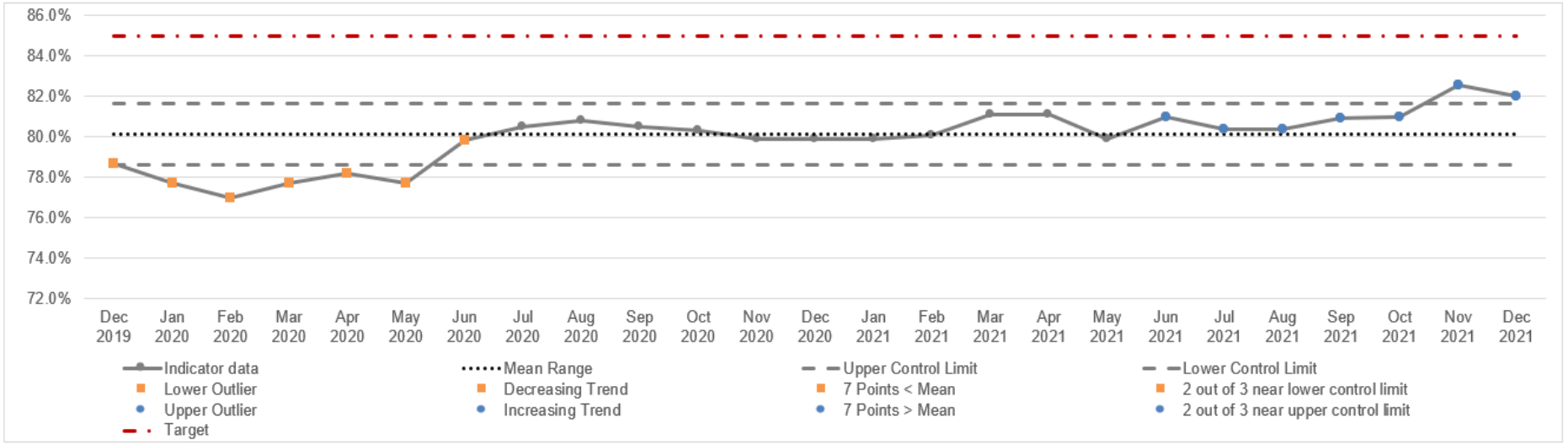
York and Scarborough Teaching Hospitals NHS Foundation Trust

Image Key



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

SPC Key - example SPC chart



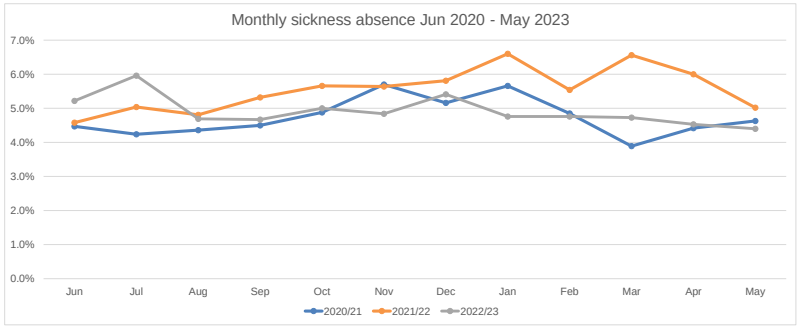
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

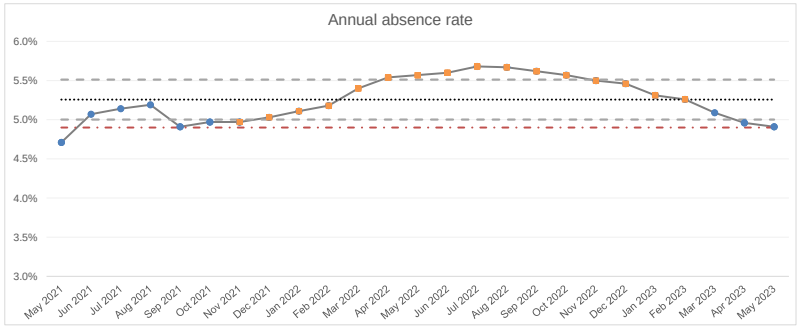
OUR PEOPLE - Sickness Absence and Staff Survey

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

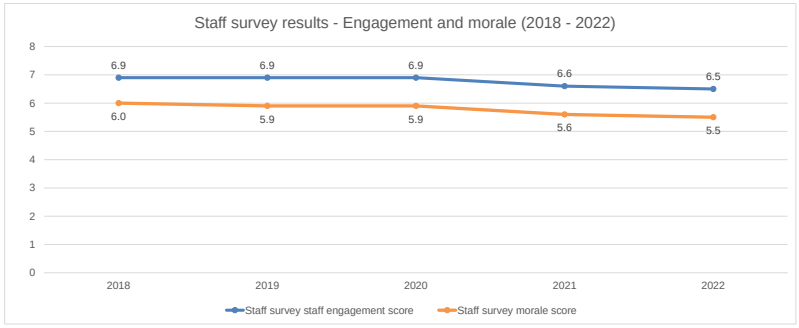
REPORTING MONTH : JUNE 2023



May 2023
4.40%
Target
No Target
Variance
Assurance



May 2023
4.91%
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 May 2023 (4.40%) is lower than that seen last year (5.02%).
Annual absence rate: The indicator was showing special cause concern from November 2021 to February 2023, being above the upper control limit from April to October 2022. Recent months are showing improvement below the lower control limit. 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

The latest available sickness data is for the month of and year ending May 2023. This shows that the monthly sickness absence rate for May 2023 is both lower than the previous month and lower than in the same month of 2022. The cumulative 12 month absence rate has decreased again for the tenth month in a row.

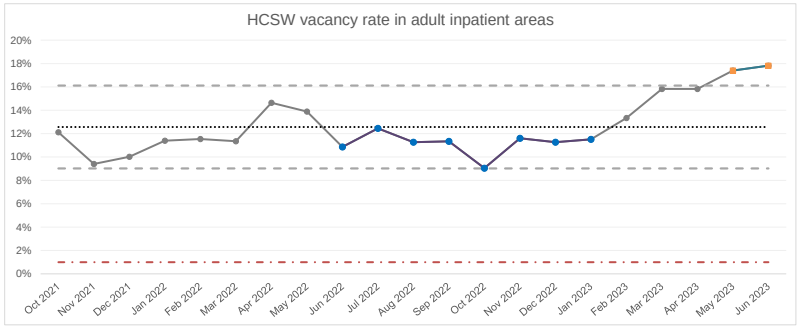
Our Voice, Our Future planning is progressing as the Organisation is in the scoping phase of the programme. With full support of the Board the Transformation Team are planning the approach for the recruitment of 'Change Agents' to be selected from the Organisation to assist through the Discovery Phase of the programme. The Board is supportive that this is a priority for the Trust and as such work should be prioritised to enable these individuals to have the time to support the culture change work.

The roll out of Appraisals within the Trust will seek confirmation that every individual has had a conversation with their line manager about their own health and wellbeing to ensure we are supporting individuals to remain in the workplace.

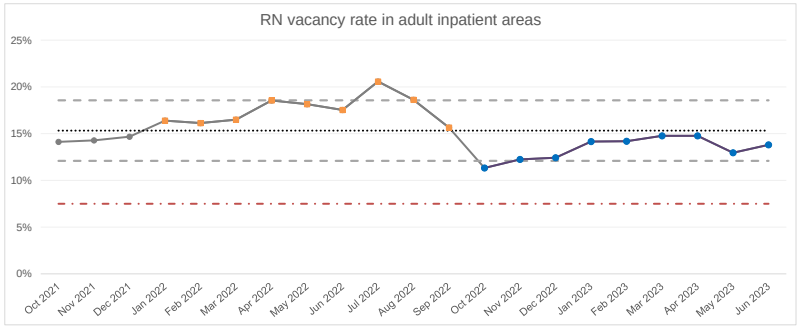
OUR PEOPLE - Vacancy Rate

REPORTING MONTH : JUNE 2023

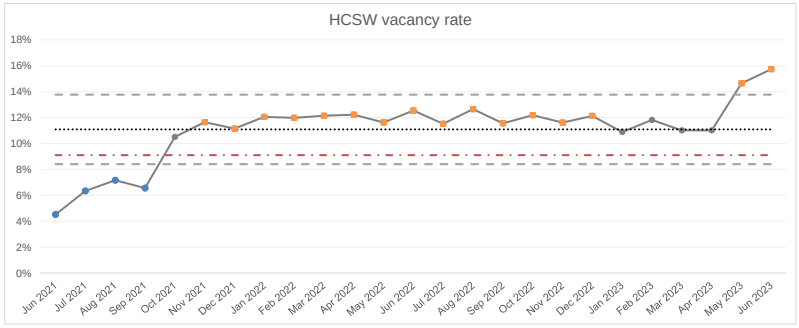
York and Scarborough Teaching Hospitals NHS Foundation Trust



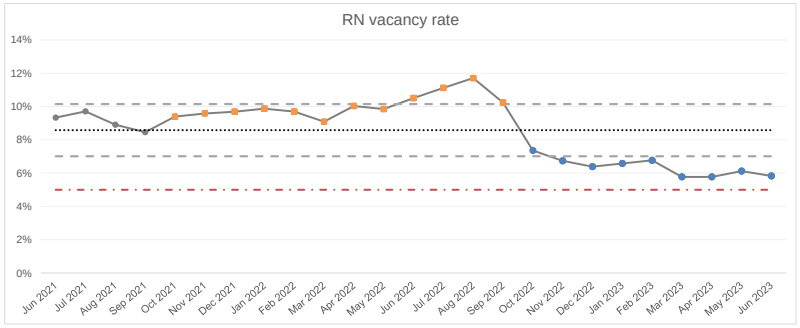
Jun 2023	Target	Variance	Assurance
17.82%	1%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Jun 2023	Target	Variance	Assurance
13.81%	7.5%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target



Jun 2023	Target	Variance	Assurance
15.74%	9.10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target



Jun 2023	Target	Variance	Assurance
5.83%	5%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target

Data Analysis: (Please note that the Apr 2023 vacancy figures are unavailable as the operational budgets were not finalised, the data points on the charts for Apr 2023 are the same as Mar 2023)

HCSW vacancy rate in adult inpatient areas: The indicator is currently showing special cause variation above the upper control limit for May and Jun 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 special cause improvement with Oct 2022 being below the lower control limit and then a series of points below the mean. Please note the vacancy rate is shown from Oct 2021 only. The target is consistently not being met.
HCSW vacancy rate: The indicator is showing special cause concern above the mean from Oct 2021, with May and Jun 2023 above the upper control limit. 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 from Jun to Sep 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

The organisation continues to welcome our new international recruits, with the next nursing cohort of 17 due to arrive in July. At present the Trust has 49 nurses under offer to allocate to future cohorts, putting the Trust in a good position to achieve our recruitment target of 90. One area of concern is our recruitment of paediatric nurses, our target is 8 (within the overall target of 90 INs) but we are not seeing a significant amount of interest in the role – a recent advert generated over 100 applications but only 1 was from a paediatric nurse. We continue to promote the role and will backfill the posts with adult nurses to meet our funded target if needed. Our latest cohort of nurses have had a low first time pass rate for their OCSEs at just 25%, the Trust target is a 45% first time pass rate by Q3. In light of these recent results, the CNT are working to a newly revised improvement trajectory to try and achieve our target.
The RN vacancy rate shown in the graphs above doesn't include our International Nurses who have not yet sat OCSEs or are awaiting their PIN. When these staff are taken into account, the vacancy rate in adult inpatient areas is reduced to 11.64%.

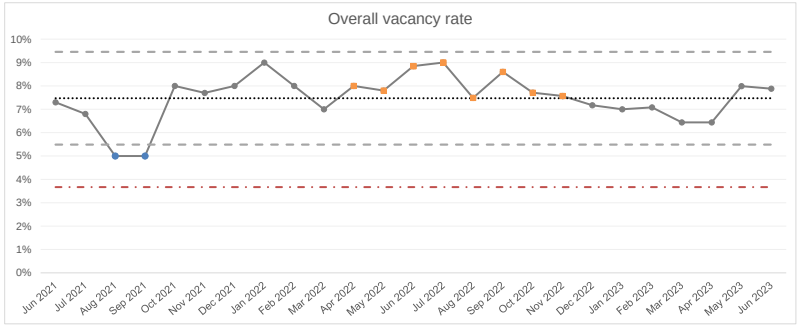
The Trust held a HCSW Event at the Scarborough Campus of Coventry University on 13th June, and made 18 offers of employment from this. There are currently a total of 52 candidates in the pipeline across sites and we have over 30 people booked on to our next inductions across both sites. We are holding a recruitment event on the 19th July which will cover Nursing, Healthcare Support Workers and Patient Services Operative roles for York Hospital. The focus for this event is to fill the vacancies that we have in Care Group 1 with a focus on ED, EAU, Medical, Acute, Elderly and Community. There will be interviews on the day for all roles, with the hope the event will be as successful as previous events at The Community Stadium. The increase in the HCSW vacancy position this month is related to a further increase in budgeted establishment of 14.5FTE (in addition to the increase reported last month), rather than a change to the number of staff in post which has remained similar to last month.

On Saturday 1st July, for the first time in a number of years, a Trust wide Recruitment Event was held in the main foyer of York Hospital. Interest was incredibly high, with around 1000 people coming through the doors. Some interviews were held on the day, including a number of Pre-Registered Nurses which will take our number of Pre-Registered nurses recruited this year to 100 – an incredible achievement. The event had representation from a number of key areas across the Trust which helped to create a fantastic atmosphere, with brilliant feedback from stallholders and potential candidates. It is hoped the event will lead to a spike in the number of applications received over the coming weeks and we look forward to holding similar events in future.

OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : JUNE 2023



Jun 2023	Target	Variance	Assurance
7.88%	3.67%	Common cause - no significant change	Variation indicates consistently falling short of the target

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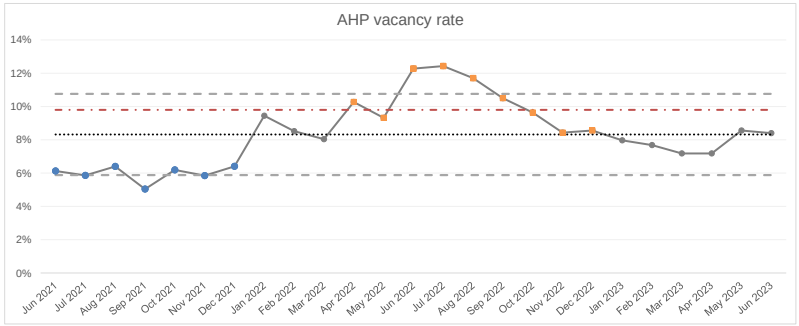
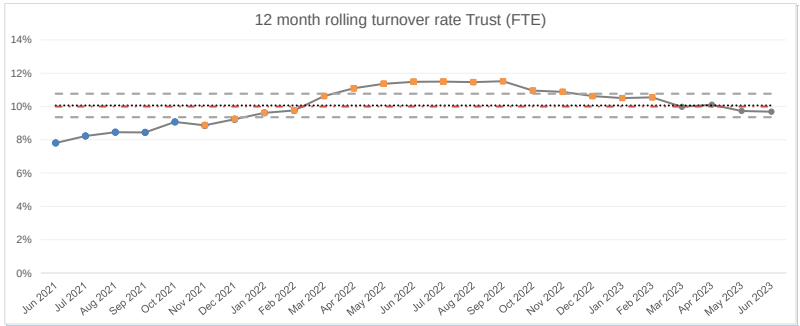


Jun 2023	Target	Variance	Assurance
8.4%	9.80%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Jun 2023	Target	Variance	Assurance
9.69%	10%	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis: (Please note that the Apr 2023 vacancy figures are unavailable as the operational budgets were not finalised, the data points on the charts for Apr 2023 are the same as Mar 2023)

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.
AHP vacancy rate: The indicator is showing special cause concern with a period 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 was showing special cause concern from November 2021. The data points were also above the upper control limit from Apr 2022 but are now showing a trend back towards the mean and a return to common cause variation. The target is currently at the mean.

Operational Update

The medical and dental vacancy rate has not been included above as changes are still being made within the finance general ledger to accurately reflect the changes to the establishment following the TUPE of GP trainees at the start of the financial year. Therefore the reports from the general ledger do not show an accurate vacancy position. The changes should be finalilsed within the ledger to be able to start reporting the vacancy position again from the ledger reports from next month. However, a manual calculation shows that the current vacancy rate is 8.43%.

OUR PEOPLE: Vacancy Projections

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : JUNE 2023

Trust HCSW adult nursing areas modelling	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	Jan-24	Feb-24	Mar-24
Establishment	1050.61	1049.34	1049.34	1049.06	1049.06	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55	1072.55
Actual In post	903.17	902.22	889.9	896.8	892.1	887.96										
Projected in post							887.86	887.76	887.66	887.56	887.46	887.36	887.26	887.16	887.06	886.96
Projected leavers (exit organisation)							8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6
Actual leavers	5.97	11.65	10.53	9.85	6.75	10.07										
Projected 'other' attrition (inc substantive to bank, moving to different roles [inc development opportunities] reducing hours etc)							11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5
Projected New Starters							20	20	20	20	20	20	20	20	20	20
Actual starters	19.53	36.48	17.21	26.44	15.27	18.23										
Vacancies	-147.44	-147.12	-159.44	-152.26	-156.96	-184.59	-184.69	-184.79	-184.89	-184.99	-185.09	-185.19	-185.29	-185.39	-185.49	-185.59

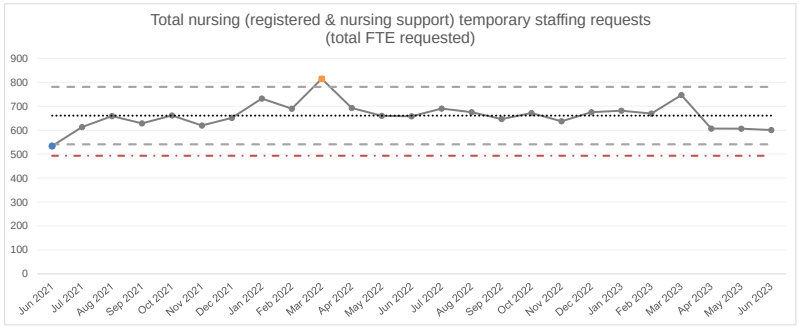
Trust RN adult nursing areas modelling	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Establishment	1858.65	1858.65	1858.18	1858.18	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28	1870.28
In post (ESR as at 310523 + 17 INs awaiting OSCE/PIN)	1744.04	1741.08	1739.45	1743.79	1742.45	1734.87	1739.29	1743.71	1813.13	1816.55	1825.97	1818.39	1822.81	1827.23	1829.65	1822.07	1814.49	1806.91	1799.33	1791.75	1860.17
Projected leavers		11.56	11.56	10.32	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58	10.58
Projected International Recruits				14	12		12	12		11	17		12	12	10						
Projected UK qualified starters	8.6	8.6	8.6	8.6	8.6	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Projected NQs inc RNDA									77												76
Vacancies	-105.83	-117.57	-118.73	-114.39	-127.83	-135.41	-130.99	-126.57	-57.15	-53.73	-44.31	-51.89	-47.47	-43.05	-40.63	-48.21	-55.79	-63.37	-70.95	-78.53	-10.11

These projections tables are used by nursing and HR teams to support planning for the year to address the vacancy position for RNs and HCSWs in adult nursing areas (CGs 1,2,3,4,6). The projections account for known plans around recruitment activity and assumptions around leavers/staff movements within the organisation and how this will impact the vacancy position for these two staff groups. The increase in budgeted establishment for both groups early in the current financial year is predominantly the result of uplifts to night shift cover linked to CQC recommendations and a business case for staffing in EAU (York). The projection tables are refreshed bi-monthly and are also presented to the People and Culture Committee.

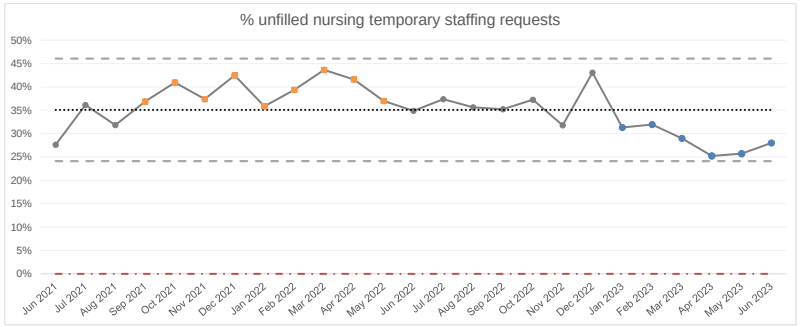
OUR PEOPLE - Temporary Staffing

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

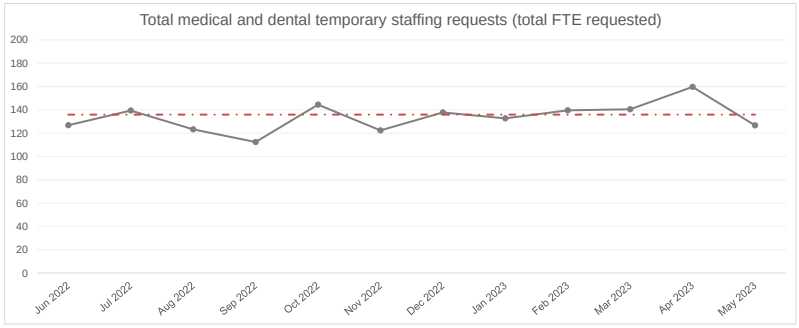
REPORTING MONTH : JUNE 2023



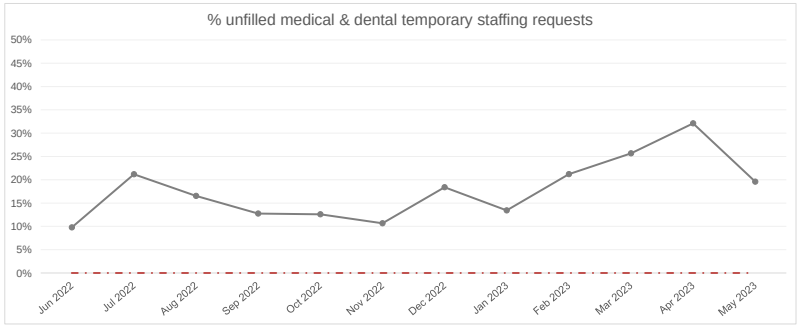
Jun 2023
600.64
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Jun 2023
28.02%
Target
0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



May 2023
126.73
Target
135.93
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently passing the target



May 2023
19.60%
Target
0%
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

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. Since then it has shown common cause variation, 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 special cause improvement below the mean from Jan 2023. 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 below 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

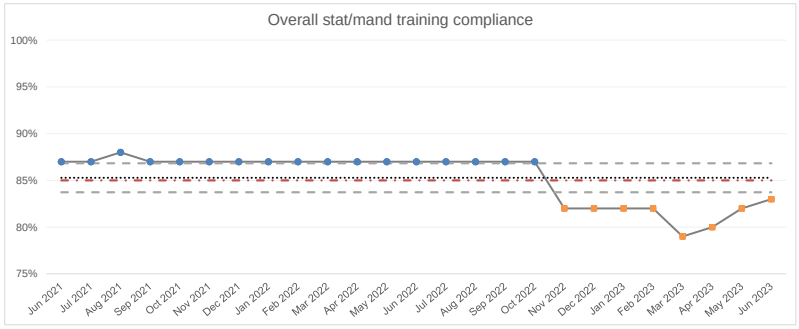
Executive Committee supported a recent paper to 'turn off' the off-framework agency Thornbury from 1st July. This change in process has been implemented across the organisation. To ensure the Trust maintains this position and to support areas to manage their staffing, summer nursing incentives have been agreed for the duration of the school summer holidays, these include the re-introduction of flexibility payments for substantive staff and Allocation on Arrival (AOA) shifts at double time for bank workers. A reduced number of AOA shifts have been approved in comparison to winter, to recognise the improved staffing position.

NHS England continue to scrutinise the Trust's agency use and are working with us to develop action plans to remove the reliance on agency supply and improve our utilisation of the workforce through effective eRostering. As part of this work, the Trust will be reviewing our off-framework use for medical shifts and our use of HCSW agency shifts, with a view to develop plans to remove the agency usage in both of these areas moving forward.

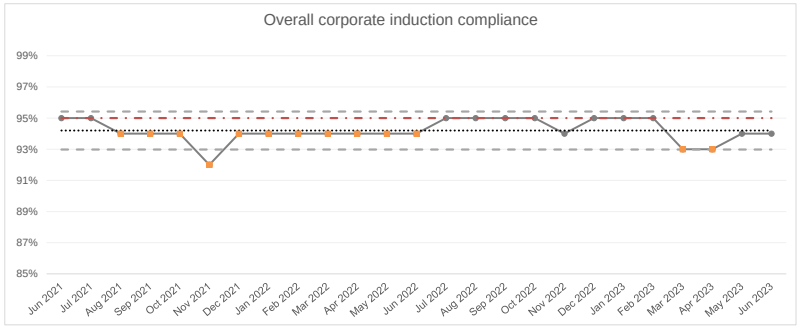
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

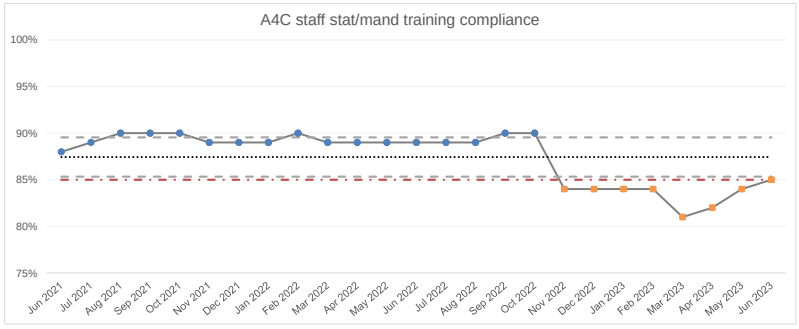
REPORTING MONTH : JUNE 2023



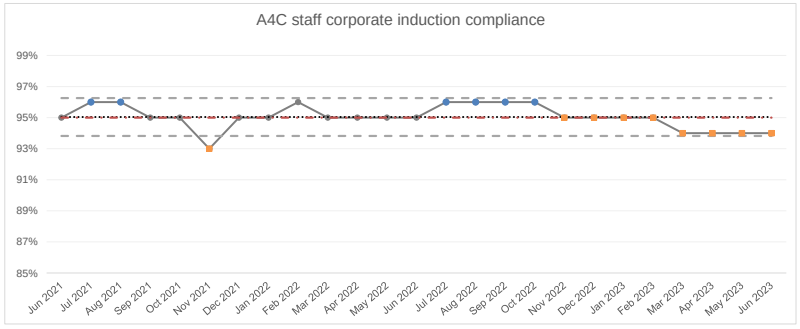
Jun 2023	Target	Variance	Assurance
83%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



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



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



Jun 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 up to Oct 2022 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 was 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 up to Oct 2022 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, thus showing special cause concern. Jun 2023 met the target, however.
A4C staff corporate induction compliance: The indicator was showing special cause concern in Nov 2021, and then again from Nov 2022 with the data points below the mean. The months from Mar 2023 to Jun 2023 have also not met the target.

Operational Update

Mandatory training compliance rates are recovering in line with the trajectory the Trust set itself following a system failure in February. Since last month, compliance has increased again to 83% overall. This is the highest rate recorded in the 2023 calendar year. A 'statutory and mandatory training month' is being planned to take place in late summer with the aim of providing a further increase as the Trust aims to hit its 85% target.

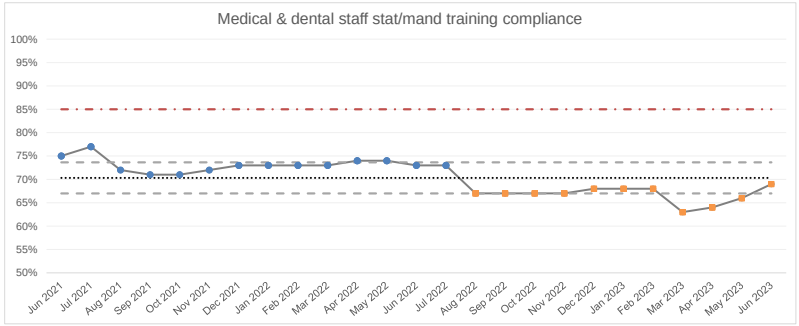
At subject level, most programmes have seen steady increases in compliance during June, though training delivered in classrooms continues to record lower take-up in comparison with training delivered purely online. Of note, the Deprivation of Liberty Safeguards Level 2 and Safeguarding Children Level 3 programmes for clinical staff saw 1% reductions in compliance from last month, though the former is attributable to cancelled sessions due to circumstances outside of the Trust's control. Equality, Diversity and Human Rights training continues to record the highest rate of improvement, with compliance reaching 70% following go-live in November 2022.

Corporate Induction compliance is at 94% which is 1% below the target of 95%.

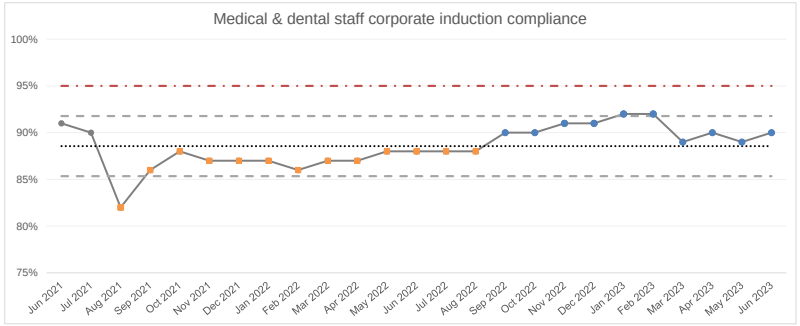
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : JUNE 2023



Jun 2023
69%
Target
85%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Variation indicates consistently falling short of the target



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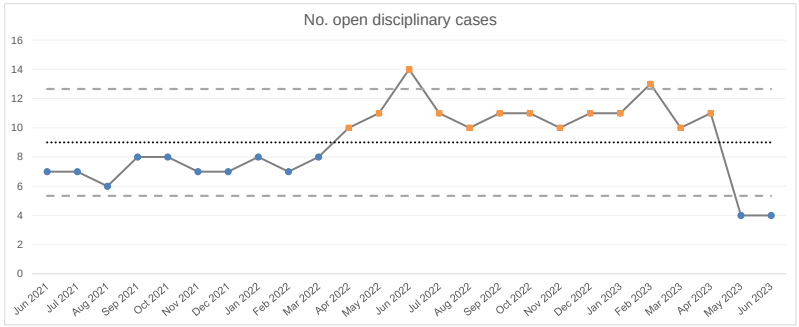
Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

Medical & dental staff stat/mand training compliance: The indicator is consistently failing target. Compliance from Aug 2022 is below or around the lower control limit, and is 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 slightly above the upper control limit.

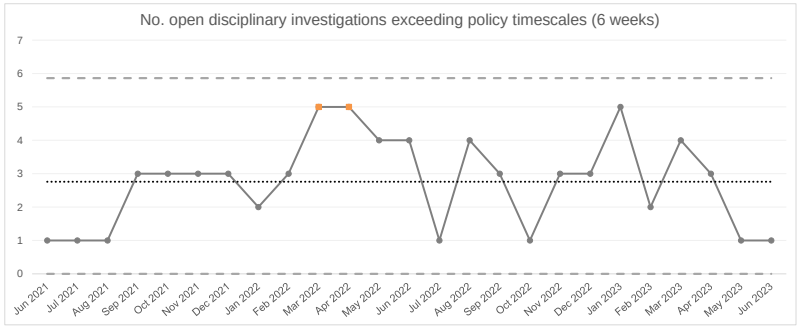
OUR PEOPLE - Employee Relations Activity

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

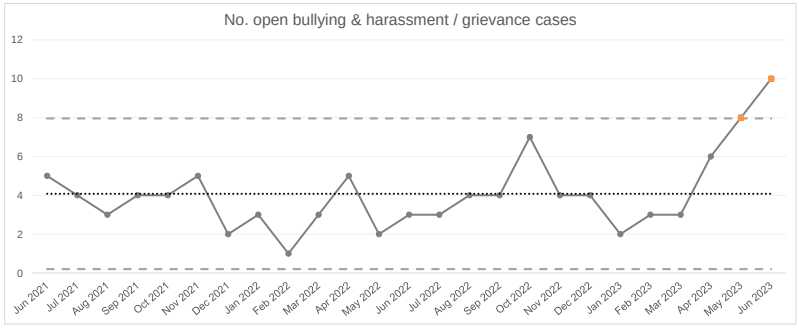
REPORTING MONTH : JUNE 2023



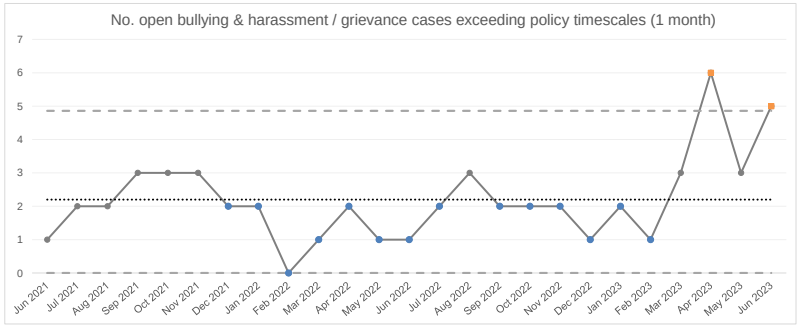
Jun 2023	4
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



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



Jun 2023	10
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



Jun 2023	5
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target, therefore target assurance is not relevant

Data Analysis:

No. open disciplinary cases: The indicator was showing points above the mean from Apr 2022 and special cause concern above the upper control limit in Jun 2022 and Feb 2023. Special cause improvement has been seen in May and Jun 2023, below the lower control limit.
No. open disciplinary investigations exceeding policy timescales (6 weeks): The indicator is currently showing common cause variation.
No. open bullying & harassment / grievance cases: The indicator is currently showing special cause concern above the upper control limit in May and Jun 2023, after a prolonged period of common cause variation with some degree of variation around the mean.
No. open bullying & harassment / grievance cases exceeding policy timescales (1 month): The indicator has shown special cause concern in Apr and Jun 2023 above the upper control limit.

Operational Update

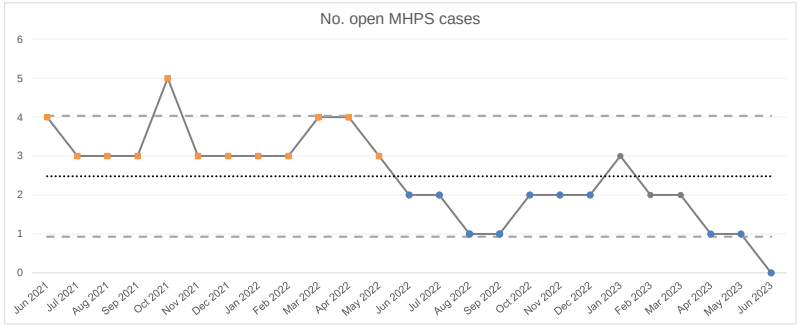
The Trust has recently lost an Employment Tribunal claim for constructive, unfair dismissal. A remedy hearing is to be scheduled; a case review process is ongoing with witnesses and members of the HR team.

We have seen a steady increase in the number of concerns being raised through formal policies, this is positive that staff have confidence to raise concerns; although it could also reflect an increase in behaviour not in line with the Trust values.

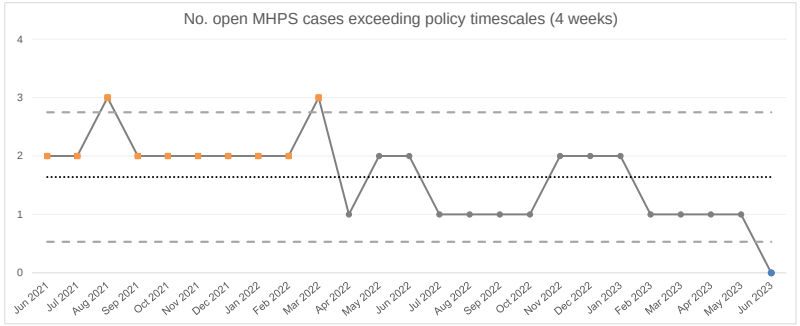
OUR PEOPLE - Employee Relations Activity and Appraisals

York and Scarborough Teaching Hospitals NHS Foundation Trust

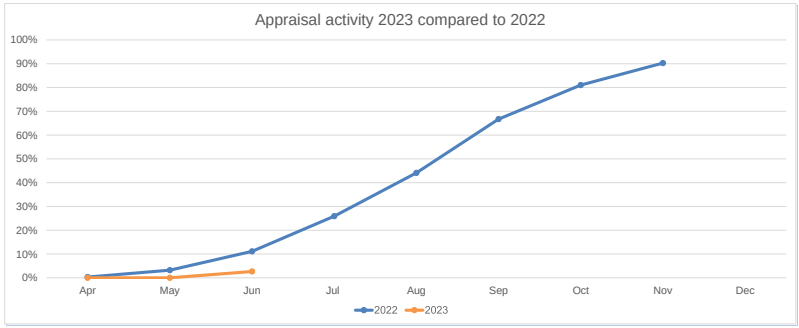
REPORTING MONTH : JUNE 2023



Jun 2023	0
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	0
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	2.65%
Target	90%

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Data Analysis:

No. open MHPS cases: The indicator is showing special cause improvement from Apr 2023, following an earlier seven-month period of improvement, with Apr to Jun 2023 near or below the lower control limit. Prior to Jun 2022, the data points were all above the mean.
No. open MHPS cases exceeding policy timescales (4 weeks): The indicator is currently showing special cause improvement, after a period of data points above the mean from Jun 2021 to Mar 2022.
Appraisal activity: This indicator is not presented as a statistical process control chart (SPC) due to the nature of the appraisal window being reopened in April of each year. Appraisal activity for 2023 is currently showing below that of 2022 (in June this was 2.65% in 2023 compared to 11.13% in 2022, however the start of the appraisal window was delayed in 2023).

Operational Update

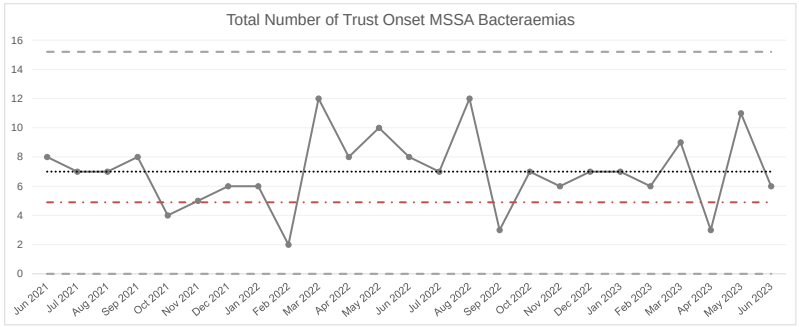
Working with the Medical Director the Trust is taking a proactive, just and learning approach to MHPS cases so we have confidence that a number of cases are being dealt with informally to ensure there is learning and individuals are supported.

The Trust appraisal window opened again in June, slightly later than last year as can be seen through the completion rates. The appraisal window is open until 30 September and objectives are being cascaded through the organisation. Line managers are being asked to book appraisal with their direct reports and record these through Learning Hub.

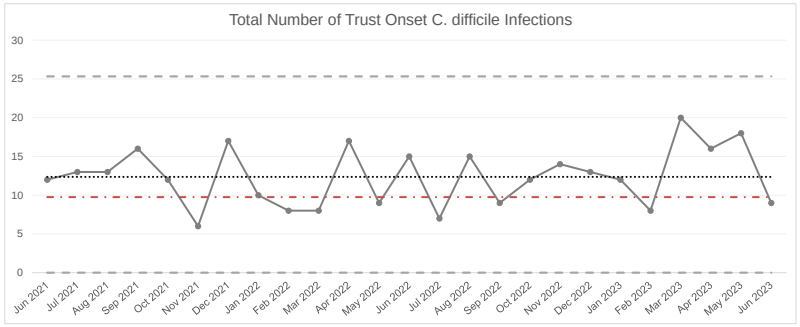
QUALITY AND SAFETY - Priority Metrics

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

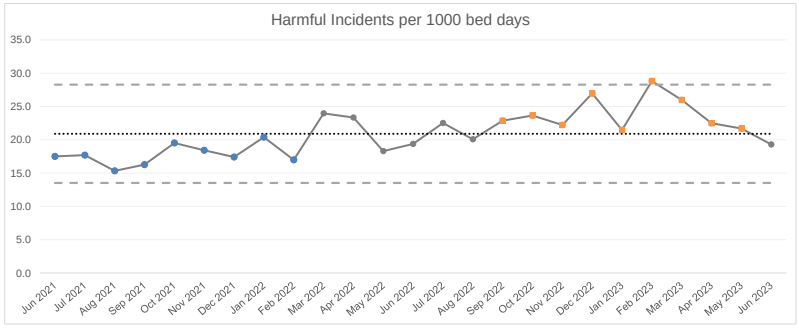
REPORTING MONTH : JUNE 2023



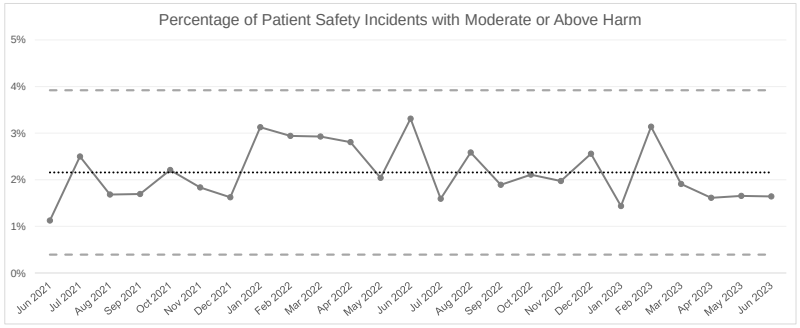
Jun 2023	Cumulative 12-month Target	Variance	Assurance
6	59	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Jun 2023	Cumulative 12-month Target	Variance	Assurance
9	116	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



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



Jun 2023	Target	Variance	Assurance
1.6%	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant

Data Analysis:

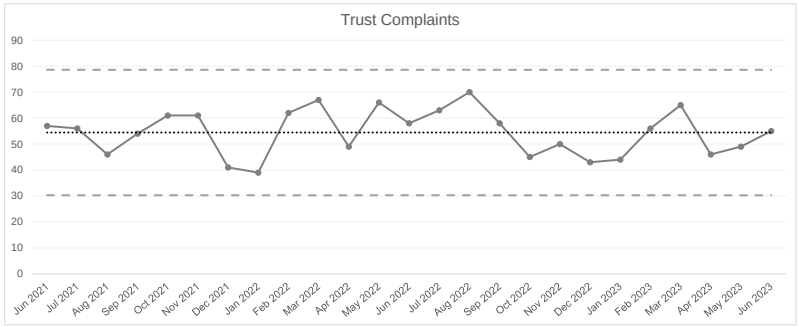
Total Number of Trust Onset MSSA Bacteraemias: The number of infections of patients with MSSA is currently showing common cause variation.
Total Number of Trust Onset C. difficile infections: The number of infections of patients with C.difficile is currently showing common cause variation.
Harmful Incidents per 1000 bed days: The number of harmful incidents per 1000 bed days was showing special cause concern due to the data points above the mean from Sep 2022, with Feb 2023 being above the upper control limit. The latest month has returned below the mean, so is no longer showing special cause variation.
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:

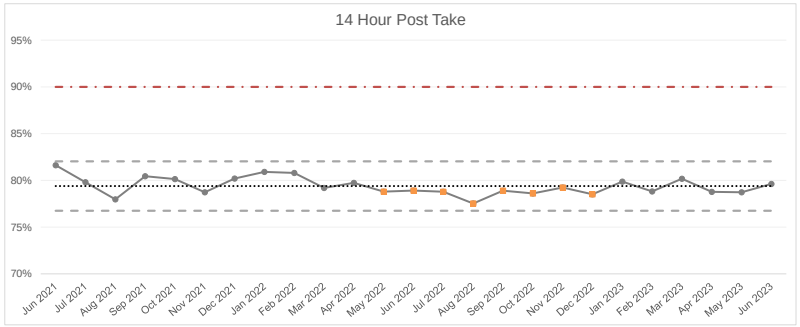
Total Number of Trust Onset MSSA Bacteraemias
MSSA bacteraemia was over trajectory by 1 case for the month of June, but overall, over trajectory has been exceeded by 4 cases since April 2023. Care Groups are focussing on ANTT training for staff to improve practice. The Staphylococcus aureus reduction group continues to support initiatives to reduce the incidence of MSSA.

Total Number of Trust Onset C. difficile infections
C.Difficile performance for June 2023 showed an improved picture from May 2023; with 9 cases against a target of 9-10 per month. Overall the trust remains over trajectory by 15 cases to the end of June 2023. Reduction strategies continue to be monitored at the C.diff Improvement Group (CDIG); utilising the C.diff Improvement Plan.

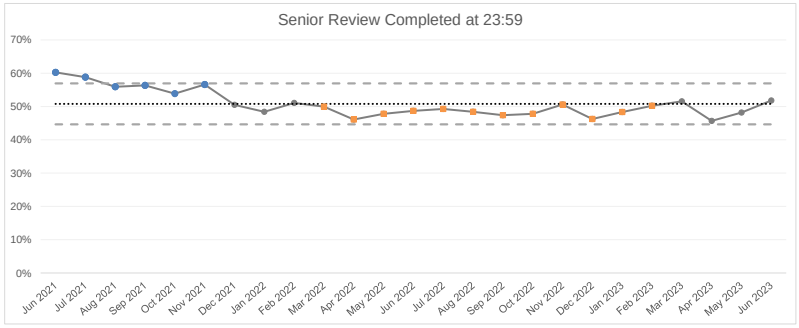
Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
There are ongoing pressures, especially on emergency and urgent care impacting on quality of care and capacity of clinical teams. The pressure on services is especially severe at present with an enhanced 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.



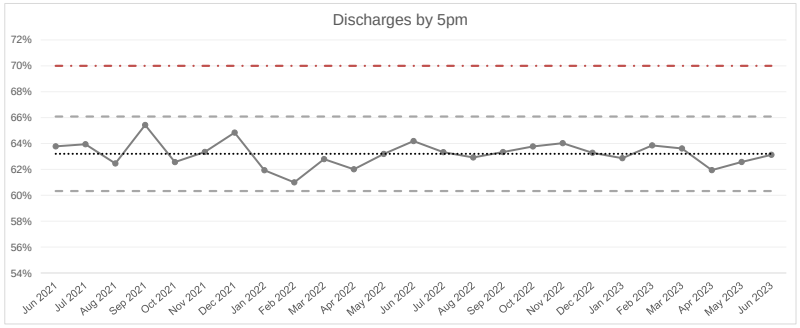
Jun 2023	55
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	79.6%
Target	90%
Variance	Common cause - no significant change
Assurance	Variation indicates consistently falling short of the target



Jun 2023	51.8%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	63.1%
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 Mar 2022 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. The ward staff on Labour ward, G2 and Triage within Maternity are currently doing improvement work involving Production boards focusing on areas of improvement including MEWS on G2. The effects are being mitigated through the wider Trust response to current and anticipated service pressures.

TPR: Icon Summary Matrix

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F		Total
Improvement	**1**	**7**	**9**		**17**
H	1	3	2		**6**
L		4	7		**11**
Common Cause	**2**	**35**	**15**	**1**	**53**
?	2	35	15	1	**53**
Concern	**4**	**4**	**14**		**22**
H	4	1	8		**13**
L		3	6		**9**
Neither					
↗					
↘					
Empty				**4**	**4**
				4	**4**
Total	**7**	**46**	**38**	**5**	**96**

MetricName	Date	Variation	Assurance	Target	Latest Value
% Community Therapy Team Patients Seen within 6 weeks of Referral	2023-06	L	?	71.0	56.6
% ED attendances streamed to SDEC	2023-06	?	?	18.0	16.3
% of End of Life Patients Dying in Preferred Place of Death	2023-06	?	?	81.0	61.9
% of patients waiting 63 or more days after referral from cancer PTL	2023-06	L	?	12.0	9.0
% of SDEC admissions transferred to downstream acute wards	2023-06	L	?	22.0	18.8
% of SLA	2023-06	?	?	90.0	83.1
2-hour Urgent Community Response (UCR) care Referrals	2023-06				74.0
2-hour Urgent Community Response (UCR) Compliancy %	2023-06			70.0	83.8
AHP Outpatients: DNA rates	2023-06	?	?	8.0	8.2
AHP Outpatients: 1st Attendances	2023-06	?	?	2299.0	2691.0
AHP Outpatients: 1st to FU Ratio	2023-06	?	?	2.0	2.1
AHP Outpatients: Follow Up Attendances	2023-06	?	?	5073.0	5570.0
AHP PIFU %	2023-06	H	P	3.0	10.5
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for no...	2023-03	?	?	0.0	11.0
Cancer - 62 Day 85th centile waits	2023-05	H	F	62.0	106.0
Cancer - 62 Day waits for first treatment (from urgent GP referral)	2023-05	?	F	85.0	49.9
Cancer - Faster Diagnosis Standard	2023-05	?	?	74.0	63.1
Cancer - Number of patients waiting 63 or more days after referral from Cancer PTL	2023-06	?	?	179.0	241.0
Cancer 2 week wait (all cancers)	2023-05	?	?	93.0	67.9
Cancer 2 week wait (breast symptoms)	2023-05	H	?	93.0	89.5
Cancer 31 day wait for second or subsequent treatment - drug treatments	2023-05	?	?	94.0	100.0
Cancer 31 day wait for second or subsequent treatment - surgery	2023-05	?	?	94.0	87.5
Cancer 31 day wait from diagnosis to first treatment	2023-05	?	?	96.0	97.1
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	2023-05	?	?	90.0	78.7

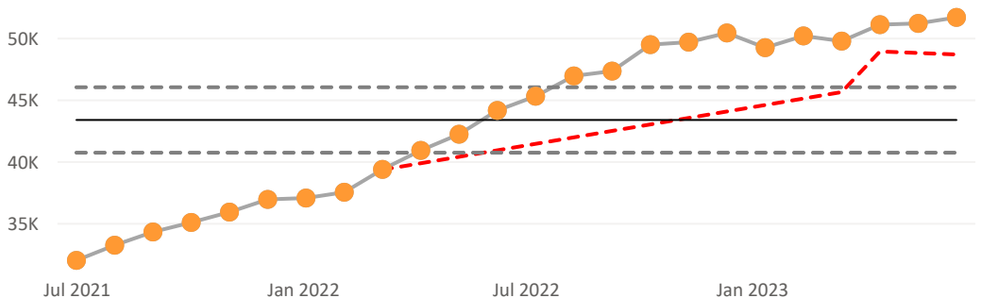
TPR: Elective Recovery Priority Metrics

Note: Moving Internal Targets (dashed red line in SPC's below) have been updated for 2023-24.

York and Scarborough Teaching Hospitals NHS Foundation Trust

MetricName: RTT - Total Waiting List

Variation: H | Assurance: P



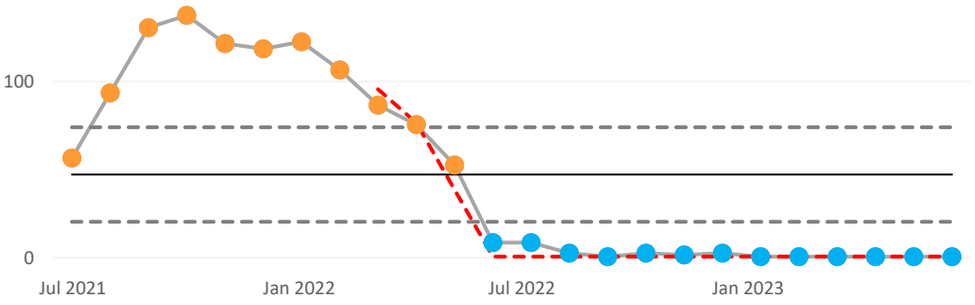
LATEST MONTH
2023-06
Value
51.6K
Target
48.6K

The indicator is **higher than** the target for the latest month and **is not** within the upper and lower control limits.

The latest months value has **increased** from the previous reporting month, with a difference of **488.0**.

MetricName: RTT - Waits over 104 weeks for incomplete pathways

Variation: L | Assurance: F



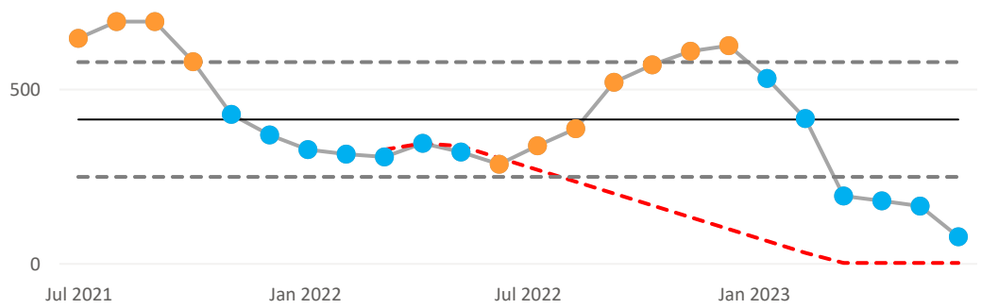
LATEST MONTH
2023-06
Value
0.0
Target
0.0

The indicator is **matching** the target for the latest month and **is not** within the upper and lower control limits.

The latest months value has **remained the same** from the previous reporting month, with a difference of **0.0**.

MetricName: RTT - Waits over 78 weeks for incomplete pathways

Variation: L | Assurance: F



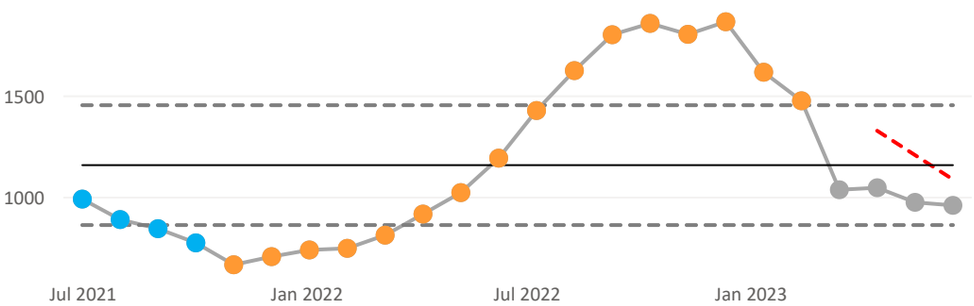
LATEST MONTH
2023-06
Value
75.0
Target
0.0

The indicator is **higher than** the target for the latest month and **is not** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **88.0**.

MetricName: RTT - Waits over 65 weeks for Incomplete Pathways

Variation: ? | Assurance: ?



LATEST MONTH
2023-06
Value
957.0
Target
1085.0

The indicator is **lower than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **15.0**.

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 was off trajectory to meet the target 143 for the end of March 2024, with 241 patients waiting over 63 days at the end of June 2023 against the improvement trajectory of 179. Insufficient established workforce in MRI to meet demands on service. National mandate to reduce outpatient follow up activity by 25% compared to 2019/20 outturn and convert to new patient capacity to support elective recovery.	Actions: 1. The Intensive Support Team (IST) continue to work with the Trust on several workstreams. The IST 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 moved to a weekly meeting with the Chief Executive, Medical Director, and Chief Operating Officer. The Trust had 75 RTT 78-week waiters remaining at the end of June in line with the planned trajectory submitted to NHSE as part of the Tier 1 Elective Recovery support. 3. “Back to Basics” workshop completed. Additional support objective agreed for drop-in sessions for operational manager and clinicians ongoing. Targeted day with H&N, Gynaecology and Outpatient Services took place on the 5th of July 2023. 4. Waiting List Harms Task and Finish Group established. 5. Electronic platform for patients to access guidance on keeping ‘fit for surgery’; ‘My Planned Care’ platform live with patient specific information ongoing. 6. Agreed SLAs with cancer alliance for funding to target improvements associated with faster diagnosis, earlier diagnosis and treatment and pathways.
Risks: 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 Senior Clinicians.	Mitigations: Tier 1 weekly meetings with National Team on elective recovery. Trust continues to utilise the nationally provided Digital Mutual Aid System (DMAS) to offer long waiting patients who are willing to travel an alternative provider. DMAS live for diagnostic patients, the Trust continues to explore the opportunities this presents. Conversations ongoing with partner providers within the ICB around provision of mutual aid. 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 June 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	22	34,595	98.18%	94.34%
Black, Black British, Caribbean or African	25	80	0.23%	0.94%
Mixed or multiple ethnic groups	24	137	0.39%	1.26%
Asian or Asian British	23	297	0.84%	2.97%
Other ethnic group	22	128	0.36%	0.49%
Unknown	22	13,078	-	-
Not Stated	22	3,406	-	-
Grand Total	**22**	**51,721**	**-**	**-**

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 June 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	23	5,962	11.85%	8.88%
2	22	7,087	14.09%	13.59%
3	22	10,463	20.80%	20.94%
4	22	11,032	21.93%	20.68%
5	22	15,756	31.32%	35.90%
Unknown	17	1,421	-	-
Grand Total	**22**	**51,721**	**-**	**-**

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.

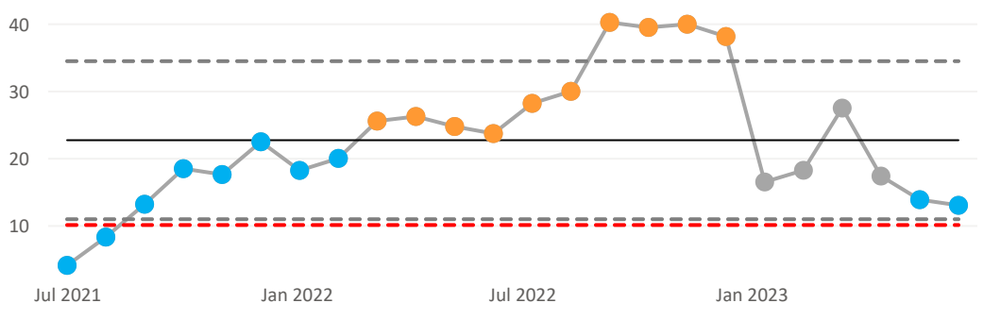
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

TPR: Acute Flow Priority Metrics

MetricName

ED - Proportion of Ambulance handovers waiting > 60 mins

Variation Assurance



LATEST MONTH

2023-06

Value

12.9

Target

10.0

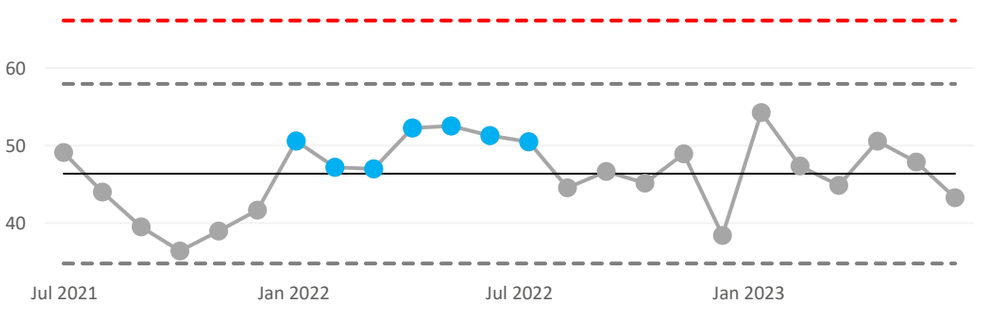
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **0.9**.

MetricName

ED - Proportion of all attendances having an initial assessment within 15 mins

Variation Assurance



LATEST MONTH

2023-06

Value

43.2

Target

66.0

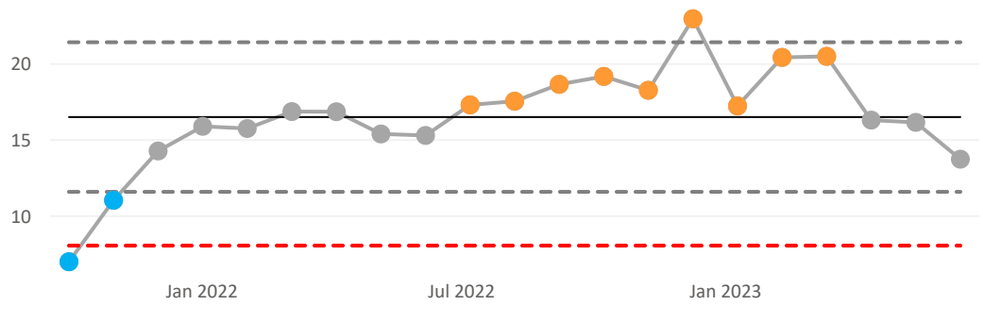
The indicator is **lower than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **4.6**.

MetricName

ED - Total waiting 12+ hours - Proportion of all Type 1 attendances

Variation Assurance



LATEST MONTH

2023-06

Value

13.7

Target

8.0

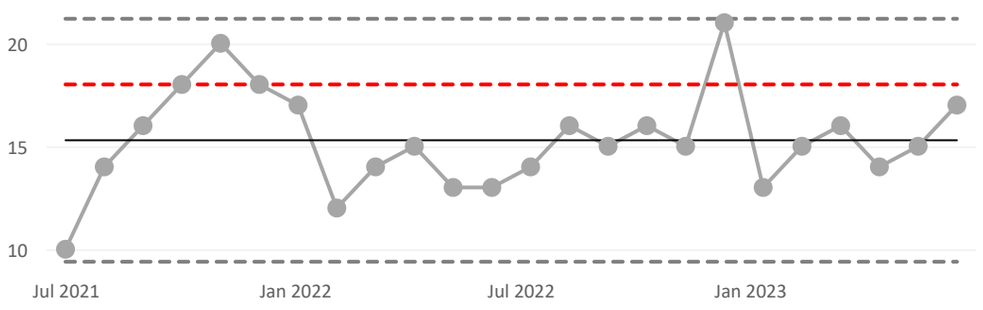
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **2.4**.

MetricName

ED - Median Time to Initial Assessment (Minutes)

Variation Assurance



LATEST MONTH

2023-06

Value

17.0

Target

18.0

The indicator is **lower than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **increased** from the previous reporting month, with a difference of **2.0**.

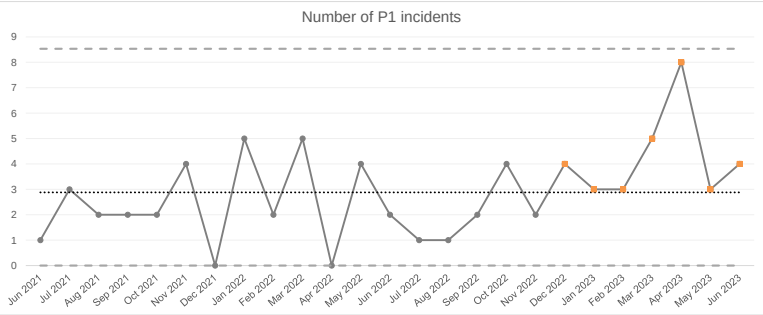
Challenges & Risks	Actions & Mitigations
Challenges: The ED Capital Build at York which commenced at the beginning of November 2021 has meant that York Emergency Department continues to operate out of a smaller footprint. The development is due to open in mid-July rather than the anticipated March 2023 due to a delay in the delivery of building materials. High number of patients without a 'Right to Reside' (210 on 6th of July 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 (18 patients on 6th July 2023) and community response teams. 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. 2.1 UEC Performance The June ECS position was 69.2%, against the planned trajectory of 70.1%. The Care Group clinical and operational teams are working closely to ensure patients receive the care and treatment they need in a timely manner. In Scarborough there is a continued piece of work with YAS in relation to handover times, testing new processes. In York, the new Emergency Department is opening on 10th July with a new clinical model and pathways planned to run which are expected to have a positive impact on ECS. The new ED facility will provide state of the art resus and assessment facilities which will transform our emergency care offering at York. In addition, the OPEL escalation framework has been reviewed to provide more focused actions to each level of escalation. 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 and a new UEC Improvement Board for North Yorkshire and York Places including all system partners commenced in June. The UEC Programme milestones for June 2023 included the requirement to understand the responsibilities of the Programme in terms of Health Inequalities and to scope the Mental Health project. As part of the system improvement plan Mental Health is to be established as a workstream in relation to UEC pathways. The project will be established and will run across all three driver areas as health inequalities does. The initial meeting will take place in July 2023 to agree more details looking at alternatives to ED and integration of mental health pathways to support patients in the ED.

Challenges & Risks	Actions & Mitigations
	In terms of the health inequality theme running through the programme, further work is required to understand the responsibility of the programme in relation to health inequalities and correlation with the trust strategy. The focus at this point is related to high intensity users and understanding and developing appropriate alternatives to the ED for these patients, these include working with Children where a social prescriber is specifically focusing on this. 2.2 UEC Programme update Each project within the UEC Programme contributes towards the above performance, 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 ED, 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 contributing to ambulance handover times, enabling improved response times. 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.
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 Senior Clinicians.	Mitigations: Ongoing daily review of medical and nursing staffing to ensure appropriate skill mix. Weekly meeting to progress the Rapid Quality Review Action Plan. Urgent Care System Programme Board established across the Integrated Care System. Ambulance Handover Plan in place and updated SOP for escalations, cohorting and diversion requests. Plans in place to mitigate impact of industrial action.

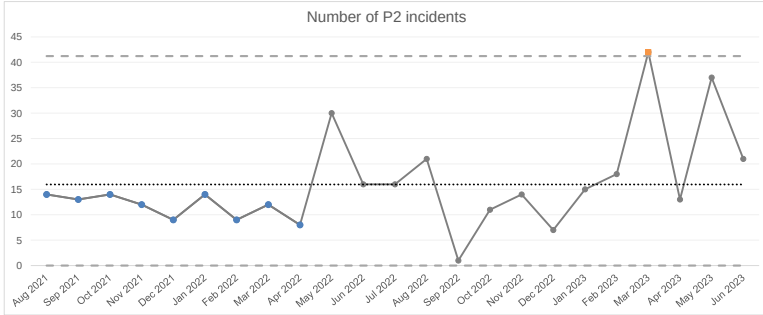
DIGITAL - Digital Indicators

York and Scarborough Teaching Hospitals NHS Foundation Trust

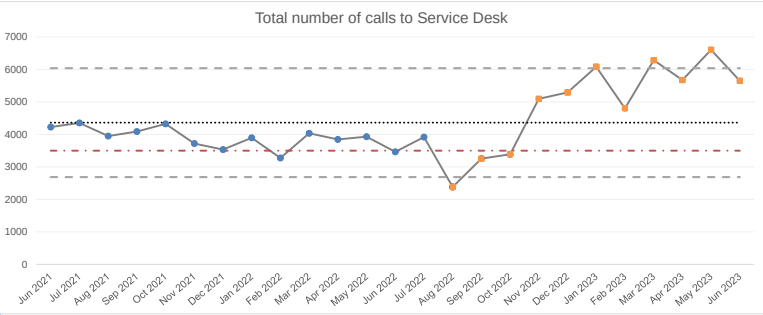
REPORTING MONTH : JUNE 2023



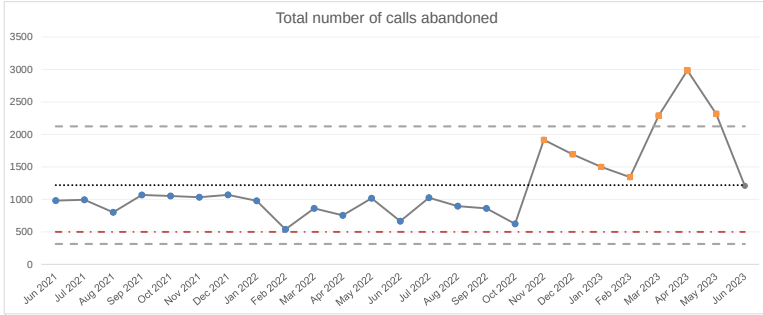
Jun 2023	4
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	21
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Jun 2023	5650
Target	3500
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



Jun 2023	1209
Target	500
Variance	Common cause - no significant change
Assurance	Variation indicates inconsistently hitting passing and falling short of the target

Data Analysis:

Number of P1 incidents: The indicator is currently showing special cause concern, the data points have been above the mean since Dec 2022.
Number of P2 incidents: The indicator is currently showing common cause variation, 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, along with data points for Mar and May 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 onwards 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 up to Oct 2022, with a rise in Nov 2022. Improvement was briefly seen prior to Feb 2023, but from Mar to May 2023 it increased above the upper control limit. The latest month has returned close to the mean. 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.

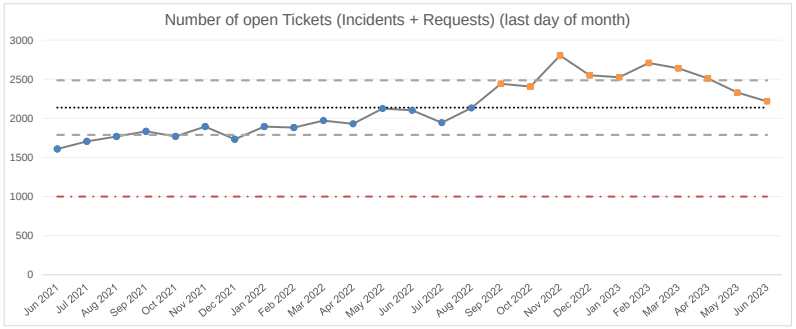
Operational Update:

P1 incidents:
6/6 Scarborough Printers offline
8/6 Nelson's Court network link fault
14/6 Telecare (sexual health) system fault
16/6 Scarborough Bleep system fault

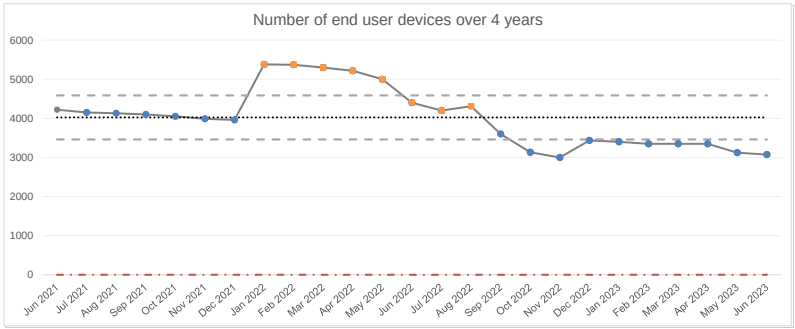
P2 incidents - large number due to "clicking on suspicious links" by users on malicious e-mails. User education/awareness issues and being exploited with using new mail services.

Total number of calls / number of abandoned calls: High volume of support calls during June showing continued high demand for NHSMail migration support.
This has stabilised and reduced now that majority of migrations are completed. Final groups of accounts being migrated early July should see this project related support demand reduce further

Abandoned call levels have reduced due to shorter waiting times mainly due to e-mail support related demand reducing.



Jun 2023
2217
Target
1000
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Variation indicates consistently falling short of the target



Jun 2023
3074
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 Tickets (Incidents + Requests) (last day of month): The indicator was showing a run of points below the mean up to Aug 2022, however after that point all months have been above the mean and therefore showing special cause concern. From Nov 2022 the data points were above the upper control limit, but this has now reduced below the upper control limit in May and Jun 2023. 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 3074 devices now over 4 years old.

Operational Update:

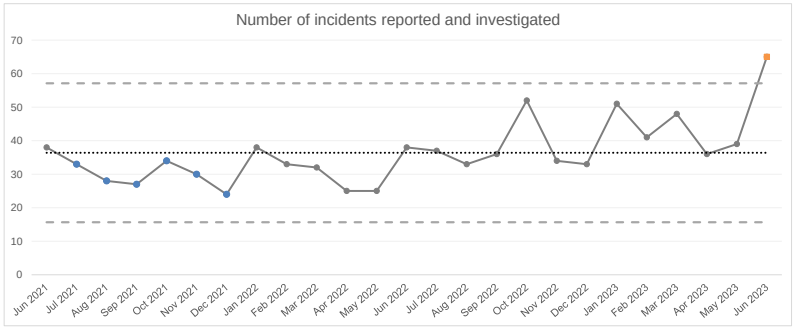
Number of open Tickets (Incidents + Requests) (last day of month)
- 32% open tickets are deferred awaiting user response/confirmation resolved. 6739 tickets were opened in June (-743 on prev month)
- NHSmail project driving significant demand, 20% of all tickets (23% in May)
- Service Desk and other teams are focussing on clearing down open tickets in preparation for moving to new 4Me Service Desk platform

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.

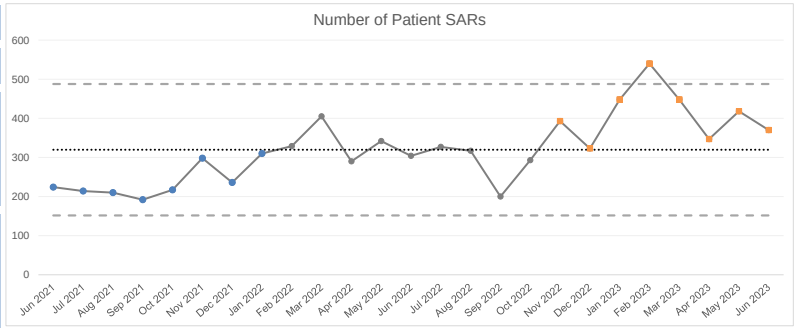
DIGITAL - Information Governance Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

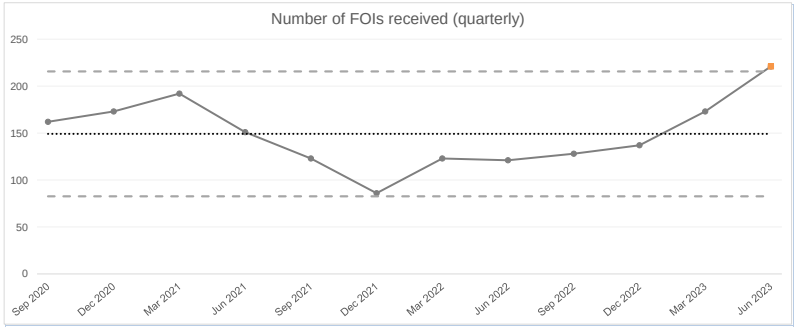
REPORTING MONTH : JUNE 2023



Jun 2023
65
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



Jun 2023
370
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



Jun 2023
221
Target
No Target
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis:

Number of incidents reported and investigated: This indicator is showing common cause variation, with Jun 2023 above the upper control limit.
Number of Patient SARS: This indicator is currently showing special cause concern with Jan to Mar 2023 close to or above the upper control limit, and has remained above the mean since Nov 2022.
Number of FOIs received (quarterly): This indicator is showing special cause variation in Jun 2023, with the data point above the upper control limit.

Operational Update:

Number of incidents reported and investigated:
There has been an increase in incidents in May as Care Group 2 completed a service standards audit and identified several records where therapy documentation has not been scanned and is now missing, likely destroyed (8 instances). These are reported as individual incidents per record. The majority of incidents reported are due to misfiles.

FoIs:
The IG team have changed the way FoIs are logged and reported, this was agreed in exec committee and has lead to an increase.
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:	26 July 2023
Subject:	Financial Position – June 2023 (Month 3)
Director Sponsor:	Andrew Bertram, Finance Director
Author:	Graham Lamb, Deputy Finance Director

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

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

Trust Priorities	**Board Assurance Framework**
☒ Our People ☒ Quality 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 £11.3m against a planned deficit of £7.6m for the period to June 2023 (month 3). The Trust is £3.7m adversely adrift of plan.

Recommendation:
The Board of Directors is asked to discuss and note the June 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	18 July 2023	The report was discussed, and the financial position of the Trust was noted.

Financial Position – June 2023 (Month 3)

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.

Plan presented at April 23 Board Meeting	£33.7m deficit
Further ICB Cost Reduction Ask improvement	£10.3m
Further ICB Ask re Share £3m improvement	£1.3m
New Income Share Allocation improvement	£6.7m
Final Adjusted Position	**£15.4m deficit**

2. Summary Dashboard

Key Indicator	Last Month (YTD)	Current Month (YTD)	Trend
I&E Variance to Plan	£1.3m Adverse	£3.7m adverse	↓ Deteriorating
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m	Static
Core CIP Delivery Variance to Plan	£1.2m Adverse	£1.4m Adverse	↓ Deteriorating
Core CIP Planning (£21.4m Target) Value Identified	£18.0m Identified	£17.6m identified	↓ Deteriorating
ICB Cost Reduction Ask (£17.5m target) Value Identified	£9.8m Identified	£10.1m Identified	↑ Improving
Variance to NHSE Agency Cap (3.7% of pay)	£0.4m Above	£1.2m Above	↓ Deteriorating
Month End Cash Position	£26.4m	£30.6m	↑ Improving
Capital Programme Variance to Plan	£1.8m favourable	£2.3m favourable	↓ Deteriorating

3. Income and Expenditure Position

Summary Position

The I&E table confirms an actual adjusted deficit of £11.3m against a planned deficit of £7.6m for June. The Trust is £3.7m adversely adrift of plan.

A major underlying influence on the reported position is the delivery of the cost improvement and stretch savings targets. Progress to date is behind plan for each and is contributing £3m underlying pressure to the reported position.

TRUST PRIORITIES REPORT : June-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Income and Expenditure Account

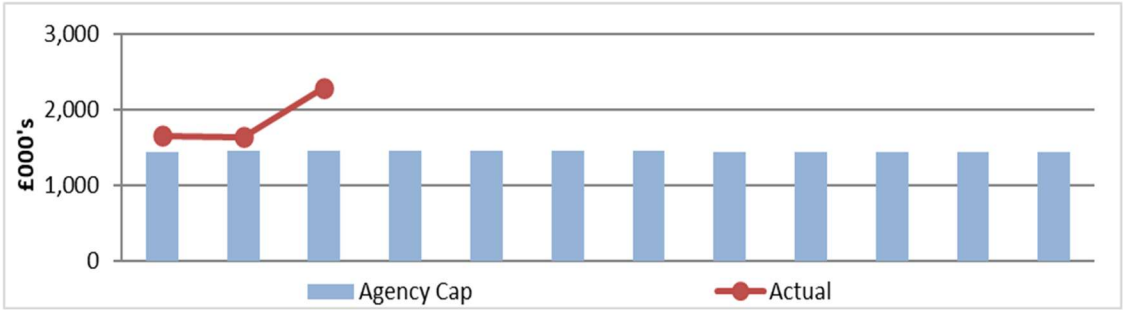
	Annual Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	FOT £000's
NHS England	81,268	20,317	20,604	287	81,268
Integrated Care Boards	546,626	136,956	136,333	-623	546,626
Local authorities	4,821	1,205	1,220	14	4,821
Non-NHS: private patients	344	86	228	142	344
Other Operating Income from Patient Care	1,466	366	450	84	1,466
Operating Income from Patient Care Activities	**634,525**	**158,931**	**158,836**	**-95**	**634,525**
Research and development	1,614	403	695	292	1,614
Education and training	22,504	5,626	5,438	-188	22,504
Other income	44,600	11,171	13,236	2,065	44,600
Other Operating Income	**68,718**	**17,200**	**19,369**	**2,169**	**68,718**
Employee Expenses	-490,228	-122,213	-123,334	-1,121	-490,228
Drugs Costs	-62,026	-15,627	-16,301	-674	-62,026
Supplies and Services - Clinical	-69,827	-17,978	-20,113	-2,135	-69,827
Depreciation	-20,401	-5,100	-5,070	30	-20,401
Amortisation	-1,521	-380	-410	-30	-1,521
CIP	18,144	1,370	0	-1,370	18,144
Other Costs	-81,851	-21,053	-21,913	-860	-81,851
Total Operating Expenditure	**-707,710**	**-180,981**	**-187,141**	**-6,161**	**-707,710**
OPERATING SURPLUS/(DEFICIT)	**-4,467**	**-4,849**	**-8,936**	**-4,087**	**-4,467**
Finance income	830	208	591	383	830
Finance expense	-956	-239	-244	-5	-956
PDC dividends payable/refundable	-10,800	-2,700	-2,700	0	-10,800
NET FINANCE COSTS	**-15,393**	**-7,580**	**-11,290**	**-3,709**	**-15,393**
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**	**-7,580**	**-11,290**	**-3,709**	**-15,393**
Remove Donated Asset Income	-800	-200	-200	0	-800
Remove Donated Asset Depreciation	740	185	210	25	740
Remove Donated Asset Amortisation	28	7	7	0	28
Remove Peppercorn Depreciation	11	3	0	-3	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**	**-7,586**	**-11,272**	**-3,686**	**-15,414**

Key Variances

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	287	Increased usage of high-cost drugs and devices for which income is earned on a pass-through basis. Offset by increased expenditure.	No mitigation or action required
ICB Income	-623	Repayment of agreed ICB income from 22/23, partially offset by released balance sheet provisions.	No mitigation or action required
Non-NHS: Private Patients	142	Private patient activity ahead of plan	No mitigation or action required
R&D income	292	Research and Development activity ahead of plan	No mitigation or action required
Other income	2,065	Primarily relates the to the sale and leaseback of endoscopes, which is offset by increased costs under clinical supplies and services. Pass through covid testing is ahead of plan, offset by increased CSS costs.	No mitigation or action required
Employee expenses	-1,121	Agency spending is ahead of plan with part of this linked to cover during strike action. There is a funding shortfall on the 23/24 pay award. Part of the unachieved pay related stretch target is also causing pressure here. These are offset by vacancies, balance sheet provision release, and by planned investments in nursing, cancer, etc., progressing behind plan.	To control agency spend within the cap. Work being led by HR Team to apply NHSE agency best practice controls, Care Group reduction programme for off-framework agency usage, continued recruitment programmes (including overseas recruitment). This work is not time limited but is ongoing. To continue to work on meeting the stretch target.
Drug expenses	-674	Relates to high-cost drugs and devices, offset by increased income; and increased in-tariff drug costs.	To investigate reasons for overspending on in-tariff drugs; develop and implement an appropriate response.
Clinical Supplies & Services	-2,135	Relates to sale and leaseback of endoscopes and covid testing ahead of plan, both offset by increased income.	No mitigation or action required.
CIP	-1,370	CIP behind plan.	Continued focus on delivery of the CIP. CET have developed a matrix of opportunity for sharing with Care Groups to progress ideas. We are supporting an ICS-wide group looking at system savings opportunities and we are participating in NHSE initiatives in relation to efficiency work. Also of note is continued work to reduce covid related expenditure and release of activity related investments are being scrutinised to check for prior work on productivity opportunities and resource transfer through follow up outpatient reduction. This work is ongoing.
Other Costs	-860	Primarily driven by the non-pay related unachieved stretch target; and increased MRI/CT costs.	To continue to work on meeting the stretch target.

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. At the end of June expenditure on agency staffing was £1.2m ahead of the cap.



4. Elective Activity: Variable Element of the Clinical Contract

To give an early indication of ERF performance, we have developed an early 'heads-up' approach using partially coded actual elective activity data and extrapolating this for the year to date 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 only marginally down against plan and potentially presents a £0.3m shortfall for the period. ICB activity is in a good position running close to the required 104% value, however NHSE Specialist Commissioned activity remains low and will be investigated. Given the limitations of this approach and the early stage in the financial year, the £0.3m potential income loss has not been reflected in the reported position. This will be monitored.

Commissioner	23-24 Target % vs 19/20	ERF Target Weighted Value at 23/24 prices (Excl 1.6% pay award)	ERF Month 3 Phase (Av 25.147%)	Activity to Month 3 Actual (Excl 1.6% pay award)	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	103.63%	£121,503,975	£30,554,605	£30,587,034	£32,429	103.7%
West Yorkshire	102.88%	£1,266,156	£318,400	£270,939	-£47,461	87.5%
Cumbria and North East	115.43%	£158,117	£39,762	£48,848	£9,087	141.8%
South Yorkshire	121.47%	£143,743	£36,147	£17,226	-£18,921	57.9%
Other ICBs - LVA / NCA	-	£572,629	£143,999	£163,477	£19,478	-
All ICBs	***103.61%***	***£123,644,620***	***£31,092,913***	***£31,087,524***	***-£5,388***	**103.60%**
NHSE Specialist Commissioning	112.54%	£4,729,638	£1,189,362	£929,752	-£259,610	88.0%
Other NHSE	102.88%	£241,309	£60,682	£60,679	-£3	102.9%
All Commissioners Total	**103.62%**	**£128,615,566**	**£32,342,956**	**£32,077,955**	**-£265,001**	**102.8%**

Detail is available for the operations team and Care Groups as to where the gains and where the shortfalls at specialty and point of delivery are occurring. This is paving the way for recovery action going forward.

5. 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. This totals a further £16.5m (shown as Technical CIP below).

2023/24 Cost Improvement Programme - June

2023/24 Cost Improvement Programme - Technical CIP - June

		June Position			Planning Position		Planning Risk		
	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
Technical CIP	**£16,525**	**£4,131**	**£4,131**	**£0**	**£16,525**	**£0**	**£16,525**	**£0**	**£0**

2023/24 Cost Improvement Programme - Core CIP - June

		June Position			Planning Position		Planning Risk		
Care Group	Full Year CIP Target	Target	Delivery	Variance	Total Plans	Planning Gap	Low	Medium	High
	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Acute, Emergency and Elderly Medicine (York)	£4,592	£500	£108	£392	£1,312	£3,279	£1,224	£49	£40
2. Acute, Emergency and Elderly Medicine (Scarborough)	£2,379	£259	£133	£126	£1,666	£713	£977	£689	£0
3. Surgery	£4,913	£535	£133	£402	£2,262	£2,651	£1,935	£327	£0
4. Cancer and Support Services	£3,084	£336	£71	£265	£1,838	£1,246	£1,035	£0	£803
5. Family Health	£2,073	£226	£158	£67	£758	£1,315	£758	£0	£0
6. Specialised Medicine	£1,863	£203	£74	£128	£1,205	£657	£1,099	£106	£0
7. Corporate Functions									
Chief Exec	£105	£11	£7	£5	£7	£98	£7	£0	£0
Chief Nurse Team	£270	£29	£22	£8	£187	£82	£187	£0	£0
Finance	£92	£10	£142	-£132	£324	-£232	£324	£0	£0
Medical Governance	£83	£9	£0	£9	£130	-£47	£130	£0	£0
Ops Management	£187	£20	£0	£20	£5	£182	£5	£0	£0
Corporate CIP	£0	£0	£6	-£6	£6,706	-£6,706	£548	£1,069	£5,089
DIS	£205	£22	£13	£9	£138	£67	£138	£0	£0
Workforce & OD	£145	£16	£21	-£5	£535	-£391	£535	£0	£0
Sub total	**£19,988**	**£2,177**	**£888**	**£1,288**	**£17,074**	**£2,915**	**£8,902**	**£2,241**	**£5,932**
YTHFM LLP	£1,400	£152	£71	£82	£540	£861	£298	£172	£70
		.							
Core Programme - Group Total	**£21,389**	**£2,329**	**£959**	**£1,370**	**£17,614**	**£3,775**	**£9,200**	**£2,413**	**£6,001**
CIP PROGRAMME TOTAL	**£37,914**	**£6,460**	**£5,090**	**£1,370**	**£34,139**	**£3,775**	**£25,725**	**£2,413**	**£6,001**

Delivery in month 3 of the Core Programme is £1.4m behind plan. Full year delivery is £3.2m of which £2.8m is recurrent (12.9% of the Core Target). Non-core CIP relating to technical efficiencies, covid spend reductions and estimated productivity gains of £4.1m have been met in line with plan. There is currently an in-year planning gap of £3.8m, as well as high risk plans totalling £6m. Work is ongoing to convert high and medium risk plans to low risk and provide assurance around in-year delivery.

Work continues on the collaborative programme of work with NY&Y Finance Director Forum with additional opportunities identified of £1m for System initiatives which are not included in the Trust position at this stage

6. 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 the planned I&E deficit being a key driver in the reduced balance.

June's cash balance showed a £10.1m adverse variance to plan, which is mainly due to the debtors and accrued income position above plan (£6.2m) and the I&E position behind plan (£3.7m). 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	26,392	30,644									

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

7. 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 3 Planned Spend £000s	Mth 3Actual Spend £000s	Variance £000s
45,852	**7,549**	**5,200**	**-2,349**

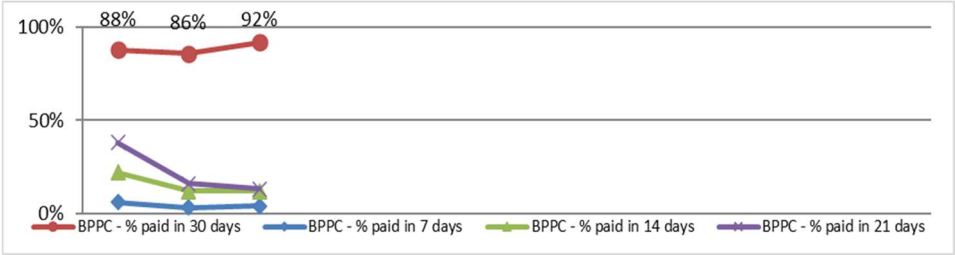
The capital programme at month 3 is £2.3m behind plan. £1.2m of this relates to IFRS 16 leases, mainly influenced by delays in completion of equipment leases and supplier lead times.

If we remove the impact of IFRS 16 figures the capital programme is £1.1m (19%) behind plan. This is due to the Scarborough UEC scheme (£2.2m) running behind the plan expenditure profile offset by other schemes running ahead of plan.

Most of the capital programme has now been approved; the Board of Directors approved £2.4m of capital schemes at the May board meeting. This leaves £1.6m discretionary expenditure to be allocated. This is currently under review by Care Group teams.

8. 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 referring to its delivery.



The table below illustrates that in June the Trust managed to pay 92% of its suppliers within 30 days.

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 quarter 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 June 2023 financial position for the Trust.

Research & Development Performance Report : Jun-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, but we have 265 accruals to add form a study the Scarborough team have recently supported so that puts us where we need to be. You will also see our Recruitment to Time and Target - main metric- is great!
- We have submitted one grant this month to try and win some funding
  - £149k to National Institute for Health Research How does an Acute Care Model provide patient benefit and address compound pressure on the health and social care system in a rural coastal town in the North of England: a qualitative study Led by Dr Bella Scantlebury, Dr Ed Smith, Dr Gerry Robins and Lisa Ballantine
- We are working hard to pull the £3.0 Million bid to evaluate Colon Capsule, led by Professor James Turvil, the submission date for this is 20th July
- We continue to work at Scarborough we have been accepted at part of the Sheffield NIHR Applied Research Collaboration as a project they are interested in supporting and we have jointly funded a communications engagement officer with SeeChange an organisation linking VCSE organisations in Scarborough. Together we will be facilitating meetings to scope out what research priorities are important to the people living in Scarborough. We have also been accepted as part of a team lead by our ICS to submit for some funds (100K) to expand this work further, the bid is due 1st August
- Dr David Seymour has decided to step down as CG3 Research lead and we are interviewing for a replacement soon
- We have held another strategic meeting with HYMs/UoY and plan to re write our memorandum of understanding
- We have held our annual Elsie May Sykes award and we funded 4 applications
  - Mr Thompson and Professor Tew, to create a 'York and Scarborough PAD Research Database'
  - Dr Simon Davies 'Phenotypes of inflammatory response to maximal exercise – a pilot study' and
  - Lucy Fettes Time to analyse data collected during a PhD to investigate how symptoms experienced by people with life-limiting cancer and/or respiratory disease affect their independence in daily activities and whether assistive devices help to maintain independence'
  - Lisa Ballantine 'Project Management time to deliver Health Inequality research and projects, improving staff opportunities and skills evolving to meet a changing landscape in population health'
- Upcoming event- Our second Celebration of Research event that will be held on 15th November at the Principal Hotel, York, invite will be out in June

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: Jul-2023

TRUST PRIORITIES REPORT : June 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-24	168	150	179										497
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 June 2023

Care Groups	Accruals Running Total 23/24
CG1 Total	184
CG2 Total	17
CG3 Total	18
CG4 Total	28
CG5 Total	0
CG6 Total	23
RP's Total	211
Cross Trust Studies Total	16
ACCRUAL TOTALS	497

Accruals Still Required	3003
Trials Open to Recruitment	109

Non-Commercial Studies 23/24 - Breakdown by Study Design (may not add to 100% as does not include commercial studies)

Study Design	% of all open studies	% of total 23/24 accruals to date	NIHR ABF Weighting
Interventional	37%	34%	*Weighted 11*
Observational	49%	18%	*Weighted 3.5*
Large Interventional	4%	4%	*Variable weighting by study*
Large Observational	4%	44%	*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	67%	60%

Closed FY 2023-2024	Percentage to Date	Target
Non-Commercial	0%	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 : JUNE 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 11/07/2023
* 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%)	Jun-23	63.1%	70%	82	23/121	*Feb 23
	UEC	ED: Median Time to Initial Assessment (Minutes)	Jun-23	17	18	26	93/117	*Mar 23
	RTT	RTT Total Waiting List	Jun-23	51638	48634	33	115/171	*Apr 23
	RTT	RTT Waits over 104 weeks for incomplete pathways	Jun-23	0	0	100	1/171	*Apr 23
	RTT	RTT Waits over 78 weeks for incomplete pathways	Jun-23	75	0	11	153/171	*Apr 23
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Jun-23	6	59 (12-month)	8	126/137	*Mar-23
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Jun-23	9	116 (12-month)	14	118/137	*Mar-23
	Patient Experience	Trust Complaints	Jun-23	55	No Target	23	162/210	*Q4 21/22

Report to:	Board of Directors
Date of Meeting:	26 July 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 July Risk Committee has approved the following new risk on the CRR:

- Prescribing Practice

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 2 August 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)**

Corporate Risk Register July 2023

BAF Ref	CRR ID Opened	Title/Description	Current Mitigation	Manager	Risk level (current)	Actions (Risk)	Action Lead	Target Date	Risk level (Target)
PR1 PR2 PR4	CRR 1D - 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.	Chief Nurse	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.	Chief Nurse	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. Approved by IGEG in May 2023. 2.Creation of vetting process with special focus on contract resource across the Trust with personal credentials issued for IT use. Amended policy on Procurement of Services. 3.Creation of a Vulnerability Management strategy. Completed in Review Stage. 4.Review and perform an independent gap analysis of the Trust's proactive monitoring systems in line with Cyber Assessment Framework - Ongoing final stages of the report. 5.Review approach to staff training and awareness of cyber risks and create an engagement strategy. 6.Review the Trust approach to physical security gap analysis and create a costed and prioritised action plan - identifed immediate quick wins (e.g. CCTV cameras in Data Centres). Still working on wider scheme. 7.Conduct a full penetration test of the entire IT estate - a continous series of Pen Test procured over next 24 months reviewing internal/external systems. 8. Plan to expediate the implementation of Multi Factor Authenitcation to reduce risk	1. Sam Marshall 2. Sam Marshall 3. Sam Marshall 4. Sam Marshall 5. Rebecca Bradley 6. Sam Marshall 7. Sam Marshall 8. Sam Marshall	1. 30 June 2023 2. 30 June 2023 3. 30 April 2023 4. 30 June 2023 5. 30 June 2023 6. 30 June 2023 7. 30 June 2023 8. 30 August 2023	5x3 Significant

BAF Ref	CRR ID Opened	Title/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.	Chief Operating Officer	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 - David Thomas 1. Scarborough - David Thomas 2. Gemma Ellison 3. Gemma Ellison 4. Gemma Ellison 5. Gemma Ellison 6. Gemma Ellison 7. Caroline Alexander	1. York July 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 October 2023	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, pathology link corridor roof, North Block link corridor roof and theatre vent plant room roof are of a reinforced airyated construction product (RAAC). We have been advised that this construction method has a limited lifespan that has been exceeded and could be subject to structural failure. There is also asbestos in the pathology ceiling void which prevents remedial works and detailed inspection being undertaken. There has been a failure of this construction type in other public buildings and as such a national NHS programme has been established to identify and support the removal of RAAC from the estate. The risk is due to the unknown structural integrity of RAAC, and the potential risk of a roof collapsing resulting in serious injuries or death and a risk of service closure.	The Trust has approved £250k for the first phase of the plan to deal with managing the RAAC in the pathology building at SGH, which is aimed at removing staff from the first floor and securing authorised only access. Temporary accommodation has been constructed at Scarborough and York hospital sites and staff and services are currently being relocated. The aim is to have the first floor vacated and secured by August. The estates team with the support and guidance of specialist structural engineers are conducting regular inspections. Photographs and images are being taken to record any deterioration or movement. Further assessment is being arranged to cover the wider estate to establish if any other Trust buildings contain RAAC construction products. It is considered to be unlikely based on current knowledge of the estate. The project programme runs across three financial years and so it is hoped that funding will be identified by NHS England from national programme slippage or unrequired contingency provisions to allow the Trust's project to commence in the current 2023-24 financial year. The aim is to demolish and rebuild the pathology lab and to replace the roof structure in all other areas containing RAAC. NHS England has already received a substantial amount of information on the capital cost forecast for the RAAC eradication work so they are sighted on the request for funding that will be formalised in the short-form business case.	Interim Managing Director	5x4 Significant	1. The main focus this period is to relocate staff and services from the first floor of the Pathology building by August and to secure funding for new years programme of works. 2. A short-form business case is being prepared and will be submitted to the NHS RAAC Programme Board by August 2023 requesting funding for the full RAAC eradication work that is required at Scarborough Hospital.	Mark Steed	01 August 2023	1x1 Very Low

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PR1 PR2 PR3 PR5	CRR ID - 20 21/08/2018 CRR 03/05/2023	**Impact of backlog maintenance on patient care -** 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.	Multi-disciplinary backlog maintenance group established to develop and oversee rolling 5 year backlog maintenance investment programme with direct reporting into CPEG. Currently overseeing £2.6m investment programme. Review of governance structures and committees to ensure data is gathered from technical sub groups to support investment prioritisation and risk management.	Interim Managing Director	4x5 Significant	1. Delivery of the FY 2023/24 backlog maintenance programme 2. Commissioning of and updated condition surveyto help inform investment priorities and risk management strategy. 3. Development and updating of the 5 year rolling investment programme with a more detailed focus on FY 2024/25	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	Chief Nurse	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	Chief Operating Officer	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
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 and/or failure to deliver the ICBs required aditional cost reduction 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 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 delivery of the 2023/24 required plans.	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. Full engagement with ICB on system recovery plan work. 5. Full engagement with National efficiency delivery programme. 6.Full engagement with National agency reduction programme.	1- 6 Finance Director	1-6 Ongoing	3x3 Medium

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PR1 PR2 PR3	CRR ID - 2 20/08/2018	**Response to Deteriorating Patient -** Poor management of Deteriorating Patients: 1. Failure to recognise the deteriorating patient. 2. Failure to follow the appropriate escalation Management pathway. Poor management of the deteriorating patient including re-assessment may 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. At Scarborough Band 7 managers have oversight of this process. 3.All incidents reviewed daily by the the Care Group Governance teams and the Patient Safety Team and immediate action taken as required. Patient Safety team flag incidents that require further investigation. PST review flagged incidents again on Fridays to ensure Care Groups have taken the appropriate action 4. Incidents feed into the Deteriorating patient group for discussion and shared learning. 5.Sepsis Management Policy 6.Individual escalation protocols 7.National Early Warning Scores and escalation prompts (and associated pathways NEWS, MEWS and PAWs) 8. Staff training Acute Illness Recognition and Assessment, RN/HCA/FY1 induction training, BLS training 9.Deterioration Adult Patient Monitoring and Escalation Policy 10.Treatment Escalation Plan and DNACPR Policy 11.Treatment Escalation Plan compliance monitoring on signal, revewed by DNACPR TEP group	Medical Director	4x4 Significant	1.Implement NICE guidance when available (expected June 2023) 2. Trust QI methodology to be deployed to drive Sepsis improvement. . 3. Review of observation compliance and barriers. 4. Review process of monitoring deteriorating patients incidents and considering replicating the falls process. 5.Undertake a review of the deteriorating patient audits with dissemination of learning and actions.	1. Daniel Palmer 2. Phil Dickinson 3.Clare Scott 4.Dan Palmer 5. Jon Redman	1.September 2023 2.December 2023 3.October 2023 4.October 2023 5. 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	Director Workforce & Organisational Development	4x4 Significant	1. Job Plan re-setting of expectations 2. Implement NHSE Safe Staffing and e-rostering report recommendations 3. AHP 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 & Director of Workforce and OD 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. March 2024 3. March 2024 4. March 2024 5. March 2024	4x3 High
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.	Chief Operating Officer	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. David Thomas/ 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. August 2023 3. September 2023	2x2 Low

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PR1 PR2 PR3	CRR ID - 21 01/04/2018 CRR 05/07/2023	**Prescribing Practice -** There is a risk of failing to prescribe medicines appropriate for the patient or in accordance with the Medicines Code. This is potentially caused by lack of knowledge, failure to follow guidelines/procedures and ineffective training. This may result in patient harm, unclear and inappropriate prescriptions, reputational damage and regulatory attention.	Formal teaching for HYMS students and FY1's on the clinical induction programme has been implemented across all sites. Chemocare software for chemotherapy prescribing has been implemented at York and Scarborough. Electronic prescribing (ePMA) has been developed and rolled out - currently covers all inpatient beds except for paediatrics. Metavision in place for ICU. This provides prescribing decision making support and contains a wide range of clinical information. A validation of the technical aspects of inpatient prescribing using ePMA was released June 2020 and provided a high level of assurance, recommending repeat audit was not requires unless significant changes occurred to the ePMA system. An audit of the clinical aspects of inpatient prescribing using ePMA and detailed action plan was released in June 2020. An audit on outpatient prescribing is undertaken every 3 years (next due September 23). Monthly medication error trend analysis is undertaken within the Medication Safety Group meeting and report. Monthly safety bulletins are released for prescribers on learning from medication incidents. FP10 and outpatient prescribing analysis is undertaken to assess new formulary items and reported to D&T 6 month and 12 months post approval. High cost drugs and formulary prescribing for outpatients and FP10s are reviewed monthly within Medicines Information and exceptions are reported to D&T.	Medical Director	4x4 Significant	1. Plan to roll out ePMA to outpatients and paediatrics- due end of 2024 - Gemma Nicholls. 2. Audit of the clinical aspects of inpatient prescribing using ePMA and action plan. 3. Audit on outpatient prescribing and action plan	1. Gemma Collins 2. Gemma Nicholls 3. Gemma Collins	1. December 2024 2. September 2023 2. July 2023	4x3 High
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. Implementation of of new ITSM solution as part of the IT Service Management Strategy. 4. Continued implementation and adoption of 2022/23 infrastructure investment in infrastructure, storage, end user compute, networks and wifi to reduce immediate risks of out of support system failure.	Chief Digital and Information Officer	5x3 Significant	1.Creation of a Vulnerability Management Strategy **(completed in review stage)** 2. Creation and implementation of an IT Disaster Recovery Plan. 3. 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. Sam Marshall 2. Adrian Shakeshaft 3. Stuart Cassidy	1. DRAFT Complete - Final draft due 30 June 2023 2. 1 December 2023 3. 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. Deep Dive review completed @DPF Committee	Chief Operating Officer	5x3 Significant	1. Continue to try to recruit to agency posts. 2. Continue to try to recruit substantive staff.	1. Karen Priestman 2. Karen Priestman	1. August 2023 2. August 2023	5x2 High
PR1 PR2 PR3 PR5	CRR ID - 19 25/07/2022 CRR 03/05/2023	**Steam Main SGH** - The steam main and condensate pipework serves the entire hospital site via a single pipework system that is 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 should a major failure occur.	The risk is mitigated by undertaking NDT ultrasonic testing every year due to the age and increased load. Vital Energy to undertake the NDT ultrasonic testing as part of annual inspection.	Interim Managing 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

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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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 10.1

Minutes

People and Culture Assurance Committee
17 May 2023

Attendance:
Jim Dillon The Chair, Matt Morgan Non-Executive Director, Lorraine Boyd Non-Executive Director, Polly McMeekin Director of Workforce & Organisational Development, Lucy Brown Director of Communications, Heather McNair Chief Nurse, Karen Stone Medical Director, Will Thornton Lead for Workforce Planning and Development, Mike Taylor Associate Director of Corporate Governance, Maya Liversidge (Governor observing), Sally Light (Governor Observing)

Welcome and Introductions

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

1-23/24 Declaration of interest

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

2-23/24 Minutes of the meeting held on 15 March 2023

The Committee acknowledged receipt of minutes from the 15 March 2023. Clarification was sought at page 7, 23/19 “Nursing Workforce Update” and the amendment was made to the final draft.

The Committee:
- **Received and agreed the minutes of 15 March meeting.**

3-23/24 Matters arising from the minutes and any outstanding actions

Action PC02: Remains ongoing; the Health and Safety Team are developing a “yellow and red card” system, which will demonstrate the Trust’s stance on inappropriate behaviour and supporting staff welfare.

Action 142 & PC05: Closed. Polly McMeekin confirmed the Trust works closely with NHS Digital and therefore restricted in terms of alternative systems and therefore feels scoping alternatives are not a priority for the organisation but investment in rolling out electronic rostering across the workforce is.

Action PC07: Closed. The survey results have been provided to the Committee.

4-23/24 Escalated Items

No escalations were received from other Committees.

5-23/24 Risk Management Report; Board Assurance Framework and Corporate Risk Register

The report was considered by the committee.

The Committee:

- **Received and noted the report**

6-23/24 Trust Workforce Plan

Will Thornton discussed the report included within the papers.

The Committee discussed the challenges the Trust faces and it was queried whether this would change the plans already in place for the recruitment of nurses. It was confirmed these plans would not be affected as the gap is closed with temporary staffing and approximately 90 international nurses will be recruited by November with also the equivalent of domestic staff.

7-23/24 Staff Health and Wellbeing

PM discussed the report included with the agenda and highlighted positive areas:

- The Trust has 117 mental health first aiders offering support across the organisation which exceeds the recommendation of 100.
- Virtual roadshows are being well received and reach a large audience

Challenges faced:

- The length of time taken to identify a “break out” space (a space has is now identified in York).
- Occupational Health and Well-Being Team’s annual target of £242k; last year the team achieved £185k managing 22 external contracts. The target is a continuing challenge. The financial position was considered at Executive Committee but an agreement to review the income target could not be reached.

8-23/24 Medical Training and Education Update

Karen Stone presented the paper included with the pack.

KS highlighted an area of concern being the significant financial implications of student accommodation which the university have recognised and will change the process for allocating students.

With regards to the GMC National Education and Training Survey and the Trust ranking so low across the region, it was queried whether priority would be given to other Trusts putting us at a disadvantage. On the whole KS felt the results would not prejudice the Trust, however, until the results of the survey are received it is difficult to gauge. Upon receipt of the results in the Autumn KS confirmed that an investigation into the detail will be conducted in a bid to understand the problems and a comparison being made against previous years and an action plan drawn up. KS feels that giving the medical students a great experience will help consultants choose our Trust as a place to work.

9 - 23/24 Nursing Workforce Report

Heather McNair presented the paper included with the agenda.

90 Keralan nurses were welcomed to the Trust in May. HM highlighted that funding for international recruitment nurses ends in March 2024 and the organisation is collaborating with the ICB to consider options beyond 2024 and the financial implications.

Of note table 4 (pg. 44) does not include any proposed investments for this year. Once confirmation has been received it will be reflected in the data.

The retention of HCAs is still a concern (pg. 45). Further work is required to understand why staff move from substantive posts to bank contracts. From initial investigations it would seem staff prefer the flexible working the bank provides and the financial initiatives i.e., 40% uplift.

The committee discussed whether a more proactive approach could be taken in relation to unmet needs in relation to temporary staffing requests and it was confirmed a nursing dashboard has been introduced which provides more. The ‘allocate on arrival’ scheme was well received and will be an initiative that will be continuing.

The recruitment event proved successful. The process of recruitment is timely and therefore the interview and job offer is made on the day of the event to help to reduce the wait before employment can commence.

10 – 23/24 Workforce and Organisational Development Update

PM presented the report included with the agenda.

PM highlighted the Culture and Leadership Programme. The project team has been recruited and the focus is now on the core team to drive the programme forward to ensure there is a cross section of the workforce including decision makers who are enthusiastic about change. The next stage will be a scoping phase to collate data, feedback, surveys and engage individuals.

It was asked at Board whether the People & Culture Committee could look specifically at what level of assurance we have in relation to the management of sickness absence across the workforce. PM advised that overall the data shows we are in line with our peers for acute trusts. However, PM referred to graph 2 on page 52 and in particular medical and dental which make up 9% of the workforce. The HR team have oversight of 492 cases of long-term sickness absence of four weeks or more and 16 of those include medical and dental. Further investigation confirmed there was no pattern across the staff groups/grades. However, until e-rostering is implemented Trust wide absence monitoring will continue to be managed inefficiently. Only 53% of staff are on e-roster which feeds into the payroll system. Due to the delay in reporting from ESR, reports can only be produced two-months after the increase in absence unless managers are proactive in seeking HR's input

The Committee discussed the ongoing problems surrounding e-rostering. HM stated that the NHSE report is likely to advise that e-rostering is not resourced fully. The Committee therefore felt that it should be presented back to Board seeking funding for the implementation Trust wide.

PM gave a brief update on industrial action and confirmed both the BMA and RCN are balloting. The BMA ballot is due to close on 27.6.23 and RCN on 23.6.23. There is a possibility the strike action could be combined which is of concern. It is believed that consultants will strike as an indicative ballot earlier in the year indicated strike action.

11 – 23/24 Research and Development Update

Lydia Harris presented the Research and Development update.

LH highlighted key achievements detailed in the report:

- Exceeded the accrual target for the seventh year in a row
- An increase in the number of grants received
- The organisation is the highest recruiter in Yorkshire and Humber to the Harmonie RSV study. The Trust also project managed the study
- Talent mapping
- HYMS offered four research PA's

- Multiple long term conditions hub at Scarborough – identified an academic lead and now in the process of securing a clinical lead

The committee are asked to refer to the report for a list of outstanding actions.

12–23/24 Staff Survey reports

The Committee received and noted the reports.

13-23/24 Issues to escalate to Board, other Committees, BAF or CRR

A solution for e-rostering. 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.

14-23/24 Any Other Business

No other business was discussed.

Maya Liversidge, Governor, queried whether any other e-rostering system has been considered. PM confirmed that the procurement process was through NHS and applications were received via that framework.

Sally Light, Governor commented on the number of papers included with the agenda. JD suggested reports should detail the difference from month on month rather than include all of the data. Discussions are ongoing regarding the corporate governance structure.

15-23/24 Summary of actions

No new actions

16-23/24 Date of next meeting

19 July 2023, 1pm

Item 10.2

People and Culture – Chair's Assurance Report

Date of Meeting:	19 July 2023			**Quorate (yes/no):**	Yes	
Chair:	Lorraine Boyd (NED - Meeting Chair)					
Members present:	Jenny McAleese (JM), Polly McMeekin, (DW&OD), Karen Stone (MD), Dawn Parkes (DP), Lucy Brown (Dir Comms)		**Key Members not present:**	Jim Dillon (Committee Chair) Matt Morgan (NED)		
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

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

People and Culture – Chair's Assurance Report

9. Nursing Workforce		The vacancy rate for Healthcare Support Workers remains high and a concern. It is not fully reflected in the reported starters and leavers numbers, as there is a lot of movement within this group, making predictions unreliable. There is a resultant potential risk to patient care and experience as HCSW are pivotal in the delivery of fundamentals of care. Recruitment plans are in place to fill these vacancies and the regional NHSE Workforce Lead is supporting the Trust to develop and delivery a HCSW plan to include induction, pastoral support and ongoing career progression with an aim to improve recruitment and retention. The Committee has asked for further update and assurance in future.	Escalation for information

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 12

Report to:	Public Board of Directors
Date of Meeting:	26 July 2023
Subject:	CQC Compliance Update Report
Director Sponsor:	Dawn Parkes, Interim 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:

The CQC inspected the Trust between 11 October 2022 and 17 March 2023. The final report was published on 30 June 2023. The Trust has an overall rating of 'Requires Improvement'.

The monthly section 31 maternity submission was made on 23 June 2023.

An Ionising Radiation (Medical Exposures) Regulations, IR(ME)R, Inspection took place on 29 June 2023 and the Trust is awaiting publication of the report. An improvement notice was received on 4 July 2023 relating to the contravention of Regulation 6 - Employer's duties: establishment of general procedures, protocols and quality assurance programmes.

There are nine open enquires with the CQC.

Recommendations:
The Board of Directors is asked to:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC enquires.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Operational Quality Group	12 July 2023	Update received.

1. CQC Inspection Update

The CQC inspected the Trust between 11 October 2022 and 17 March 2023. The draft inspection report was received by the Trust on 12 May 2023.

The CQC report was published on 30 June 2023. Click here to view the report. The overall ratings were as follows:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The York Hospital	Inadequate ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Inadequate ↓↓ Jun 2023	Inadequate ↓↓ Jun 2023
Scarborough Hospital	Requires Improvement ↑ Jun 2023	Requires Improvement →← Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023	Requires Improvement →← Jun 2023
Bridlington Hospital	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019
Overall trust	Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Inadequate ↓ Jun 2023	Requires Improvement →← Jun 2023

In terms of the areas for improvement:

- There are 95 actions the Trust MUST take to comply with its legal obligations.
- There are 45 actions the Trust SHOULD take to prevent the Trust from failing to comply with legal requirements in future, or to improve service.

All 140 must and should do actions were reviewed and those containing repeated themes were amalgamated. As a result, the number of actions within the improvement plan has reduced to 73. All 73 actions have been linked to the seven Trust Improvement Workstreams – delivery of which will be overseen through the Journey to Excellence: Focussed Improvement Programme chaired by the Trust Chief Executive.

The deadline for submission of the Trust action plan is 20 July 2023.

2. Maternity Section 31 Submission

A monthly submission is made to the CQC providing an updated position on progressing in addressing the issues highlighted in the Section 31 notice. The submission is due on the 23rd of each month.

The Maternity Improvement Advisor is in the process of refining the maternity improvement plan and the associated outcome measures. It is acknowledged that there are gaps in assurance which remains a risk to the organisation.

Oversight on progress with the maternity improvement plan is provided by the Maternity Assurance Group. A paper on the requirements of the Section 31 is drafted by Care Group 5 and approved through the Quality and Safety Assurance Committee. The submission is approved in its entirety by the Interim Chief Nurse.

The monthly section 31 maternity submission was last made on 23 June 2023.

3. Ionising Radiation (Medical Exposures) Regulations, IR(ME)R, Inspection

Medical ionising radiation is used widely in hospitals, dental care, clinics and in medical research to help diagnose and treat conditions. Examples are x-rays and nuclear scans, and treatments such as radiotherapy.

IR(ME)R aim to make sure that it is used safely to protect patients from the risk of harm when being exposed to ionising radiation. They set out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection and the basic safety standards that duty holders must meet.

The Trust was informed on 15 June 2023 of the intention to inspect the York Hospital CT department. The inspection took place on 29 June 2023 and consisted of a half day document and governance review and half a day in the CT department.

A written report from the inspection is due be received by the Trust. This will not be published and does not impact on CQC ratings. It is anticipated that this will be received by the end of July 2023.

An improvement notice was received on 4 July 2023. The inspector was of the opinion that the Trust has contravened the regulation below:

Ionising Radiation (Medical Exposure) Regulations 2017, Regulation 6 Employer's duties: establishment of general procedures, protocols and quality assurance programmes.

These contraventions must be remedied by 12 September 2023. Actions are in train and progress will be overseen through the Care Group governance and the Trust Regulation and Accreditations Group (inaugural meeting on 20 July 2023).

4. CQC Enquiries

The CQC receive information from a variety of sources in relation to the quality of care provided at the Trust. This information can be related to known events, for example serious incidents (SI's), formal complaints and Datix incidents, or unknown events, such as concerns submitted directly to the CQC from either patients, staff, members of the public, or other organisations. Following receipt of such information, the CQC share the concerns with the Trust for review, investigation, and response.

The CQC monitor themes and trends of enquiries received, and these can inform inspection and other regulatory activity.

The Trust has received two CQC enquiries in June 2023. At the time of writing (5 July 2023) the Trust has 9 open enquiries. A summary of all open enquiries is provided in appendix 1.

5. Quality Regulation and Assurance Group

Assurances on the completion and use of clinical risk assessments were reviewed at the QRAG meeting on the 8 June 2023. The meeting was also attended by the Lead Nurse for Digital Project who gave an update on progress with Nucleus.

The focus of the QRAG meeting on the 22 June 2023 was on the approach for developing and overseeing the actions needed to address the findings in the recently published CQC report and was attended by the Interim Chief Nurse.

Included in the June 2023 update report were actions arising from the QRAG session on the Management of Pain. A monthly Pain Task and Finish Group has been established and has its inaugural meeting on 20 July 2023. The requirements of an audit and the capacity of the team will feature on the groups agenda.

6. Recommendations

The Board of Directors is asked to:

- Note the current position regarding the recent CQC inspection activity.
- Note the current position of the open CQC enquires.

Appendix 1 - Open CQC Enquiries

Date Received	Reference	Ward / Dept	Care Group	Site	Type of Concern
04/05/2023	ENQ1-15499543117	Ward 34	CG1	York	Safeguarding
10/05/2023	ENQ1-15688147776	Various	CG2	Scarborough	Complaint
15/05/2023	ENQ1-15861915915	Emergency Department	CG1	York	Discharge
16/05/2023	ENQ1-15862963166	Ophthalmology	CG4	Trustwide	Patient Safety
16/05/2023	ENQ1-15869585739	Maternity	CG5	Trustwide	Information Request
16/05/2023	ENQ1-15870476998	A&E	CG2	Scarborough	Treatment Delay
16/05/2023	ENQ1-15870477066	Various	CG2	Scarborough	Patient Death
26/06/2023	ENQ1-16377844806	Maternity	CG5	Scarborough	Incident
29/06/2023	ENQ1-15863726684	Ward 32	CG1	York	Complaint

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	The Board of Directors
Date of Meeting:	26 July 2023
Subject:	Maternity and Neonatal Quality and Safety Report
Director Sponsor:	Dawn Parkes - Interim Chief Nurse
Author:	Sue Glendenning, Interim Director of Midwifery Sarah Gallagher, Quality and Governance Lead, Care Group 5

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

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

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

Summary of Report and Key Points to highlight:
The report includes maternity May and June data.

- Oversight from the Maternity Improvement Programme
- Progress with the Maternity Safety Actions
- Current position of SBLCB V2 / V3
- Plans for Ockenden Benchmarking
- Fetal Monitoring Compliance
- PPH rates and continued monitoring and oversight.

Recommendation:

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

Report Exempt from Public Disclosure

No ☒ Yes ☐

Report History

Meeting	Date	Outcome/Recommendation
Quality and Safety Assurance Committee	18th July 2023	Clear reporting into the Maternity Assurance Group re risks and assurance and shared learning from SI's and HSIB Clear trajectories for mandatory training compliance

Perinatal Surveillance Model

CQC Maternity Rating **June 2023**	Overall	Safe	Effective	Caring	Responsive	Well Led
Maternity Safety Support Programme		Yes	Amanda Pearson			

	2023											
	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool	3	0	0	0	3	1						
Findings of review of all cases eligible for referral to HSIB	0	1	0	0	1	0						
Report on the number of incidents logged graded as moderate or above, or PSIRF reportable and what actions are being taken	3	3	1	5	7	5						
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	74.5%	-	-	73.8%	72.8%	88.5%						
Minimum safe staffing in maternity services to include. Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	√	√	√	√	√	√						
Service user feedback	99%	92%	97%	99%	-	-						
Staff feedback from frontline champion and walk abouts												
HSIB/NHSR/ CQC or other organisation with a concern or request												
Coroner reg twenty-eight made directly to the Trust	0	0	0	0	0	0						
Progress in achievement of Maternity Incentive Scheme												
Proportion of midwives responding with Agree or 'strongly agree' on whether they would recommend their trust as a place to work or receive treatment												annual
Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours												annual

Report Overview

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 Quality and Safety Assurance Committee 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 and neonatal services team. The information within the report will reflect proposed plans to provide a position on where the service is compliant with the Essential and Immediate Actions as required by Ockenden. This position will be shared with the Trust Board in September 2023 in the same way the service has provided assurance in this paper for compliance with the Maternity Incentive Scheme Year 5.

York and Scarborough Maternity Services continue to work to address the Section 31 received in November 2022 and provide assurance against the minimum data set as required in the Perinatal Clinical Quality Surveillance model which includes the external reporting criteria to the Healthcare Safety Investigation Branch (HSIB), MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and Perinatal Mortality Review Tool (PMRT).

Maternity Improvement Programme (MIP)

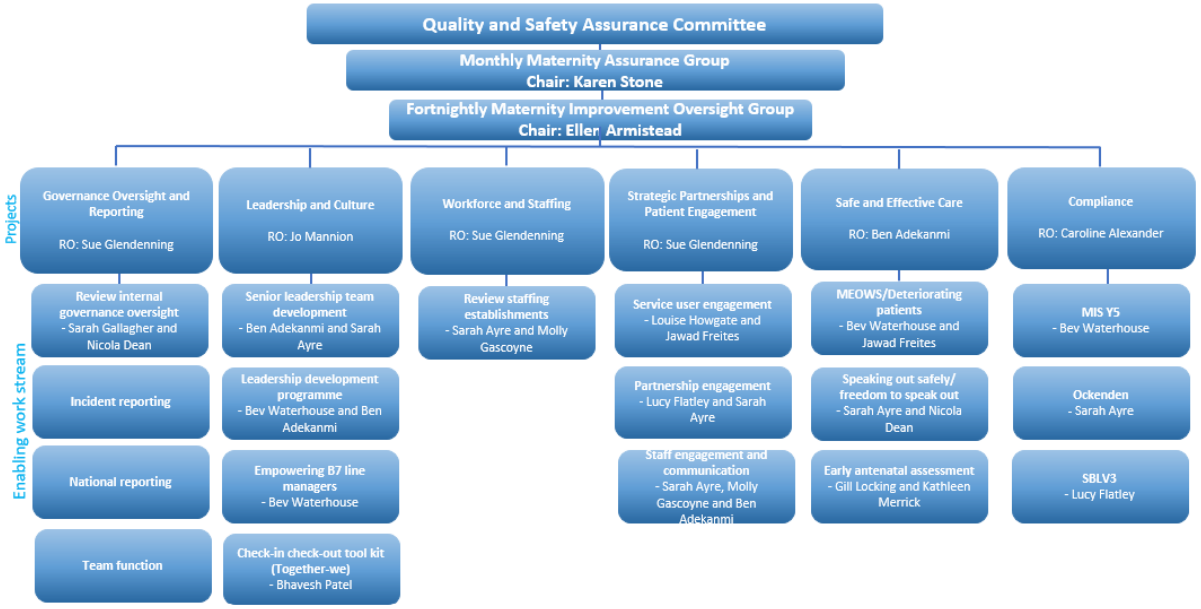
There is a Maternity Improvement Plan which is established, and which reports monthly to provide assurance on progress with our response to the CQC must and should dos.

A wider Maternity Improvement Programme is in the process of being established to bring together all intelligence from:

- Maternity Service Support Programme (full diagnostics report expected in July)
- CQC
- Saving Babies Lives Care Bundle v3.
- Maternity Incentive Scheme Year 5
- Ockenden

Our Programme Management Office (PMO) is now established and supporting the maternity improvement programme with dedicated programme managers, Business Intelligence lead, workforce/ HR and finance lead. The PMO team works closely with our dedicated Transformation Lead Midwife, the corporate teams (governance, chief nurse, communication and engagement), Maternity Voices Partnership, NHS Resolution and Local Maternity and Neonatal System to align reporting. The service has support from the NHSE Maternity Improvement Advisors and Director of Improvement facilitating rapid learning from existing MIPs / Trusts with highly effective assurance and oversight, risk assessment and reporting frameworks.

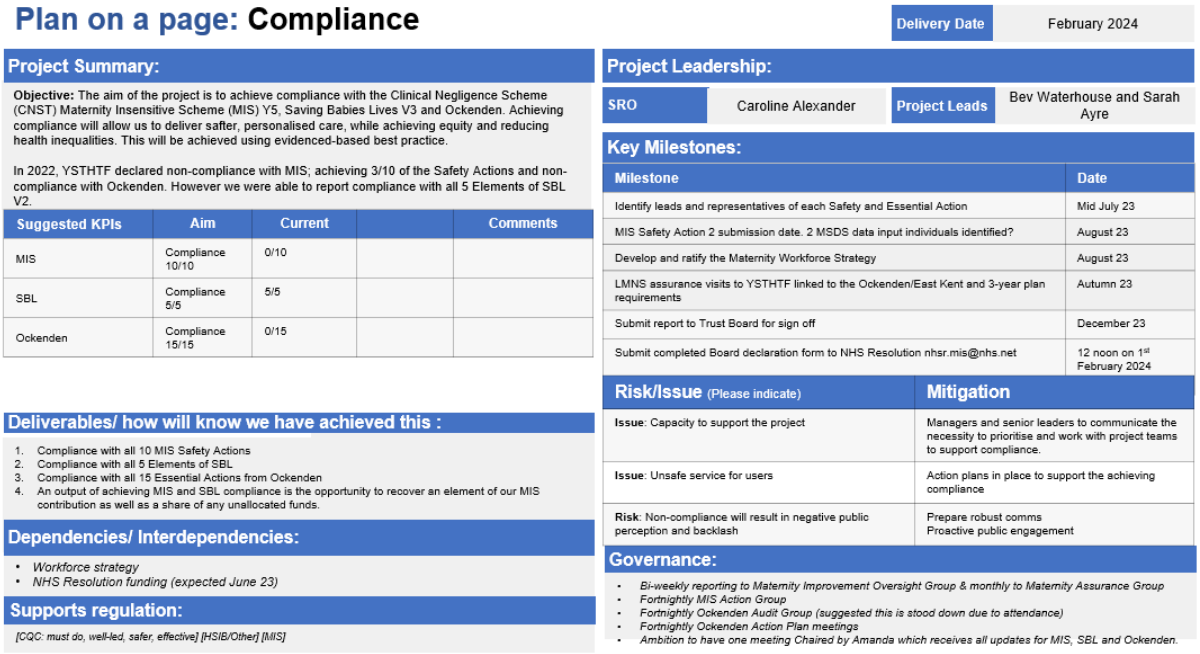
A Maternity Assurance Group (MAG), Maternity Improvement Oversight Group (MIOG) and Maternity Finance Oversight Group (MFOG) have been established and Terms of Reference agreed, adopting the best practice maternity meeting structures which are required to underpin effective maternity governance frameworks and deliver an aligned MIP as outlined below.



As seen above there are six identified workstreams for improvement. Project Groups have met to establish initial engagement for the identified workstreams in the MIP and agree scope, SROs and support requirements. First drafts of the plan on a page documentation are being completed this includes information on:

- Objectives
- Deliverables
- KPIs
- Key milestones,
- Risks and issues
- Governance and escalation routes
- Delivery dates

The purpose of the plan on a page is to agree the scope and expected outcomes of the project area so we have a baseline to report progress against each month to provide assurance, an example is provided below.



Plan on a page: Compliance

Delivery Date	February 2024

Project Summary:

Objective: The aim of the project is to achieve compliance with the Clinical Negligence Scheme (CNST) Maternity Insensitive Scheme (MIS) Y5, Saving Babies Lives V3 and Ockenden. Achieving compliance will allow us to deliver safter, personalised care, while achieving equity and reducing health inequalities. This will be achieved using evidenced-based best practice.

In 2022, YSTHTF declared non-compliance with MIS; achieving 3/10 of the Safety Actions and non-compliance with Ockenden. However we were able to report compliance with all 5 Elements of SBL V2.

Suggested KPIs	Aim	Current		Comments
MIS	Compliance 10/10	0/10		
SBL	Compliance 5/5	5/5		
Ockenden	Compliance 15/15	0/15		

Deliverables/ how will know we have achieved this :

1. Compliance with all 10 MIS Safety Actions
2. Compliance with all 5 Elements of SBL
3. Compliance with all 15 Essential Actions from Ockenden
4. An output of achieving MIS and SBL compliance is the opportunity to recover an element of our MIS contribution as well as a share of any unallocated funds.

Dependencies/ Interdependencies:

- *Workforce strategy*
- *NHS Resolution funding (expected June 23)*

Supports regulation:

[CQC: must do, well-led, safer, effective] [HSIB/Other] [MIS]

Project Leadership:

SRO	Caroline Alexander	Project Leads	Bev Waterhouse and Sarah Ayre

Key Milestones:

Milestone	Date
Identify leads and representatives of each Safety and Essential Action	Mid July 23
MIS Safety Action 2 submission date. 2 MSDS data input individuals identified?	August 23
Develop and ratify the Maternity Workforce Strategy	August 23
LMNS assurance visits to YSTHTF linked to the Ockenden/East Kent and 3-year plan requirements	Autumn 23
Submit report to Trust Board for sign off	December 23
Submit completed Board declaration form to NHS Resolution nhsr.mis@nhs.net	12 noon on 1st February 2024

Risk/Issue (Please indicate)	Mitigation
Issue: Capacity to support the project	Managers and senior leaders to communicate the necessity to prioritise and work with project teams to support compliance.
Issue: Unsafe service for users	Action plans in place to support the achieving compliance
Risk: Non-compliance will result in negative public perception and backlash	Prepare robust comms Proactive public engagement

Governance:

- *Bi-weekly reporting to Maternity Improvement Oversight Group & monthly to Maternity Assurance Group*
- *Fortnightly MIS Action Group*
- *Fortnightly Ockenden Audit Group (suggested this is stood down due to attendance)*
- *Fortnightly Ockenden Action Plan meetings*
- *Ambition to have one meeting Chaired by Amanda which receives all updates for MIS, SBL and Ockenden.*

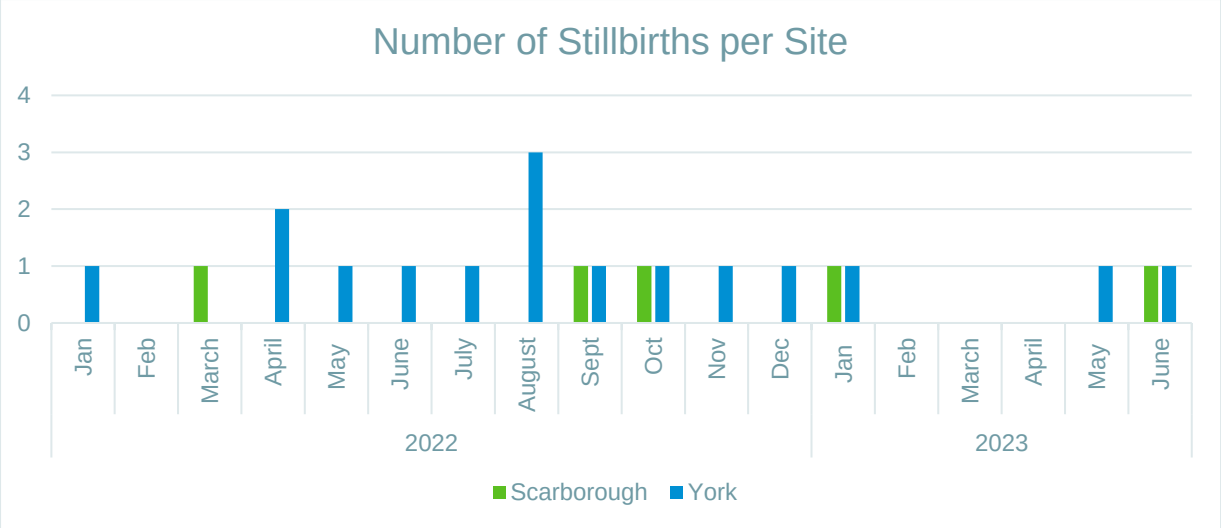
The Maternity Improvement Programme was presented to the ICB Quality Improvement Group on 5 July 2023. A copy of the slide deck included in Appendix A.

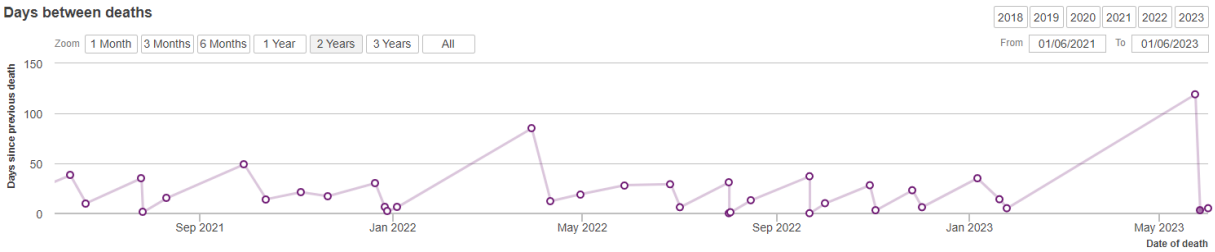
1.2 Perinatal Mortality Rate

In England, the government has an ambition to halve the neonatal mortality rate for babies born at a gestational age of 24 weeks or over to 1.0 per one thousand births and to half the 2010 stillbirth rate by 2025 to 2.6 per one thousand births.

The national MBRRACE-UK report for 2021 births is due for publication in September 2023, however 2021 data from the Office of National Statistics (for England) are.

- Stillbirth – 4.1 per one thousand births an increase from 3.8 per one thousand births in 2020
- Neonatal deaths – 1.4 per one thousand births





There were three perinatal deaths or stillbirths at the Trust in May and June 2023 that meet the criteria for inclusion in the MBRRACE-UK national audit. The perinatal deaths were a term intrapartum stillbirth, an antenatal stillbirth at 25+1 weeks gestation, and a late fetal miscarriage at 23+1 weeks gestation.

These deaths have been notified to MBRRACE-UK and the perinatal deaths will be reviewed using the perinatal mortality review tool (PMRT - details in section 1.5). In the period between January and May 2023 there was a period of 119 days between stillbirths which this is the longest period in two years.

The 2021 MBRRACE-UK report is included in Appendix B and the Trust analysis of the report in Appendix C.

1.3 Coroner Reg 28 made directly to Trust.

There were no coroner Reg 28 made directly to the Trust in May and June 2023.

1.4 NHSR referrals

There were no referrals made to NHS Resolution in May and June 2023.

1.5 Health Care Safety Investigation Branch (HSIB) and Maternity Serious Incidents (SI's)

HSIB was launched in 2015 to support the national ambition of halving the number of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth by 2025.

Where the following criteria are met, HSIB will undertake an investigation on behalf of the Trust.

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby dies within the first week of life (0-6 days) of any cause.

- Severe brain injury diagnosed in the first seven days of life when the baby:
- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreases central tone and was comatose and had seizures of any kind.

Any incident meeting the HSIB criteria are reported to the ICB as Serious Incidents to ensure transparency and oversight.

There was one notification made to HSIB in May 2023. There were no incidents that met the reporting criteria in June 2023.

Date Reported	Incident Details	Immediate Action Taken
24/05/2023	Low risk pregnancy, attended the Maternity Triage Unit in labour, no fetal heart present.	• Bereavement support provided to the woman and her family. • Staff support • MBRRACE and HSIB notifications made. • Clinical review and prioritisation of the women due for induction • Case discussed at Maternity Case Review, no identified immediate learning.

At the last quarterly review meeting with HSIB the following themes were identified from the Trusts recent cases and subsequently improvement actions were taken as detailed below.

Identified Theme	Action Taken
Guidance	• Induction of labour guideline updated in April 2023 been updated to include prioritisation of high-risk pregnancies and where there is high acuity on the unit, a RAG process is in draft and will be added as an appendix to this guidance in July 2023. • A check sheet has been developed to support in the event of a neonatal resuscitation to ensure all staff have the correct contact details of the paediatric team as well as initial prompts.
Risk Assessment	• All women who were registered as having epilepsy were reviewed to ensure that they are on the correct care pathway and a detailed guideline is in place which reflects RCOG guidance. • The telephone triage and initial assessment has improved following the introduction of BadgerNet and BSOTS
Clinical Oversight	• Any delayed caesarean section or induction of labour is reviewed and agreed by the on-call Consultant. • A change in practice at the York site where the sonographers will bring the scanning machine to the ward or bereavement suite to confirm intrauterine death to prevent women having to be scanned in the antenatal clinic.

The maternity case review meeting review incidents and identify any repeated themes for local learning which inform weekly patient safety briefs.

In July, the Quality and Governance Lead will be meeting with the Maternity Improvement Advisors to review all open actions from Serious Incidents and HSIB investigation reports to theme recommendations and actions. These will then be aligned to improvement workstreams and monitored as part of the Maternity Improvement Programme.

Current open investigations:

HISB aim to complete investigations within six months of reporting, the next final report is expected in August 2023 and related to Neonatal hypoxic - ischemic encephalopathy (HIE) / cooling identified below.

HSIB Notification Category	Number Investigations Open
Intrapartum Stillbirth	1 (notified May 2023)
HIE/Cooling	1 (notified February 2023)

Moderate Harm and Serious Incidents

There has been an increase in the reporting of incidents with moderate harm, in response to the Ockenden Report which recommended that harm should be considered from the perspective of the woman's experience. So, whilst we have noted a higher reporting rate this constitutes a comprehensive review of the care provided to ensure that appropriate pathways have been followed, women and families are informed of the outcome and offered appropriate de brief and support.

National and regionally, amongst maternity services there is discussion as to what constitutes a moderate harm incident. There is a suggestion that all recognised complications of childbirth, haemorrhage, significant perineal tears and babies born in poor condition or admitted to the special care baby unit are moderate incidents that reflect the psychological and physical harm to the woman.

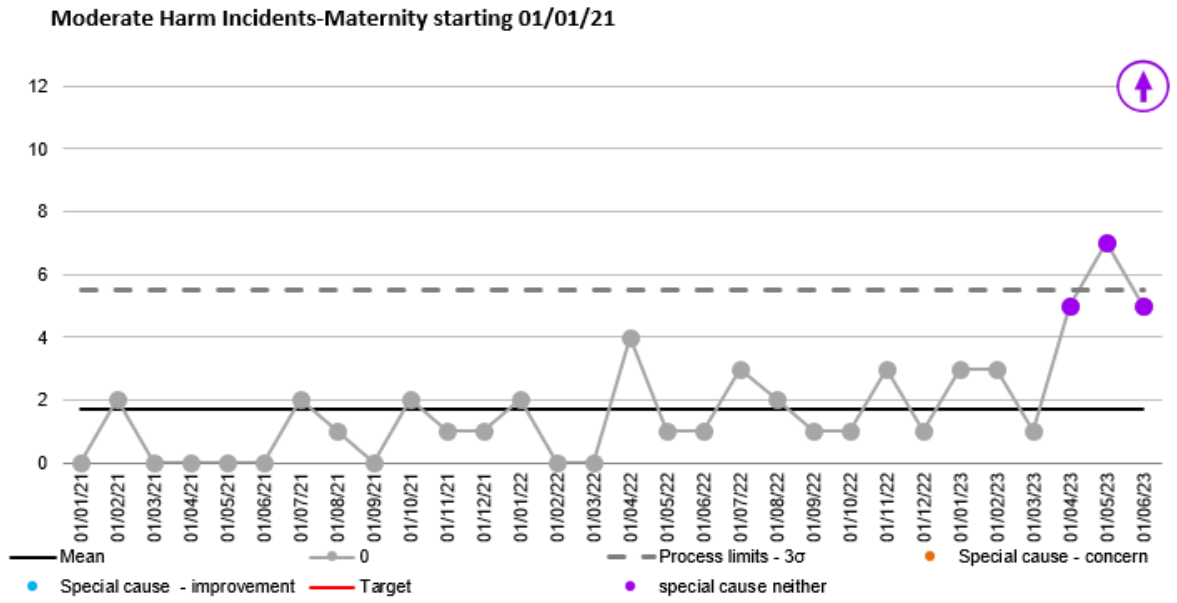
There were thirteen moderate incidents reported in May and June that equates to 8% of all obstetric incidents reported. Reporting these incidents as moderate ensures the appropriate level of multidisciplinary review at the Maternity Case, ATAIN or Perinatal Mortality reviews.

May 2023

Datix Number	Incident Category	Outcome/Learning/Actions
3rd and 4th degree tears		
WEB185324	3B tear following episiotomy.	The Maternity Services Data Set at February 2023 reports that the national average for 3rd and 4th degree tears is 27/1000 births, the Trust average is 22/1000 births. A thematic review of 3rd and 4th degree tears has commenced in June 2023, results of this will be shared in the next report.
WEB185003	Instrumental delivery as failure to progress, 3b tear.	
WEB184458	Fourth degree tear	
WEB183803	3b tear	
Other Moderate Harm Incidents		
WEB184938	Intrapartum stillbirth	Reported to HISB
WEB186521	Readmission to ICU	Joint investigation with ED being undertaken

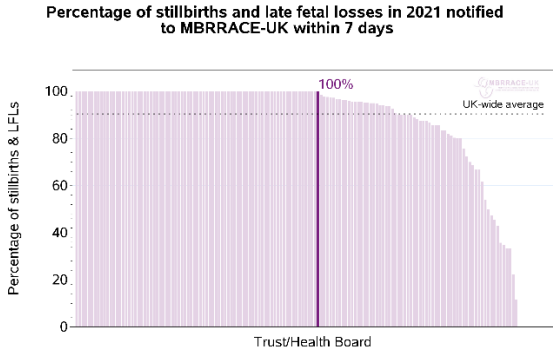
June 2023

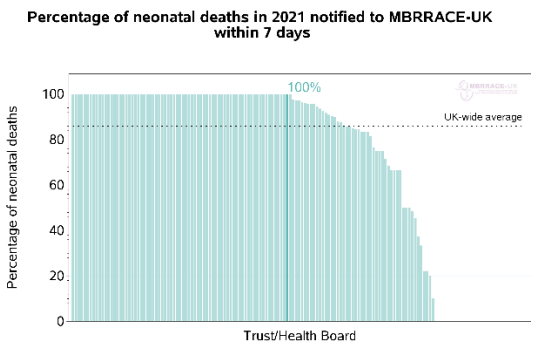
Datix Number	Incident Category	Outcome/Learning/Actions
WEB186402	3.3l blood loss	PSIR completed and awaiting review
WEB186712	Missed antenatal appointment.	PSIR completed and awaiting review
WEB186077	Unexpected admission to SCBU	To be reviewed at ATAIN meeting
WEB185839	Missed Fragmin administration	PSIR completed and awaiting review
WEB186521	Postnatal readmission requiring ITU	Joint investigation with ED
WEB187032	Delay in histology receiving placentas	PSIR completed and awaiting review
WEB186950	Delivery at 23+3 weeks gestation	To be reviewed at ATAIN meeting



1.5 Perinatal Mortality Review Tool

All deaths of babies over 22 weeks gestation and all neonatal deaths for babies aged up to seven days are reviewed by the multidisciplinary team using the perinatal mortality tool, this is a 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. The graphs below indicate that the Trust is compliant with notification to MBRACE within 7 days.





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

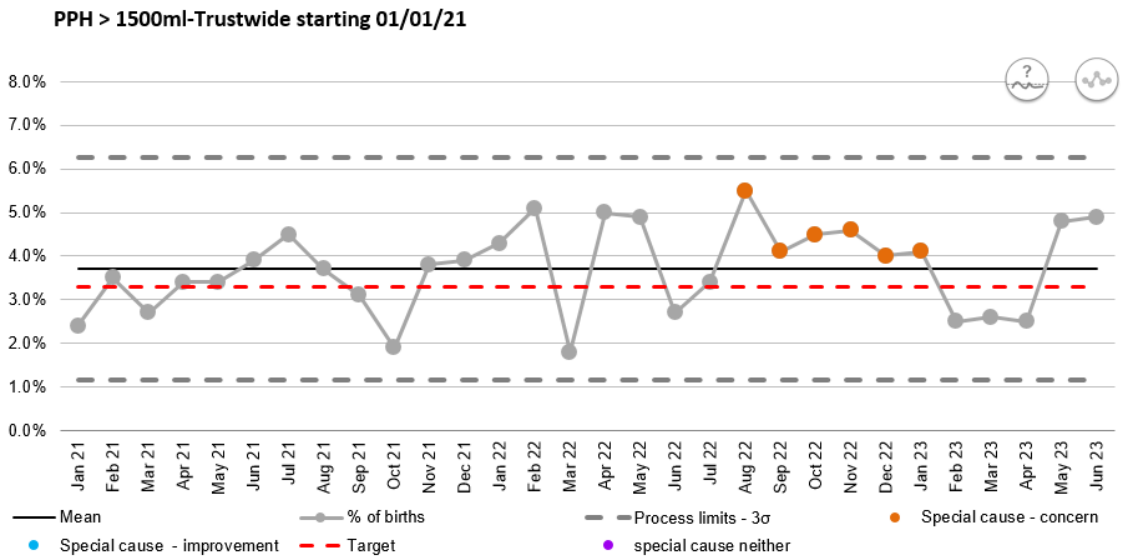
PMRT Case Reported May 2023					
Date of incident	Reporting criteria	Gestation	Details	Themes	Actions
24.05.23	Intrapartum Stillbirth	41+4	Low risk pregnancy attended the MTU in labour, no fetal heart present. Referred HSIB	Prioritisation of induction of labour Bereavement care	Development of delayed Induction of Labour and Lower Segment Caesarean Section Standard Operating Procedure – under development. Review PSIR for immediate learning. Await HSIB report.
25.05.23	Antenatal Stillbirth	25+1	No fetal heart present at community midwife appointment. Confirmed via Ultrasound Scan.	Fetal Monitoring	Review via PSIR and PMRT.

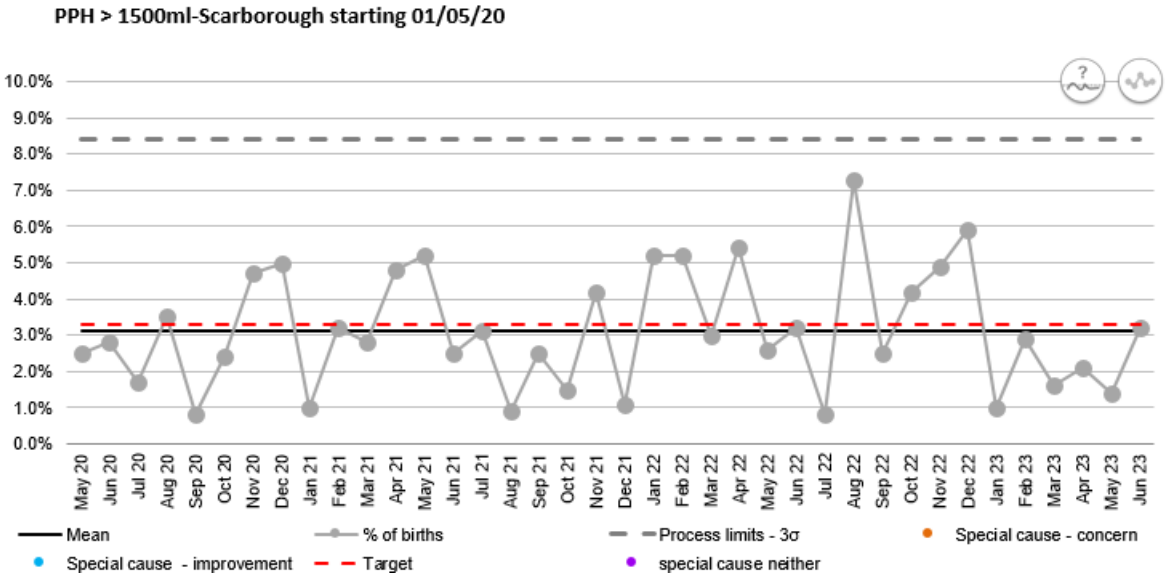
27.05.23	Termination of Pregnancy	31 +1	Termination of Pregnancy for congenital abnormalities	N/A	A notification is required however a review using the PMRT is not required.
01.06.23	Late Miscarriage	23 + 1	Attended Maternity Triage with abdominal pain	None identified in initial review	Review via PMRT

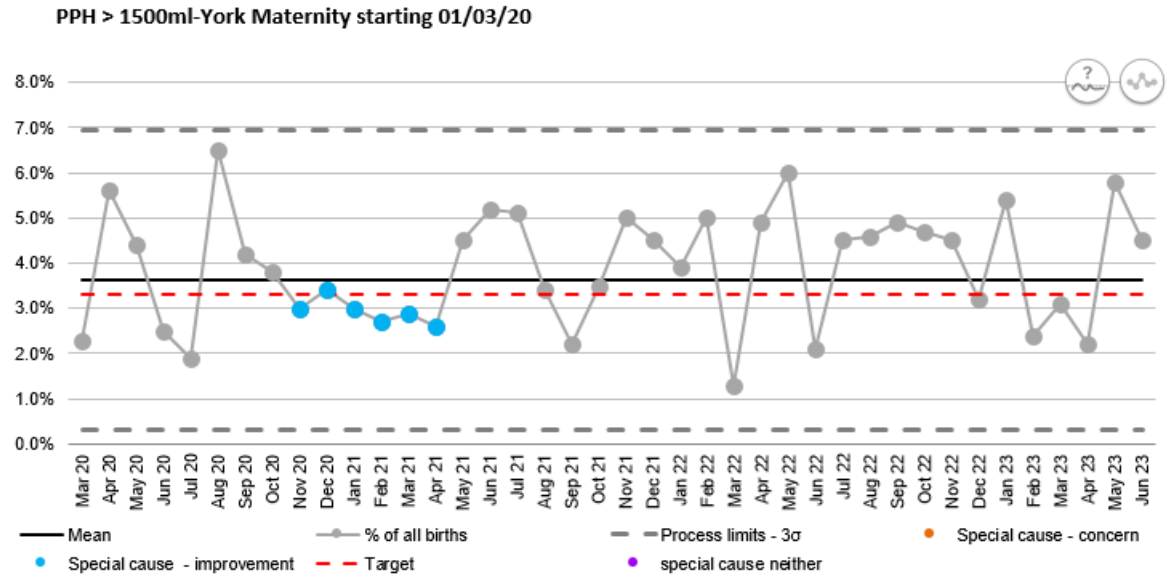
2.1 Postpartum Haemorrhage

The >1500mls Postpartum Haemorrhage (PPH) rate increased on both sites in May 2023 with an increase in reported blood loss over 2000mls. A cluster review was undertaken of all fourteen cases and the initial findings indicated there was no one identified cause for this increase. In four of the cases reviewed three were identified with elevated risk factors that would increase the likelihood of PPH. Ten cases of PPH>1500ml were associated with episiotomy and nine with trauma during birth and were reviewed as part of the Maternity Case Review Meeting and formed part of the cluster review by the Obstetric MIA.

Blood Loss	Number in May 2023
1.5l – 1.9l	5 (range 1.5l – 1.8l)
2l – 2.4l	7 (range 2l – 2.2l)
> 2.5l	2 (range 3l – 3.08l)
Blood Loss	**Number in June 2023**
1.5l – 1.9l	9 (range 1.5l – 1.8l)
21 – 2.4l	2 (range 2.1l – 2.3l)
>2.5l	1 (3.3l)







All PPH under 1500ml are reviewed by the cross site PPH Scrutiny Panel and the monthly snapshot audit overseen by the panel. Weighing scales were introduced into delivery rooms following a previous snapshot audit to accurately weigh blood loss, the clinical teams report that whilst these are useful, they do not consider they have made a difference in accurately assessing blood loss.

The snapshot audit in May 2023 identified that the PPH proforma had not been used in all of the ten cases audited at York and in one of the seven cases audited in Scarborough, this was highlighted on the weekly safety brief dated the 12th of June and the importance to be reaffirmed through PROMPT training. Feedback from staff is that the introduction of BadgerNet has caused some confusion about how and where the proforma should be stored and completed, the safety brief explained the use of the paper proforma was acceptable which can be scanned to BadgerNet. A cross site audit was undertaken in June where this use of the proforma was to be

reaudited and will be discussed at the July Panel. The date for the July panel meeting has been delayed due to a clash with the Speciality Clinical Governance meeting and the junior doctor and consultant strikes. A date will be arranged for later in the month. Due to capacity and staffing challenges the audit has not been fully completed. Audit results will be provided in August 2023.

The service is planning to trial new lithotomy drapes with pockets that measure ongoing blood loss as the panel have identified that following audit and case review that there is a delay in identifying blood loss due to collecting behind the green drapes or on the sheets behind the woman. The drapes, expected in June now have a delivery date the week of the 10th of July and will record the blood loss accurately with the sticker changing to red when the blood loss reaches five hundred mls, this is demonstrated in the attached photograph.

The panel have also identified that increased blood loss can be as a result of the suturing skills and confidence of the midwife and can lead to delays in closing the perineum with an associated increased blood loss, this delay in suturing has been highlighted as an issue at the Scarborough by the Labour Ward Manager who will address this with individuals as required. A practice development midwife and clinical skills midwife has been recruited to the Scarborough site which will support further midwifery training and several peri health suturing workshops have been commissioned for staff to attend. A case-by-case review will take place for the month of July to ensure that there are no delays in suturing and rapid escalation to obstetric medical staff for support.

2.4 Serious Incidents

There was one Serious Incident declared in June 2023 for a PPH over three litres and a baby born before arrival at hospital. The family have been offered a debrief and have provided feedback following their birth experience. An incident investigator has been identified and will be using the feedback from the family to inform the investigation. The service will be looking at the out of hours support for midwifery staff at the time of escalation, this is challenging due to the capacity of the senior midwifery team, current include weekend working for the senior team to provide onsite presence.

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’ (2022), provides a list of clinical scenarios and situations where a consultant should be informed and when they should attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for learning with agreed action plans implemented, at this Trust this will be the cross-site weekly consultant meeting.

The service has not previously reported on this standard however this is now a requirement of the Maternity Incentive Scheme Year 5, safety action four. The reporting period for this standard is 30 May 2023 – 7 December 2023.

Data for the requirements to attend team debrief and review of MEOWS/sepsis six screening tool is missing due to this not currently being captured, this is being explored through the Badgernet Project Board.

The table below demonstrates that there was consultant presence in all required cases:

Situations in which a consultant MUST ATTEND	Reported number of clinical incidents (May 2023)	Attendance Y/N
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	0	0
Any return to theatre for obstetric emergency	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	0	0
Caesarean birth for women with a BMI>50	0	0
Caesarean birth <28 /40	0	0
Premature twins <30/40	0	0
Fourth degree perineal tear repair	1	Y x 1
Unexpected intrapartum stillbirth	1	Y x 1
Eclampsia	0	0
Maternal Collapse e.g., septic shock, massive abruption	0	0
PPH >2l where the haemorrhage is continuing, and Massive obstetric haemorrhage protocol has been instigated	9	Y x 9

2.6 Risk Register

One new risk added to the Obstetric Risk Register in May and one in June

Risk 1966: There is a risk that the service will not meet the required compliance standard for CTG training due to lack of capacity in the service to deliver the training and support to staff. This could result in patients receiving unsafe care due to staff not having the requires skills and knowledge.

Current Mitigation: The planned training sessions for July 2023 will be provided by the obstetric fetal monitoring lead and the clinical skills midwives. The LMNS have been contacted for support and a neighbouring Trust have offered additional resource for August.

Risk 1937: There is a risk of inadequate fetal monitoring during labour and birth. This could result in increased CTG interpretation anomalies and / or increased operative births. Increased risk of missed identification of fetus at risk of hypoxic event.

Current Mitigation: Stock currently controlled by labour ward coordinators. Fetal Scalp Electrodes (FSE) only to be applied by experienced Registered Midwife. Mutual aid requested from region, LMNS, alternate FSE leads, and FSE connectors ordered.

3. Quality and Safety Metrics

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 Digital Midwife is now in post and will be prioritising the maternity dashboard and reviewing in line with the clinical network to align with the regional requirements. This will be presented in the August Report. Badgernet provides a dashboard with real time reporting and the service is looking to review how this links to the maternity dashboard and how themes and trends can be monitored.

An overview of key quality metrics is highlighted in the following table.

Metric	Target	October 2022	Q4 22/23	May 2023	Improvement Actions	Data Quality
PPH>=1500ml	**Target:** National average of 3.5% **Target date:**	4.5%	3% ↑	4.8% ↓	Production Boards PPH scrutiny panel Rapid adopting of best practice from other centres	The digital midwife quality assures PPH data
Fetal Monitoring Training – Medical	**Target:** Compliance of 85% is expected in June 2023 **Target date:**	42%	not available	66% ↑	Individuals who are non-compliant identified and training arranged Extra training sessions to be arranged to maintain compliance (mutual support from Harrogate)	The Trust Learning Hub was unavailable between Jan – March 2023, this highlighted the requirement for data to be held at a ward level for oversight to ensure all staff complete mandatory training in time
Fetal Monitoring Training - Midwifery	**Target:** Compliance of 85% is expected in June 2023 **Target date:**	67%	not available	73% ↑		
PROMPT - Medical	**Target:** Achieved compliance of 85% **Target date:**	66%	not available	88% ↑	Continued monitoring and oversight through Governance process	
PROMPT - Midwifery	**Target:** Achieved Compliance of 85% **Target date:**	88%	not available	87% ↔	Continued monitoring and oversight through Governance process	
Moderate Harm Incidents	**Target:** Improvement in the accuracy in grading of harm so we can learn lessons	1	1 ↔	5 ↑	Support from the MIA to accurately review and grade incidents Ongoing review of incidents and assurance from MIA that these are robust	Increased reporting figures is a positive and reflective of an open culture. Incidents are reported on Datix
MEOWS Compliance	**Target:** Compliance of 90% is required by the Trust **Target date:**	71%	81% ↑	92% ↑	Working with the BI team to create a reporting mechanism to allow accurate reporting, similar issue in other Trusts	Currently through small dip audit undertaken daily by ward managers, 2 sets of notes a day

Key:
- ↓ At risk
- ↑ Improved position, at risk
- ↑ Improved position
- ↔ Position maintained

The MDT Labour Ward Forum is to be re-established with a meeting planned for the 16th of August where there will be opportunities to discuss the key quality metrics identified, actions and shared learning.

3.3 Caesarean Section List

All women where there is a delay in procedure or change in site have a clinical assessment undertaken by a consultant to ensure that women are prioritised safely.

Consultants oversee the elective caesarean section lists during their acute clinical commitments. To ensure the safety of women and babies and following clinical assessment procedures they may be progressed as a Category 3 to ensure safe care. The senior obstetric multi-disciplinary team are currently working on a refreshed approach to scheduling section lists before undertaking the demand and capacity analysis which will confirm the capacity required at York. An associated SOP which is in development and escalation process during times of higher demand to support manage the increase both the complexity of birthing individuals using the service and being identified through scanning to national guidance. The requirement for a business case for any additional list will then be confirmed.

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

3.4 Saving babies lives Care Bundle (SBLCB) V2 / V3

The timeline indicates progress to date and plans to progress benchmarking against SBLCB V3 and an overview of current position against SBLCB V2, this is the position that was reported to the Quality Improvement Group on the 5th of July.

To date:

- February 2023**:** Declared non-compliance with Maternity Incentive Scheme (MIS) Y4, including non-compliance Safety Action (SA) 6 SBLV2.
- March 2023: Recruited a dedicated Transformational Lead Midwife to lead on SBL.
- April/May 2023: Undertook audit of Q4 SBLV2 (see appendix – this indicates compliance with 1/5 elements).
- June 2023**:** Gap analysis started for SBL V3.

Key areas of focused improvement:

- Scanning capacity expansion phased approach.
- Our work to address immediate actions identified by CQC Section 31 Notice have driven improvement against the fetal monitoring element of SBL V2
- Established an MDT Preterm Birth forum.
- CO monitoring including equipment and collaborating with the Trust Tobacco Dependency Lead.

Next steps:

- July 2023**:** An audit of Q1 2023/24 to be undertaken for SBL V2.
- August 2023**:** Development of detailed improvement plans for supporting. delivery of SBL V3 to achieve compliance by March 2024.
- September 2023**:** Full presentation of SBL V3 including risk assessment to Maternity Assurance Group and Quality and Safety Assurance Committee.

	RAG	Action being taken to reach compliance
Element 1: Reducing Smoking in Pregnancy		▪ The Transformation Lead Midwife and Tobacco Dependency Lead are working together to implement the NHS long term plan to reduce smoking at time of delivery rates to 6% or less as per the national ambition. ▪ The audit highlighted CO testing compliance of 82.4% at booking and 13.4% at 36 weeks. The 36 week data is thought to be partially attributed to a data capture issue due to the move to BadgerNet and is being closely monitored via the community midwife with the use of weekly Production Boards, reporting data and staff communication.
Element 2: Risk assessment and surveillance for fetal growth restriction (FGR)		▪ The service has all appropriate policies to include definition, risk assessments and surveillance pathway with demonstration of compliance. ▪ Scanning capacity is currently being expanded as scan referrals are frequently breaching >72 hours between the referral and the scan to support compliance in this element.
Element 3: Raising awareness for reduced fetal movements (RFM)		▪ Element 3 is well embedded. The quarter 4 audit 22/23 demonstrated 100% of women had a RFM leaflet by 28 weeks and the use of computerised CTGs for RFM is established. ▪ From the week commencing 3rd July the fetal monitoring checklist will be available via BadgerNet every appointment from 24 – 42 weeks
Element 4: Effective fetal monitoring during labour		▪ CTG training figures have steadily improved however still remain below the required 85%, the department has enacted a robust plan to address this. ▪ The department has an Intrapartum Fetal Monitoring Risk Assessment with a plan for a paper assessment on the day of training to support timely compliance. ▪ The Director of Midwifery is arranging additional support with training to support un planned absence in the training team.
Element 5: Reducing pre-term birth		▪ A new MDT Pre-term birth forum has been established on a monthly basis to review the PTB cases against the perinatal optimisation indicators and embed across site ▪ Off Pathway births will also be reviewed at this forum and submitted to the LMNS quarterly. ▪ Administration of magnesium sulphate is well embedded following the Prevention of Cerebral Palsy in PreTerm Labour (PReCePT) project. This is required for the other indicators including corticosteroids and early maternal breast milk to ensure these aspects are embedded.

3.5 NHS Resolution Maternity Incentive Scheme – Year 5

The Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element. On the 31st of May 2023, the MIS Year 5 Guidance was released, submission due the 1st of February 2024. THE Current position as outlined below was reported to the Quality Improvement Group on the 5th of July.

Current delivery position:

We have spent 8 weeks refreshing our approach to compliance, undertaking a detailed gap analysis, and ensuring we have detailed action plans owned and resourced by Responsible Officers. The action plans have been updated and considered against the Year 5 guidance. We have NHS Resolution funding confirmed and will consider high impact actions to accelerate compliance with the funding available.

Current compliance position:

- We are not compliant with any of the 10 MIS Safety Actions but SAs 1, 3, 8 and 10 are now well progressed with high levels of assurance that we will be able to demonstrate evidence of compliance in line with required periods for assessing.
- SA 4&5 will progress during July underpinned by Workforce Review with MIA and rerun of BR+
- SA6 will be the focus of a detailed assessment of SBLV2 position with actions required to meet stretched targets for SBLV3 during July

Current risks:
The main risk to delivery and compliance across the MIS year 5 and Ockenden at this time is the capacity across the multi-disciplinary teams to prioritise and co-ordinate non-clinical time together regularly to progress key workstreams and in turn report effectively to Trust Board bi-monthly. There are also some Responsible Officers and lead officers on long-term absence which is affecting capacity to lead workstreams. The Senior Leadership Team, Maternity Improvement Advisors and Programme Management Office are working to mitigate this through ensuring existing supernumerary time is protected and reviewing all Consultant SPA time and clinical lead SPA to align to the priorities. Mutual aid from other maternity units is being explored. The teams have also started receiving 'writing for maternity assurance' training to support them in writing reports for assurance and oversight.

The risk of reduced data quality and dataset incompleteness during the implementation of Badgernet is known and this is overseen by the Badgernet Project Board with the digital midwives, BI analyst and project lead updating on mitigations for this and improvements in response to retrospective data input on the risk reducing.

4. Mandatory Training

Background

As required by the NHS Litigation Authority (NHSLA), now NHS Resolution (NHSR), standards (2021) and following recommendations from the MBRRACE-UK report (2020) and the Ockenden Report (2020 & 2022) multidisciplinary study days should be embedded into practice to enhance safety. These training days consist of a hybrid model of both virtual teaching sessions and face to face sessions. As required by the NHSR standards, maternity staff and allied health professionals jointly undertake multidisciplinary training throughout the training programme to include operating department practitioners (ODPs), anaesthetists and theatre staff.

	Obstetric Medical staff	Anaesthetic medical staff	Midwives	Maternity Support workers	Theatre staff
PROMPT	86%	55%	92%	80%	71%
Fetal Monitoring	84%	N/A	90%	N/A	N/A
Adult resuscitation	72%	N/A	88%	70%	N/A
Neonatal resuscitation	N/A	N/A	92%	N/A	N/A
Safeguarding children level 2/3	78%	N/A	66%	83%	N/A
IPC	80%	N/A	79%	92%	N/A
ANTT - Theory	86%	N/A	80%	76%	N/A
ANTT - Practical	45%	N/A	54%	48%	N/A
SBL	50%	N/A	53%	N/A	N/A

The SBLCBv2 training is a suite of five eLearning packages and compliance is currently below the required 85% across all staff groups. As part of the Maternity Improvement Workstreams, it is proposed that staff will be given an additional 7.5 hours to complete the eLearning package as a bank shift to minimise the impact on the service.

On the 12 July 2023, there is a planned meeting aimed at mapping the current mandatory maternity training requirements and reviewing the time staff need to complete to support a comprehensive plan to achieve compliance across core and maternity specific training requirements.

4.1 Fetal Monitoring

The Director of Midwifery has contacted the LMNS regarding the situation with training at the Trust in the absence of the Fetal Monitoring Lead and Harrogate have offered support in joining their fetal monitoring training days in July and August. The Medical Fetal Monitoring Lead at this Trust is able to facilitate the two planned training days in July, in York on the 19th of July and Scarborough on the 13th of July with the support of the Practice Development and Clinical Skills Midwives and there are plans in sending staff to join Harrogate for their training in August.

Harrogate have not yet implemented the updated nice guidance as wished to understand how this would link into the implementation of BadgerNet. The Director of Midwifery will discuss with the Associate Director of Midwifery at Harrogate to understand if there are any difference to training that could pose a risk when practising to the York and Scarborough Fetal Monitoring Guideline.

The Trust Fetal Monitoring Guideline has been updated to reflect national guidance and shared for comments and will be ratified at a virtual Extraordinary Specialty Governance by the end of July. The new national guidance has been incorporated in the training

sessions since January 2023, and has been promoted by posters in ward areas, social media posts and fetal monitoring boards in the handover areas,

A rolling year action tracker is in development where both elements of the fetal monitoring training to include face to face training and the competency assessment will be included with a sign off for the competency assessment completed on the same day of training. This will provide assurance of monthly training figures and will be monitored at the Labour Ward Forum,

Following reviews of fetal monitoring training figures there has been a focused approach through May and June and during the week of the 26th of June support was provided to clinicians and midwives who had undertaken face to face training but were not compliant with their fetal monitoring assessment to complete. There were daily updates provided to the Clinical Director and Director of Midwifery and staff were informed that if at the end of the five-day period of monitoring they were still not compliant they would be unable to practise until compliance received.

Current Fetal Monitoring compliance figures by site at the end of June are outlined below.

	York	Scarborough
Midwives	92%	86%
Consultants	71%	100%
Obstetric medical staff	82%	91%

Staff that are due for fetal monitoring updates have been booked onto one of the training days in July and the projections for training compliance on the 31st of July are outlined below.

	York	Scarborough
Midwives	96%	97%
Consultants	100%	100%
Obstetric medical staff	100%	100%

A guideline is in development to sit alongside the training needs analysis that will outline responsibilities for training for both management and employee with a clear pathway if a member of staff is not able to attend training to ensure clear oversight of compliance across the Department.

4.2 Safeguarding

The training figures received monthly from the Named Midwife for Safeguarding are now colour coded to provide enhanced oversight in respect of overdue training and shared with the Deputy Head of Midwifery to discuss with the Matrons. Safeguarding Level 3 training requirements have increased and includes three modules on the Learning Hub equivalent of 6 hours of training and a 3-hour face to face session. To achieve Safeguarding Level 3, it is a requirement to undertake a total of 9 hours every 3 years, those that are Specialist (All Midwives) must complete 12 hours every 3 years. The additional hours are achieved via attendance at mandatory training, supervision, attending Child Death Overview Panel, writing statements for care proceedings or reading serious case reviews and additional

learning is available on the Trust Learning Hub and the Safeguarding Partnership websites. All staff need to self-declare on the learning hub when this has been achieved and this has not been widely understood, in addition to the recently added enhanced requirements has caused challenges in compliance.

It is recognised that the compliance figures for midwifery staff is low, an exercise will be undertaken in July to ensure that all staff have completed the required elements of the training and have self-declared compliance. A trajectory will be developed to evidence improved compliance. The next face to face training session is planned for 3 August 2023, the Matrons will ensure all planned to attend the session are rostered to do so. All staff continue to be supported with a 7.5-hour bank shift to undertake safeguarding training.

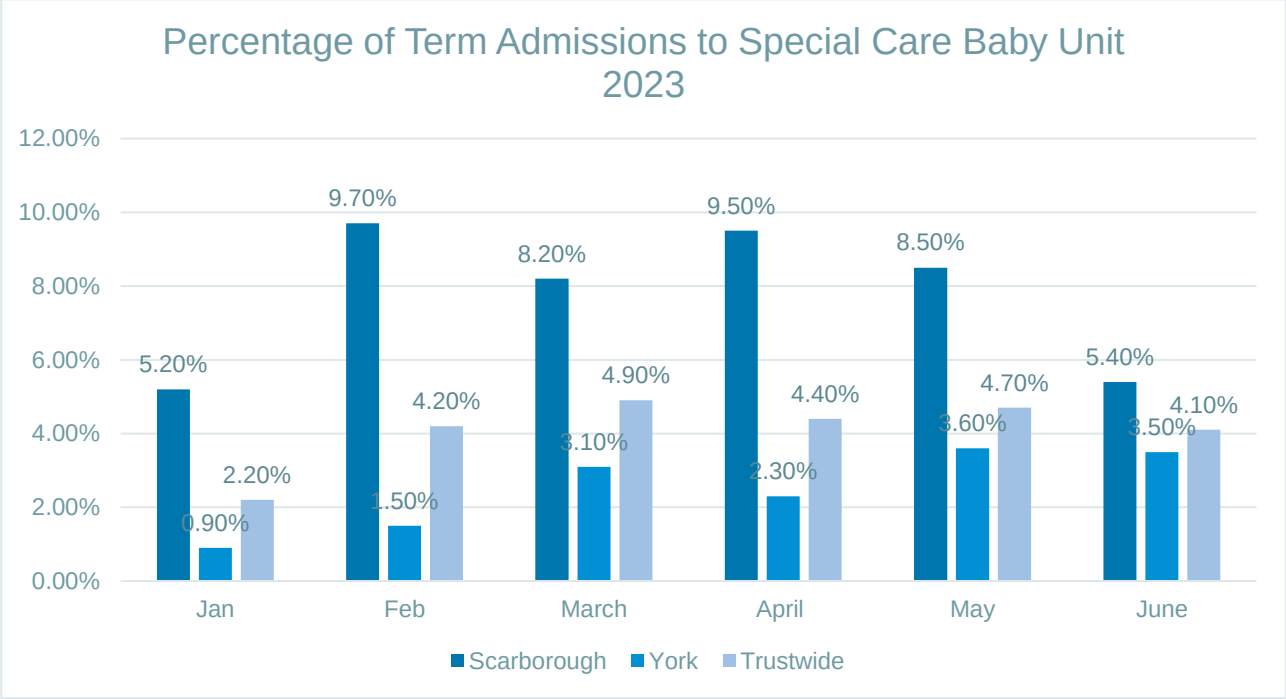
5. Staffing

A full workforce review is in progress led by the Maternity Improvement Advisor and supported by Birthrate Plus, the data from the 2021 Report has been refreshed to support this paper.

A Maternity Biannual workforce paper is a requirement of the MIS safety Action 4 and 5 to be presented at Trust Board. The current paper will reflect January to June 2023 data and will be presented to the Board in July.

6. Unexpected term 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. 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.



Date source: Signal/BadgerNet

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.

In Scarborough there is no neonatal lead, however interest has been shown in a cross site Neonatal Lead consultant post and ATAIN will be a key objective for the postholder. There has been a barrier to ATAIN reviews occurring as an MDT and the Interim Associate Chief Nurse and Deputy Head of Midwifery have worked together to improve this situation culminating in a cross site ATAIN meeting on the 5th of July.

The details of this review which highlighted five key themes regarding avoiding term admissions into neonates to include, observation, hypothermia, feeding support, hyperglycaemia and cord gases and associated action plans are included in Appendix D.

All admissions to transitional care are audited and reviewed to ensure compliance against the agreed transitional care pathway. Any learning identified from this process is categorised into themes and shared with the wider team through our 'Safety Briefing.' To improve the robustness of our review process, we are developing a multidisciplinary approach to monitor findings and ensure shared learning through the nursing and medical teams.

There are no formal Transitional Care facilities at the Scarborough site. This is currently being reviewed in terms of location and staff in terms of being able to support.

There was a total of three babies admitted to transitional care in York in Q1. Seventeen babies went to transitional care following a SCBU admission.

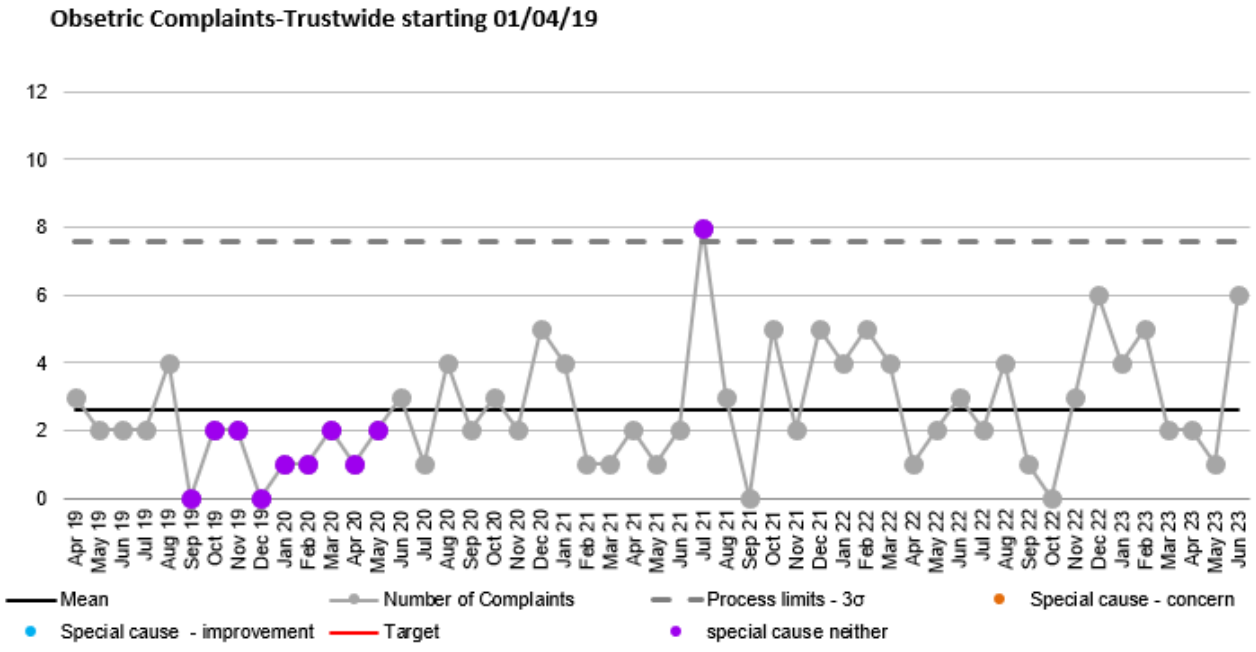
There was a total of two babies on a transitional care pathway in Scarborough in Q1. A full refresh of the auditable standards in relation to transitional care are currently being reviewed which will include reason for admission into transitional care, length of stay and will provide some rich data which will be shared in the next report. This will also demonstrate the required need to enhance the services on the Scarborough site.

Five babies were not admitted to the neonatal unit, keeping mum and baby together. The Transitional Care Q1 2023 Report and associated action plan can be found in Appendix E.

7. Service User Feedback

7.1 Compliments and Complaints

Maternity Services are an outlier in terms of performance for managing complaints and the Director of Midwifery is working to address this with improved oversight of the process and support to the Band 7's and Matrons reviewing and answering the complaints. We are actively encouraging trying to address concerns on receipt and making contact when the complaint is received. We have examples where this contact can ensure resolution or facilitate an arrangement for a maternity debrief which de-escalates the situation. This service is not funded, a coordinator at York is released when able to undertake the debriefs and is very experienced in this role, we currently do not have a comparable arrangement in Scarborough. There does need to be consideration for formal feedback and after thoughts service which is appropriately resourced.



There has been an increase in the number of complaints in June 2023 however the rate in comparison to the number of births is low. However, it is acknowledged that every complaint is extremely important to the individual (s) raising their concern and a valuable learning experience for the team and appreciate there is much more work to do here in how we share and learn from these experiences.

7.2 Family and Friends

The response to Family and Friends Test at the York site remains low and the Matrons and Ward Managers are working with the teams to understand how this could be improved, with a good response rate in Scarborough. In Scarborough, this feedback is used to make improvements in the clinical areas and using positive feedback to feed back to staff in the form of word clouds and an example is included below.

The Friends and Family Reports are included in Appendix E

7.3 Maternity Voices Partnership

As a service we are closely working with the York and Scarborough Maternity and Neonatal Voices Partnership (MNVP) Meeting. A key aim is to build a diverse MNVP which is representative of service users. Ongoing communication with key stakeholders to promote MNVP engagement, feedback and co-production. We have refreshed the MNVP leaflet and also recently held a ’15 moments’ event based in York on the ’15 steps’ principles. The service has received verbal feedback which was positive and are awaiting the written report from the MNVP Chair, this is a crucial step towards increasing co-production with the MNVP and on receipt of the report an action plan will be developed. There will also be a plan to repeat the ‘15 moments’ at Scarborough site and in the community settings.

A mechanism of feedback between the MNVP and Transformation Lead Midwife has been established to ensure there is a clear process for reviewing themes of feedback. This will be discussed with the MNVP and transformation lead each month with plans to include in the safety champions meeting.

The Director of Midwifery attended the meeting in July and shared updates from the service and the briefing that was shared to staff and external partners on release of the CQC Report with an opportunity to answer questions and share progress.

7.4 Safety Champions

The MAT Neo Maternity Safety Champions Meetings were refreshed earlier in the year with new terms of reference and agenda and last met formally in April. The planned focus of the meetings going forward was discussed to be implementation of the learning from the Walkabouts at the request of the Non-Executive Director (NED).

Feedback from the walkaround with the Chief Nurse and NED on the 27th of April In York raised the themes highlighted below and continue to be discussed as a senior team, mask raising was raised as an issue but are no longer required in line with Trust Policy. Communication remains an issue and this is variable. A concern was made by a Labour Ward Coordinator in that 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 previous walkabouts 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, there is always a member of the senior team on each site and it needs to continue to be explored and different feedback measures how this can be improved / met staff expectations.

The Chief Nurse undertook a safety walkabout on the 6th of June in Scarborough and concerns were raised regarding support for the midwife sonographers and communication with the lead sonographer in the main department, the midwife sonographers are feeling unsupported. The Director of Midwifery has met with the lead sonographer and midwife sonographers, there was a good discussion and a plan for enhanced communication which hopefully will improve the situation going forwards in regard to professional development, ongoing support and future plans.

Issues were also raised about a lack of a support package for newly appointed Labour Ward Coordinators, the Matrons do have plans for supervisory time and we have discussed a more structured induction and there are plans to support with an external coordinators programme, unfortunately the RCM bespoke programme has no places for the remainder of the year , once funding is determined further exploration of this course will be progressed.

With a new Chief Nurse in post as a Board Level Safety Champion they will be able to provide their viewpoint on the way forward alongside the NED as current Board Level Safety Champion and a new Director of Midwifery will be joining the service in August.

A full review will be undertaken on how we feedback to staff who raise concerns to ensure that their voices are heard. There is a plan to have posters outlining who our safety champions are and how staff or service users can contact them. Further detail will be provided in the next report.

8. Recommendations

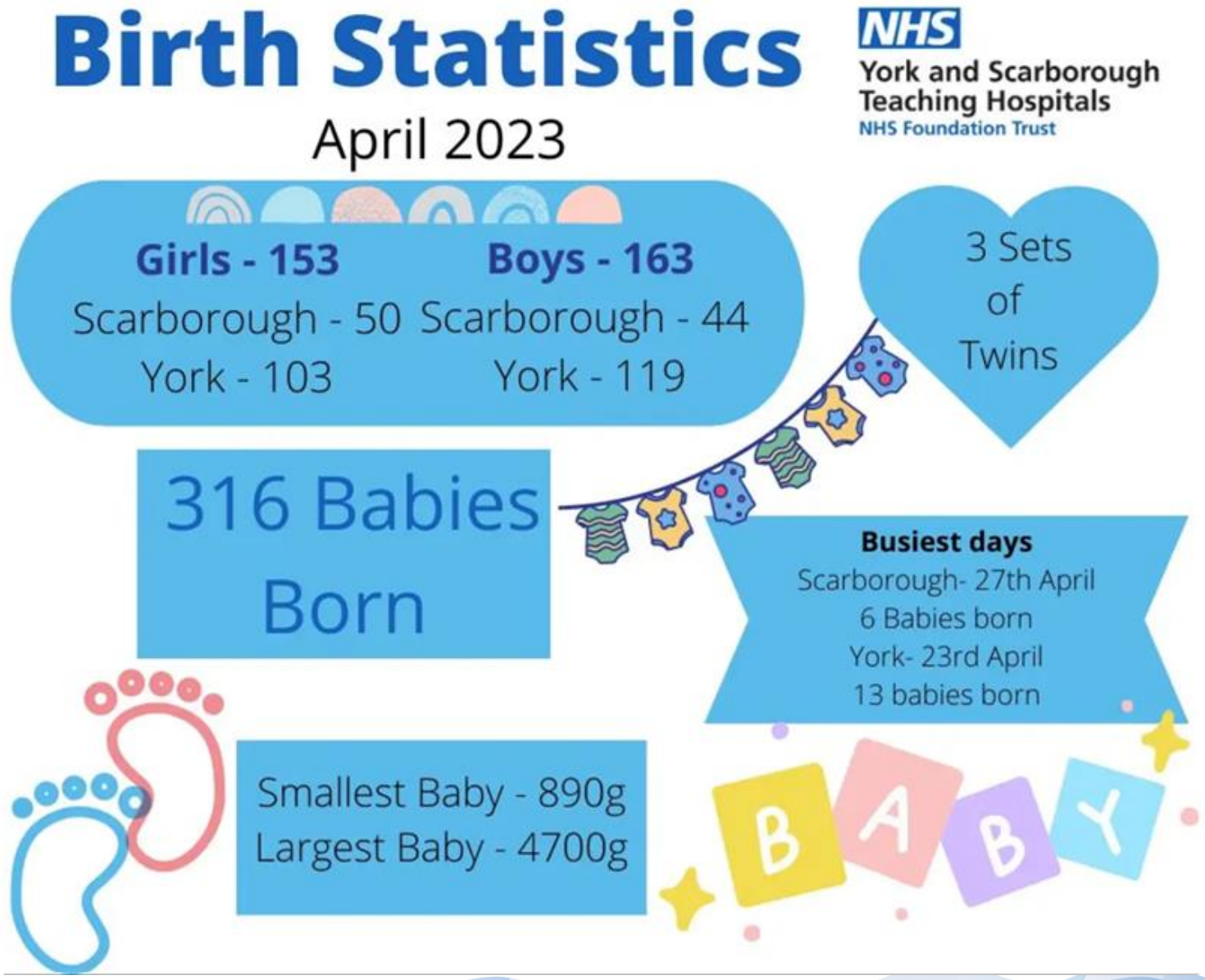
The Board of Directors are to.

- Receive and discuss the report.
- Recognise the significance of this report for the Maternity Service and that further detailed work is required to ensure full compliance.
- Note the associated risks involved.

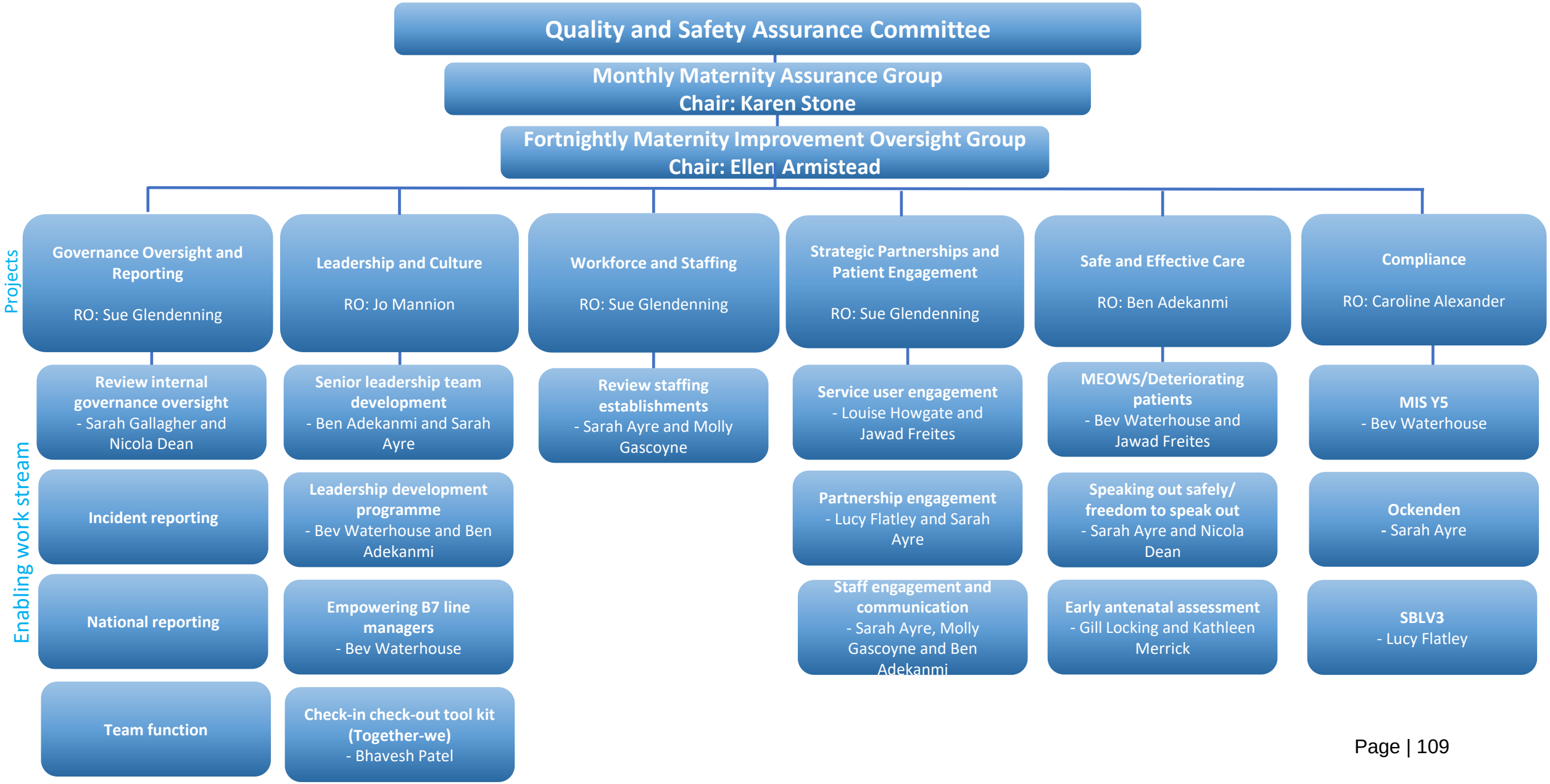
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Maternity Improvement Programme – Update to QIG

5th July 2023


Birth Statistics
April 2023
NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust
Girls - 153
Boys - 163
Scarborough - 50
Scarborough - 44
York - 103
York - 119
3 Sets of Twins
316 Babies Born
Busiest days
Scarborough- 27th April
6 Babies born
York- 23rd April
13 babies born
Smallest Baby - 890g
Largest Baby - 4700g
BABY

Maternity Improvement Programme – Year 1



Proposed maternity reporting into QIG

York and Scarborough Teaching Hospitals NHS Foundation Trust

August/September meeting: All Plans on Pages to be received into QIG, including milestones, KPIs and outcome measures.

- High level summary on workstreams to be presented to QIG monthly, and on a rolling programme provide a deep dive on agreed improvement workstream.
- Summary Safety Dashboard to be developed and presented monthly.
- Monthly summary update on CQC Must and Should actions.
- Summary on assurance against exit criteria to move to segment 2 of NHS Oversight Framework, frequency to be determined.

Plan on a page: EXAMPLE

Delivery Date	

Project Summary:

Suggested KPIs	Aim	Current		Comments

Deliverables/ how we will know we have achieved this :

Dependencies/ Interdependencies:

Supports regulation:

]

Project Leadership:

SRO		Project Leads	

Key Milestones:

Milestone	Date

Risk/Issue (Please indicate)	Mitigation

Governance:

- .

Plan on a page: Compliance

Delivery Date	February 2024

Project Summary:

Objective: The aim of the project is to achieve compliance with the Clinical Negligence Scheme (CNST) Maternity Incentive Scheme (MIS) Y5, Saving Babies Lives V3, Ockenden and CQC Must Dos. Achieving compliance will allow us to deliver safter, personalised care, while achieving equity and reducing health inequalities. This will be achieved using evidenced-based best practice.

Suggested KPIs	Aim	Current	Comments
Maternity Incentive Scheme	Compliance 10/10	0/10	
SBL	Compliance 6/6	0/5	
Ockenden	Compliance 15/15	0/15	
CQC Must Dos	Completion of all Must Dos to meet exit criteria	To be assessed by 23rd July	

Deliverables/ how we will know we have achieved this :

1. Compliance with all 10 MIS Safety Actions
2. Compliance with all 6 Elements of SBL V3
3. Compliance with all 15 Essential Actions from Ockenden
4. An output of achieving MIS and SBL compliance is the opportunity to recover an element of our CNST contribution as well as a share of any unallocated funds.

Dependencies/ Interdependencies:

- *Workforce Plan*
- *NHS Resolution funding (expected June 23)*

Supports regulation:

[CQC: must do, well-led, safer, effective] [HSIB/Other] [MIS]

Project Leadership:

SRO	Caroline Alexander	Project Leads	Bev Waterhouse and Sarah Ayre

Key Milestones:

Milestone	Date
Identify leads and representatives of each Safety and Essential Action	Mid July 23
MIS Safety Action 2 submission date. 2 MSDS data input individuals identified?	August 23
Develop and ratify the Maternity Workforce Strategy	August 23
LMNS assurance visits to YSTHTF linked to the Ockenden/East Kent and 3-year plan requirements	Autumn 23
Submit report to Trust Board for sign off	December 23
Submit completed Board declaration form to NHS Resolution nhsr.mis@nhs.net	12 noon on 1st February 2024

Risk/Issue (Please indicate)	Mitigation
Issue: Capacity to support the project	Managers and senior leaders to communicate the necessity to prioritise and work with project teams to support compliance.
Issue: Unsafe service for users	Action plans in place to support the achieving compliance
Risk: Non-compliance will result in negative public perception and backlash	Prepare robust comms Proactive public engagement

Governance:

- *Bi-weekly reporting to Maternity Improvement Oversight Group & monthly to Maternity Assurance Group*
- *Fortnightly MIS Action Group*
- *Fortnightly Ockenden Audit Group (suggested this is stood down due to attendance)*
- *Fortnightly Ockenden Action Plan meetings*
- *Ambition to have one meeting Chaired by Amanda which receives all updates for MIS, SBL and Ockenden.*

Improvement workstream 1: **Governance oversight and reporting.**

We will : provide assurance that we learn from incidents/events and have the processes embedded to support best practice.

Key achievements/ Progress:

Review of all governance structures and processes underway and being led by MIA

Review underway of all open actions following SIs

Internal review of high transfer rate into SCBU in Scarborough has been undertaken

Next steps:

Thematic review of all incidents

Process for appointing a medical clinical governance lead to be concluded

Monthly ATAIN review process to be further rolled out and embedded

Key risks:

Length of time to close down backlog of SI open actions

Capacity of maternity governance team

Obstetric staff capacity to be involved in SI work

Improvement workstream 2: **Leadership and Culture**

We will : create a culture where staff feel they are listened to, valued and empowered to speak up. Develop a strong and inclusive leadership approach.

Key achievements/ Progress:

100 staff have attended the MDT cultural training

National Health and Well Being Team visit (June 23)

Clinical leadership model defined and agreed

Next steps:

Finalise DoM interim appointment

Self assessment following East Kent report findings

Await report from NHSE well-being visit, action plan following receipt

Key risks:

Fragility of current leadership arrangements

Impact of CQC report publication on staff morale

Staff capacity to engage in Trust wide leadership and culture programme

Improvement workstream 3: **Workforce and Staffing**

We will: ensure staffing levels and skill mix meet the needs of our birthing individuals and demographics to provide a safe and outstanding experience.

Key achievements/ Progress:

Recruited full cohort of student midwives

Theatre Scrub Nurse coordinator appointed to oversee recruitment, retention and deployment of workforce

Workforce Plan in development which includes review of obstetric workforce has commenced

Next steps:

Continue with the recruitment to scrub nurse posts

Complete the review of rostering practices

Improve roster sign off processes

Key risks:

Gaps in the current scrub nurse rota

Embedding at pace the oversight processes for roster sign off

There are some gaps in consultant rota on the Scarborough site

Improvement workstream 4: Partnerships and Patient engagement

We will: listen to our service users and partners engaging with them in our continuous improvement journey

Key achievements/ Progress:
15 Steps in York in partnership with Maternity Neonatal Voices Partnership (MNVP)
Established regular communication and feedback between MNVP and Maternity Services
Secured additional MNVP funding
Next steps:
Develop an approach to engaging service users and the public in our improvement journey progress
Recruit to Scarborough Engagement Lead
Develop a strategy for improving the experience of the LGBTQ+ community
Key risks:
Staff capacity to support required improvement work
Lack of communication and engagement with staff and patients
Fragility within the leadership structure to drive improvement works

Improvement workstream 5: **Safe and Effective Care**

We will: ensure women and families receive safe and effective care, that they feel safe in our hands and have a positive and fulfilling experience et every stage of their journey

Key achievements/ Progress:

BSOTS now in place

Production Boards are now widely in use

IPC review action plan is being progressed

Next steps:

Complete the process for identifying QI programmes

Security system update by the end of July

Continued refresh of all SOPs and policies

Key risks:

Colleague capacity to support policy and SOP updates

Impact of CQC report of staff morale and turnover

BadgerNet transition

Quality and Safety Metrics

Metric	Target	October 2022	Q4 22/23	May 2023	Improvement Actions	Data Quality
PPH>=1500ml	**Target**: National average of 3.5% **Target date**:	4.5%		4.8%	Production Boards PPH scrutiny panel Rapid adopting of best practice from other centres	The digital midwife quality assures PPH data
Fetal Monitoring Training – Medical	**Target**: Compliance of 85% is expected in June 2023 **Target date**:	42%		66%	Individuals who are non-compliant identified and training arranged Extra training sessions to be arranged to maintain compliance (mutual support from Harrogate)	The Trust Learning Hub was unavailable between Jan – March 2023, this highlighted the requirement for data to be held at a ward level for oversight to ensure all staff complete mandatory training in time
Fetal Monitoring Training - Midwifery	**Target**: Compliance of 85% is expected in June 2023 **Target date**:	67%		73%		
PROMPT - Medical	**Target**: Achieved compliance of 85% **Target date**:	66%		88%	Continued monitoring and oversight through Governance process	
PROMPT - Midwifery	**Target**: Achieved Compliance of 85% **Target date**:	88%		87%	Continued monitoring and oversight through Governance process	
Moderate Harm Incidents	**Target**: Improvement in the accuracy in grading of harm so we can learn lessons	1		5	Support from the MIA to accurately review and grade incidents Ongoing review of incidents and assurance from MIA that these are robust	Increased reporting figures is a positive and reflective of an open culture. Incidents are reported on Datix
MEOWS Compliance	**Target**: Compliance of 90% is required by the Trust **Target date**:	71%		92%	Working with the BI team to create a reporting mechanism to allow accurate reporting, similar issue in other Trusts	Currently through small dip audit undertaken daily by ward managers, 2 sets of notes a day

Key:

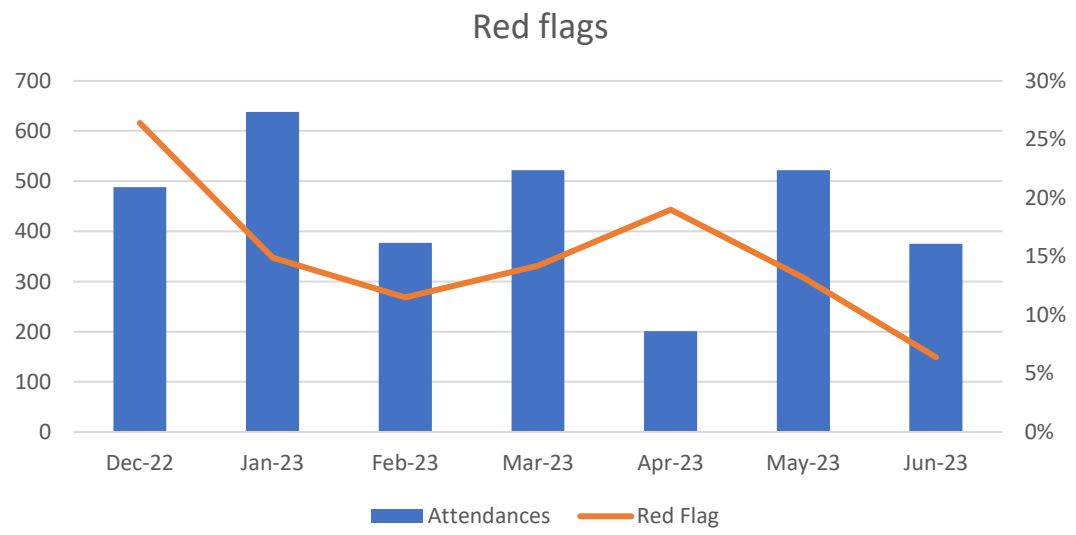
- **At risk**
- **Improved position, at risk**
- **Improved position**
- **Position maintained**

Triage and Assessment - BSOTS

York and Scarborough Teaching Hospitals
NHS Foundation Trust

The service has introduced the Birmingham Symptom Specific Obstetric Triage System (BSOTS) at York in December and will start in Scarborough from the 3rd July.

BSOTS is a triage system specifically designed for use in maternity services which factors in the physiological changes associated with pregnancy. Its use is supported by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.



Since it's introduction in December the number of instances where women have waited over 15 minutes between presentation and initial assessment (NICE Red Flags) has dropped significantly.

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

HSIB Investigation Reports

York and Scarborough Teaching Hospitals NHS Foundation Trust

The Service has received eight completed HSIB investigation reports to date in 2023 with a further two investigation reports undertaken, 3 themes were identified:

Identified Theme	Action Taken
Guidance	• Induction of labour guideline updated in April 2023 been updated to include prioritisation of high-risk pregnancies and where there is high acuity on the unit, a RAG process is in draft and will be added as an appendix to this guidance in July 2023. • A check sheet has been developed to support in the event of a neonatal resuscitation to ensure all staff have the correct contact details of the paediatric team as well as initial prompts.
Risk Assessment	• All women who were registered as having epilepsy were reviewed to ensure that they are on the correct care pathway and a detailed guideline is in place which reflects RCOG guidance. • The telephone triage and initial assessment has improved following the introduction of BadgerNet and BSOTS
Clinical Oversight	• Any delayed caesarean section or induction of labour is reviewed and agreed by the on-call Consultant. • A change in practice at the York site where the sonographers will bring the scanning machine to the ward or bereavement suite to confirm intrauterine death to prevent women having to be scanned in the antenatal clinic.

Improvement workstream 6: **Compliance and Regulation**

We will: ensure compliance with Clinical Negligence Scheme (CNST) Maternity Incentive Scheme (MIS) Y5, Saving Babies Lives V3, Ockenden and CQC Must Dos.

Key achievements/ Progress:

NHSR funding has been agreed to support targeted improvement

Developed systems and processes for increased MIS compliance oversight

Strengthened working relationship with the LMNS

Next steps:

Safety Actions 1 will be RAG rated green

Urgent development of a performance dashboard, supported by the MIA team

Re-assessment in preparation for the next planned NHSE Ockenden Review

Key risks:

Data gaps following transition to BadgerNet

Capacity of clinical and governance teams

Current performance dashboard is not fit for purpose

Maternity Incentive Scheme Current Position

York and Scarborough Teaching Hospitals
NHS Foundation Trust

The Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. On the 31st of May 2023, the MIS Year 5 Guidance was released.

Current delivery position:

We have spent 8 weeks refreshing our approach to compliance and ensuring we have detailed action plans owned and resourced by ROs. The action plans have ben updated and considered against the Yr5 guidance.
We have NHSR funding confirmed and considered high impact actions to accelerate compliance.

Current compliance position:

- We are not compliant with any of the 10 MIS Safety Actions but SAs 1, 3, 8 and 10 are now well progressed with high levels of assurance that we will be able to demonstrate evidence of compliance in line with required periods for assessing
- SA 4&5 will progress during July underpinned by Workforce Review with MIA and rerun of BR+
- SA6 will be the focus of a detailed assessment of SBLV2 position with actions required to meet stretched targets for SBLV3 during July

Current risks:

The main risk to delivery and compliance is our capacity in our teams to identify and prioritise non-clinical time together regularly.

- Competing staff priorities (operational and improvement)
- Insufficient dedicated supernumerary staff to support
- Insufficient PA's allocated to clinical staff
- Data quality/ gaps from Badgernet transition

Safety Action	RAG	Trajectory for compliance
Safety Action 1	On track, but not complete	February 2024
Safety Action 2	On track, but not complete	September 2023
Safety Action 3	On track, but not complete	February 2024
Safety Action 4	On track, but not complete	October 2023
Safety Action 5	On track, but not complete	February 2024
Safety Action 6	On track, but not complete	March 2024
Safety Action 7	On track, but not complete	February 2024
Safety Action 8	On track, but not complete	September 2023
Safety Action 9	On track, but not complete	July 2023
Safety Action 10	On track, but not complete	February 2024

Additional support to drive compliance:
- 1x B5 12M Fixed Term Clinical Governance Coordinator – in post
- other supporting investments utilising NHSR funding are being considered by the maternity finance oversight group in WC 10/7/23

Saving Babies Lives V2 & V3

York and Scarborough Teaching Hospitals NHS Foundation Trust

To date:

- **February 2023:** Declared non-compliance with Maternity Incentive Scheme (MIS) Y4, including non-compliance Safety Action (SA) 6 SBLV2.
- **March 2023:** Recruited a dedicated Transformational Lead Midwife to lead on SBL.
- **April/May 2023**: Undertook audit of Q4 SBLV2 (see appendix – this indicates compliance with 1/5 elements).
- **June 2023:** Gap analysis started for SBL V3.

Key areas of focused improvement:

- Scanning capacity expansion phased approach
- Our work to address immediate actions identified by CQC Section 31 Notice have driven improvement against the fetal monitoring element of SBL V2
- Established a MDT Preterm Birth forum
- CO monitoring including equipment and collaborating with the Trust Tobacco Dependency Lead

Next steps:

- **July 2023:** An audit of Q1 2023/24 to be undertaken for SBL V2.
- **August 2023:** Development of detailed improvement plans for supporting delivery of SBL V3 to achieve compliance by March 2024.
- **September 2023:** Full presentation of SBL V3 including risk assessment to Maternity Assurance Group and Quality and Safety Assurance Committee.

From a Must Do to a Success

York and Scarborough Teaching Hospitals
NHS Foundation Trust

BSOTS
Scarborough

June 2023

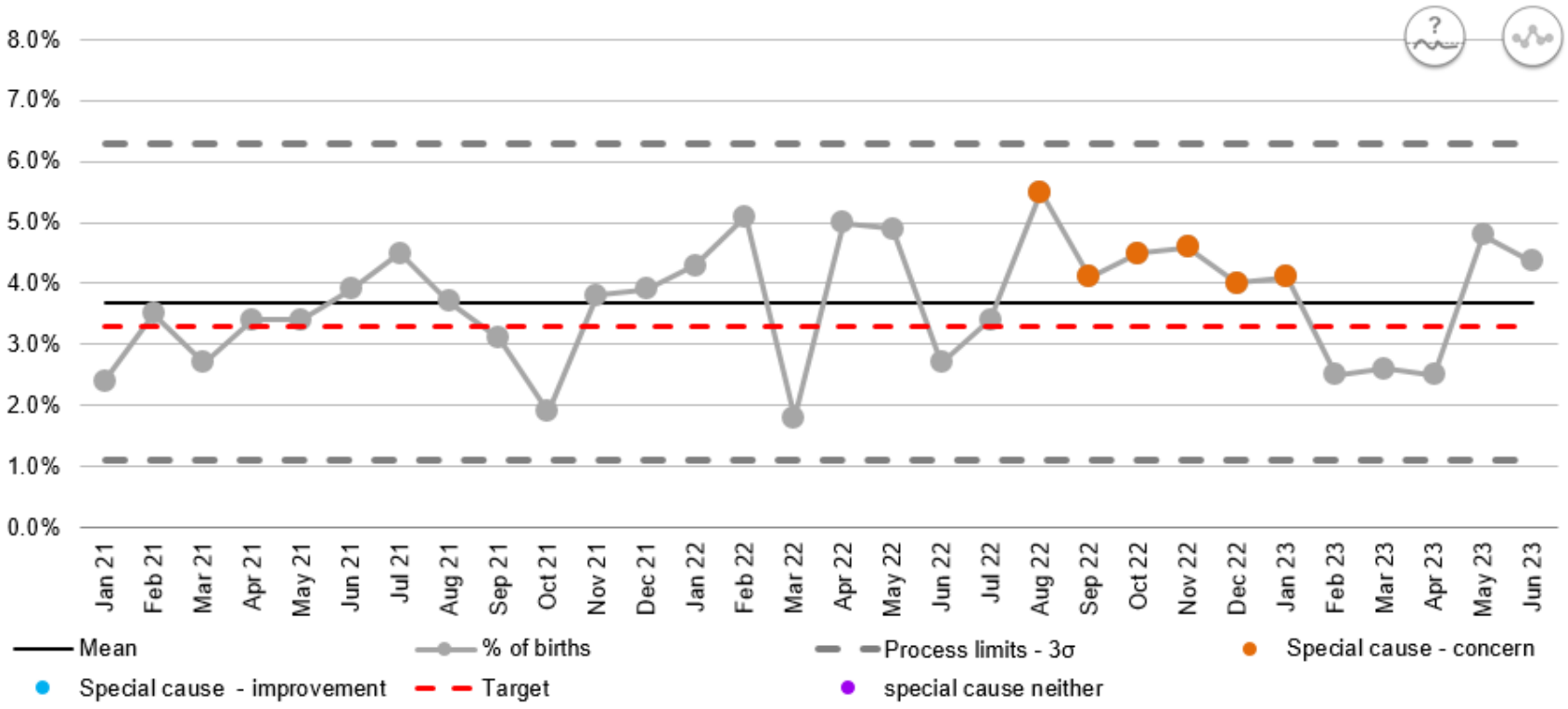
Adobe Acrobat Document

Escalations

- Interim DoM arrangements
- Impact of CQC report publication

Q&A

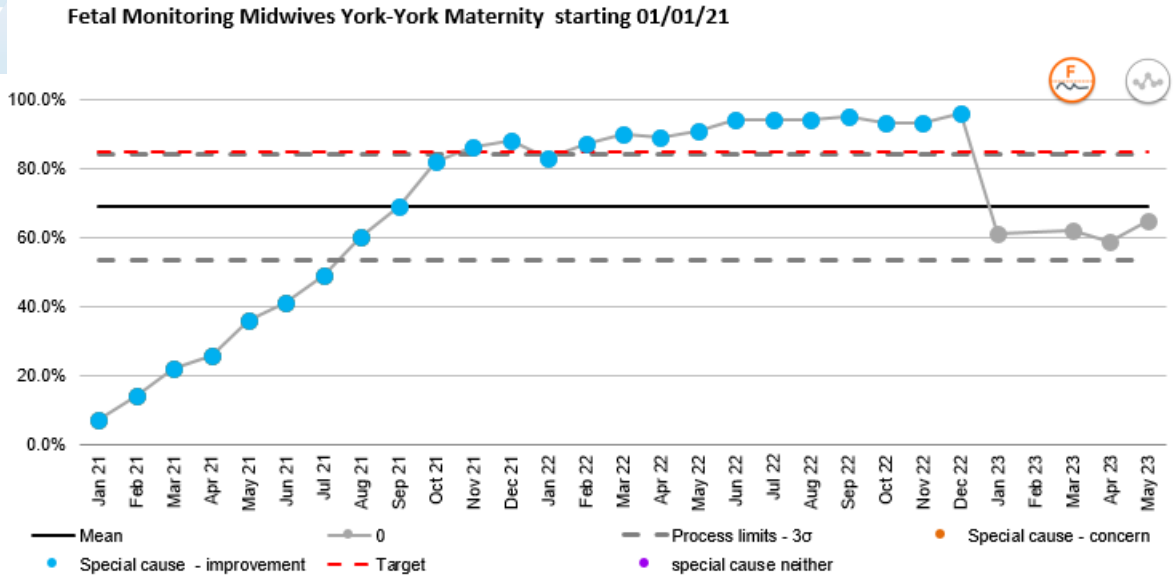
Appendix

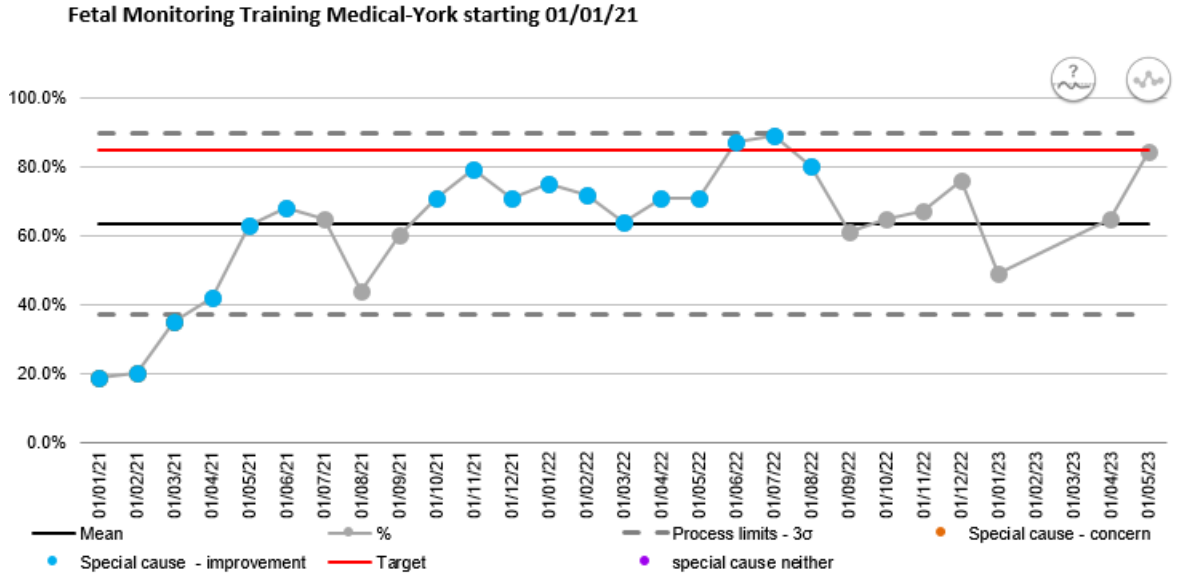


- There was an increase in the PPH rate >1500ml during May 2023 however has decreased in June
- The MIA Consultant Obstetrician has undertaken a cluster review of all PPH in May, findings inconclusive, may be linked to BadgerNet implementation

Fetal Monitoring Training - York

York and Scarborough Teaching Hospitals
NHS Foundation Trust

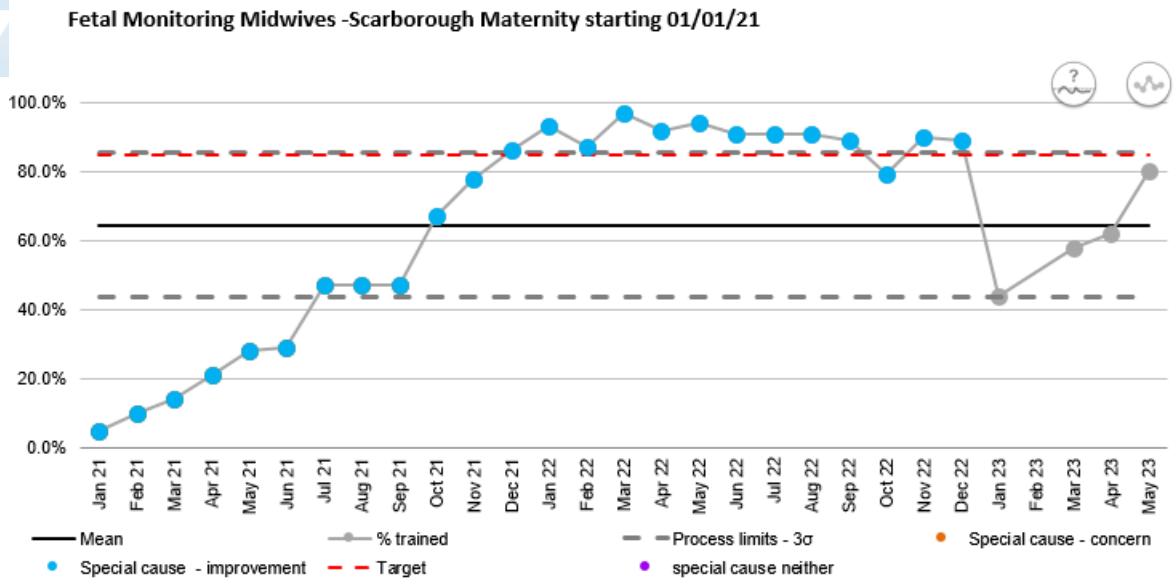


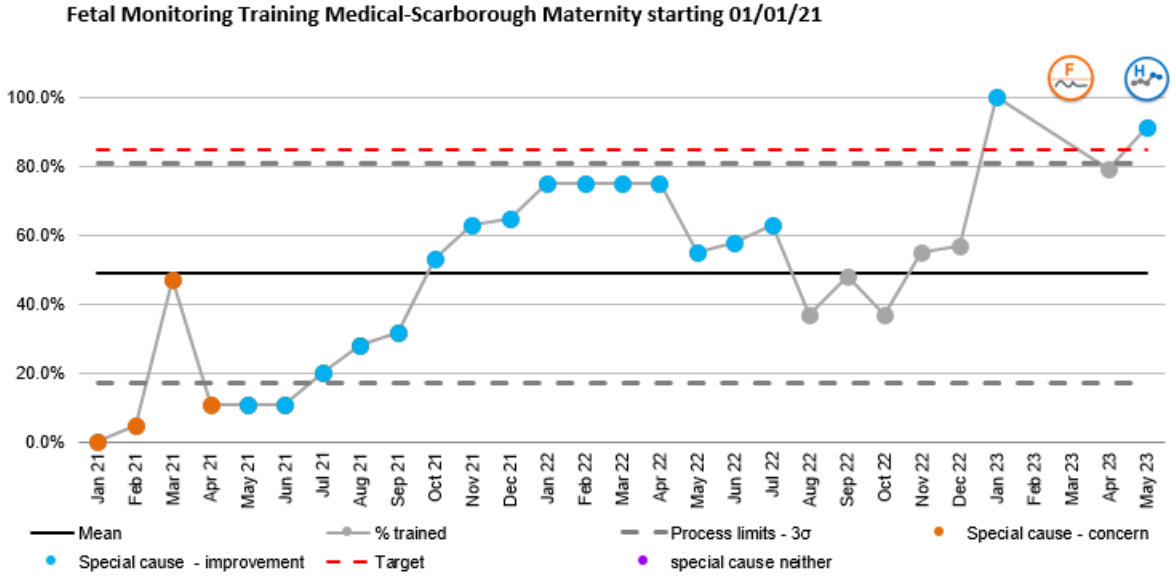


- Previously training and assessment were delivered and recorded separately; this created an issue with accurate recording of compliance.
- All staff who are at work have been contacted by the Director of Midwifery or the Clinical Director and asked to complete the assessment.

Fetal Monitoring Training - Scarborough

York and Scarborough Teaching Hospitals
NHS Foundation Trust

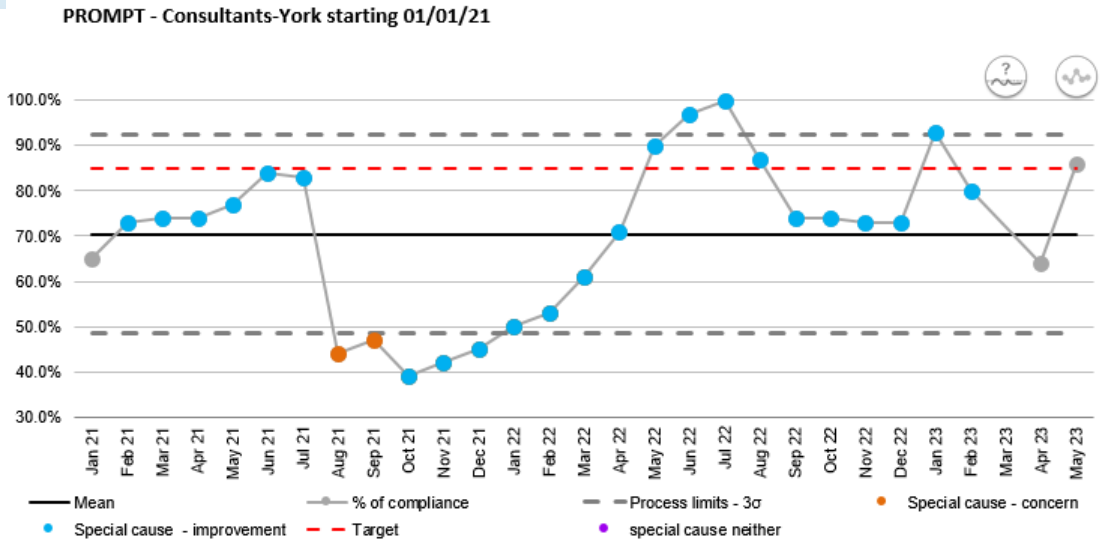


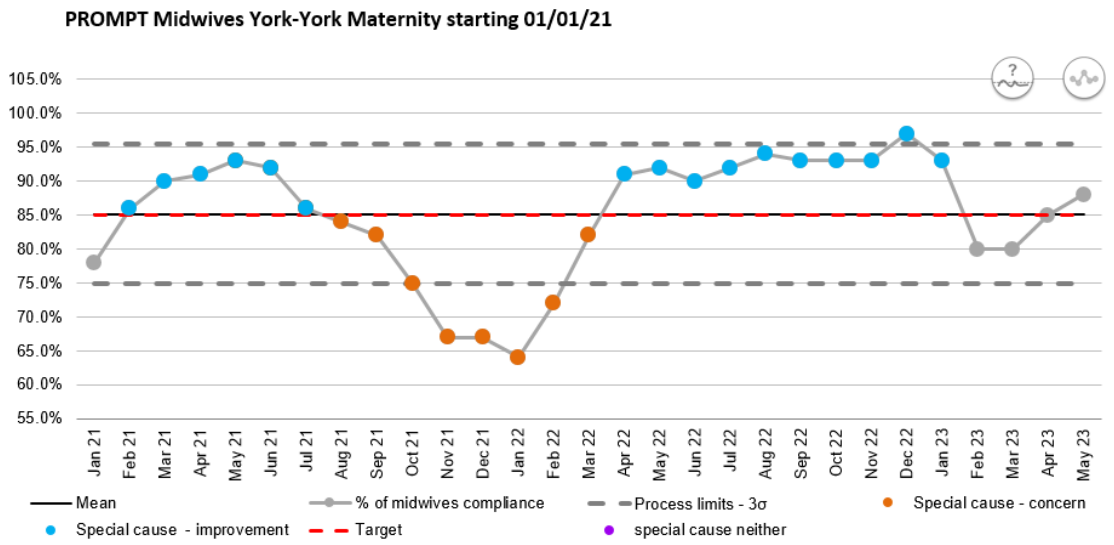


- Previously training and assessment were delivered and recorded separately; this created an issue with accurate recording of compliance.
- All staff who are at work have been contacted by the Director of Midwifery or the Clinical Director and asked to complete the assessment.

Practical Obstetric Multi-Professional Training (PROMPT) Compliance - York

York and Scarborough Teaching Hospitals
NHS Foundation Trust

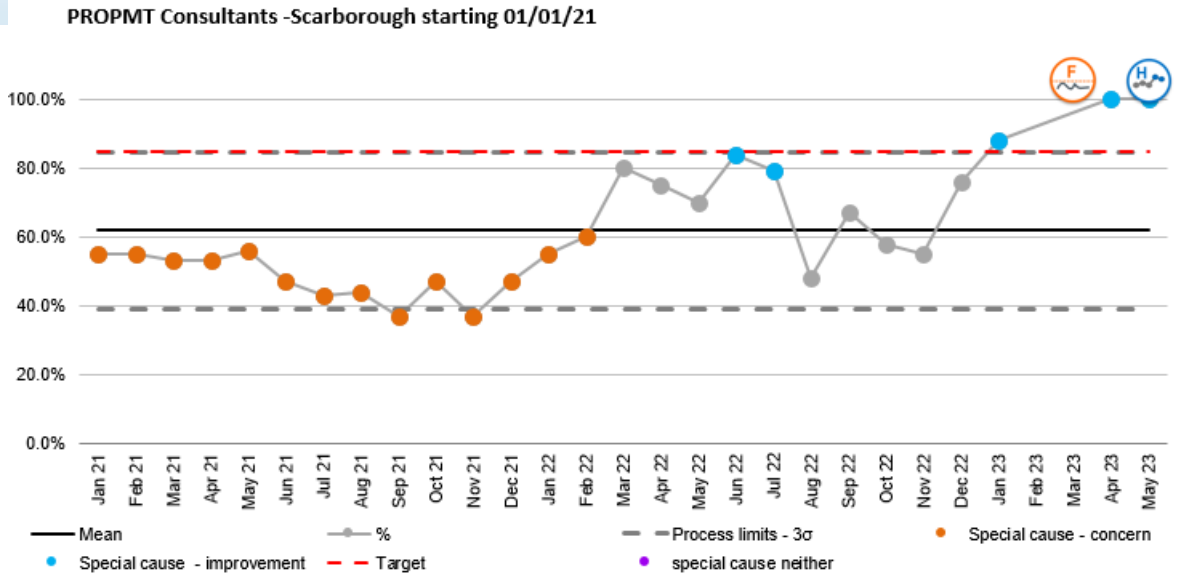


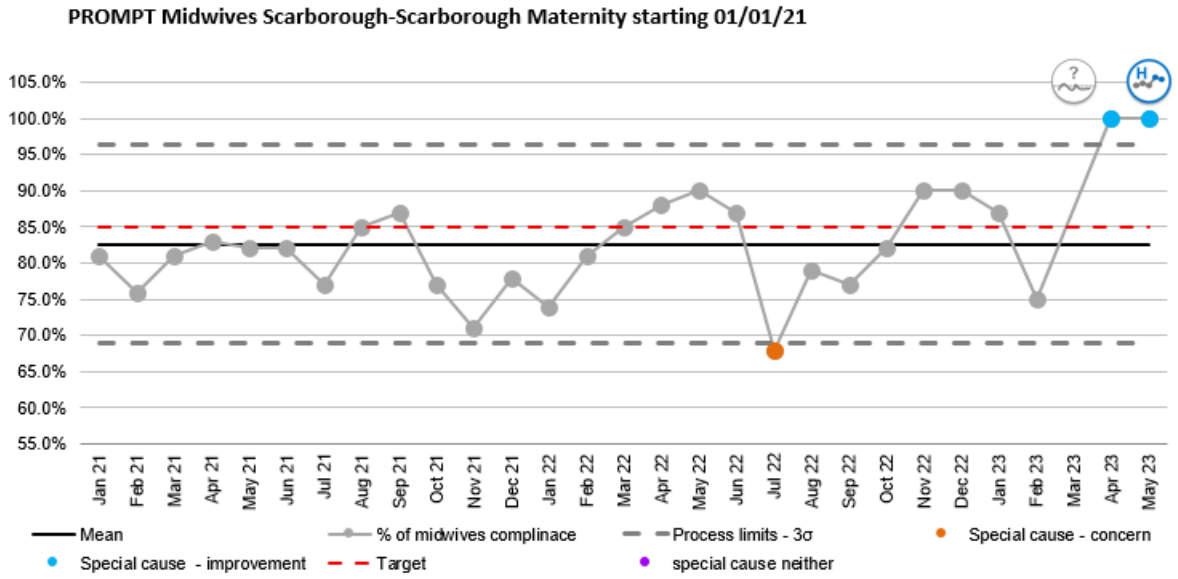


Between Feb and March the Trust Learning Hub was unavailable which accounted for the dip in performance.

Practical Obstetric Multi-Professional Training (PROMPT) Compliance - Scarborough

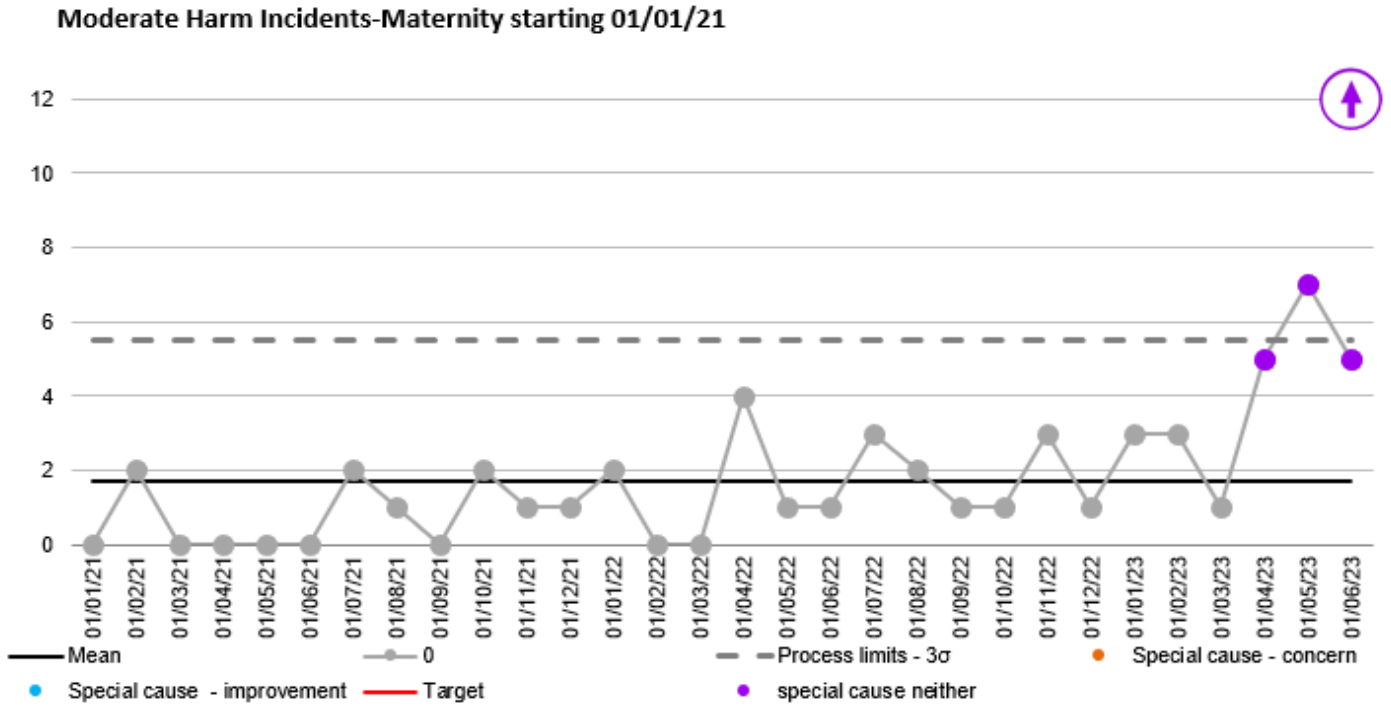
York and Scarborough Teaching Hospitals
NHS Foundation Trust





Scarborough have achieved 100% compliance with PROMPT for the last two months for midwifery and medical staff

Moderate Harm Incidents



- Support from the MIA to accurately review and grade incidents
- Ongoing review of incidents and assurance from MIA that these are robust
- Increased reporting figures is a positive and reflective of an open culture. Incidents are reported on Datix

Saving Babies Lives Care Bundle v2 – audit Q4 22/23

	RAG	Action being taken to reach compliance
Element 1: Reducing Smoking in Pregnancy		▪ The Transformation Lead Midwife and Tobacco Dependency Lead are working together to implement the NHS long term plan to reduce smoking at time of delivery rates to 6% or less as per the national ambition. ▪ The audit highlighted CO testing compliance of 82.4% at booking and 13.4% at 36 weeks. The 36 week data is thought to be partially attributed to a data capture issue due to the move to BadgerNet and is being closely monitored via the community midwife with the use of weekly Production Boards, reporting data and staff communication.
Element 2: Risk assessment and surveillance for fetal growth restriction (FGR)		• The service has all appropriate policies to include definition, risk assessments and surveillance pathway with demonstration of compliance. • Scanning capacity is currently being expanded as scan referrals are frequently breaching >72 hours between the referral and the scan to support compliance in this element.
Element 3: Raising awareness for reduced fetal movements (RFM)		▪ Element 3 is well embedded. The quarter 4 audit 22/23 demonstrated 100% of women had a RFM leaflet by 28 weeks and the use of computerised CTGs for RFM is established. ▪ From the week commencing 3rd July the fetal monitoring checklist will be available via BadgerNet every appointment from 24 – 42 weeks
Element 4: Effective fetal monitoring during labour		▪ CTG training figures have steadily improved however still remain below the required 85%, the department has enacted a robust plan to address this. ▪ The department has an Intrapartum Fetal Monitoring Risk Assessment with a plan for a paper assessment on the day of training to support timely compliance. ▪ The Director of Midwifery is arranging additional support with training to support un planned absence in the training team.
Element 5: Reducing pre-term birth		▪ A new MDT Pre-term birth forum has been established on a monthly basis to review the PTB cases against the perinatal optimisation indicators and embed across site ▪ Off Pathway births will also be reviewed at this forum and submitted to the LMNS quarterly. ▪ Administration of magnesium sulphate is well embedded following the Prevention of Cerebral Palsy in PreTerm Labour (PReCePT) project. This is required for the other indicators including corticosteroids and early maternal breast milk to ensure these aspects are embedded.

York and Scarborough Teaching Hospitals NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2021 births

This report concerns stillbirths and neonatal deaths among the 4,262 babies born within your Trust in 2021, EXCLUDING births before 24 weeks gestational age and all terminations of pregnancy.

It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2021, as well as background information on all births. Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **3.37 per 1,000 total births**. This is more than 5% higher than the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **1.02 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **4.35 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **3.03 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.80 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.80 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

As the stillbirth rate has been highlighted above, it is important to: a) review the data that was entered locally about your Trust to ensure it is accurate and complete; and b) ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

Definitions

Late fetal loss:	A baby delivered between 22^{+0} and 23^{+6} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby delivered at or after 24^{+0} weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

1. Your perinatal mortality rates

The mortality rates are reported for babies born within your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2021. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies. The **stabilised & adjusted mortality rate** provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Trust in 2021.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision; (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later**.**

Your Trust has been included in the comparator group with 4,000 or more births per annum.

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**15**	**3.52**	**3.37**	**(2.60 to 4.40)**	**More than 5% higher**
Neonatal	**4**	**0.94**	**1.02**	**(0.63 to 1.57)**	**More than 5% and up to 15% lower**
Extended perinatal	**19**	**4.46**	**4.35**	**(3.54 to 5.65)**	**Up to 5% higher or up to 5% lower**

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**14**	**3.29**	**3.03**	**(2.38 to 3.79)**	**Up to 5% higher or up to 5% lower**
Neonatal	**4**	**0.94**	**0.80**	**(0.53 to 1.19)**	**Up to 5% higher or up to 5% lower**
Extended perinatal	**18**	**4.22**	**3.80**	**(3.26 to 4.80)**	**Up to 5% higher or up to 5% lower**

Comparisons with similar Trusts, Health Boards and the UK average

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a circle:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

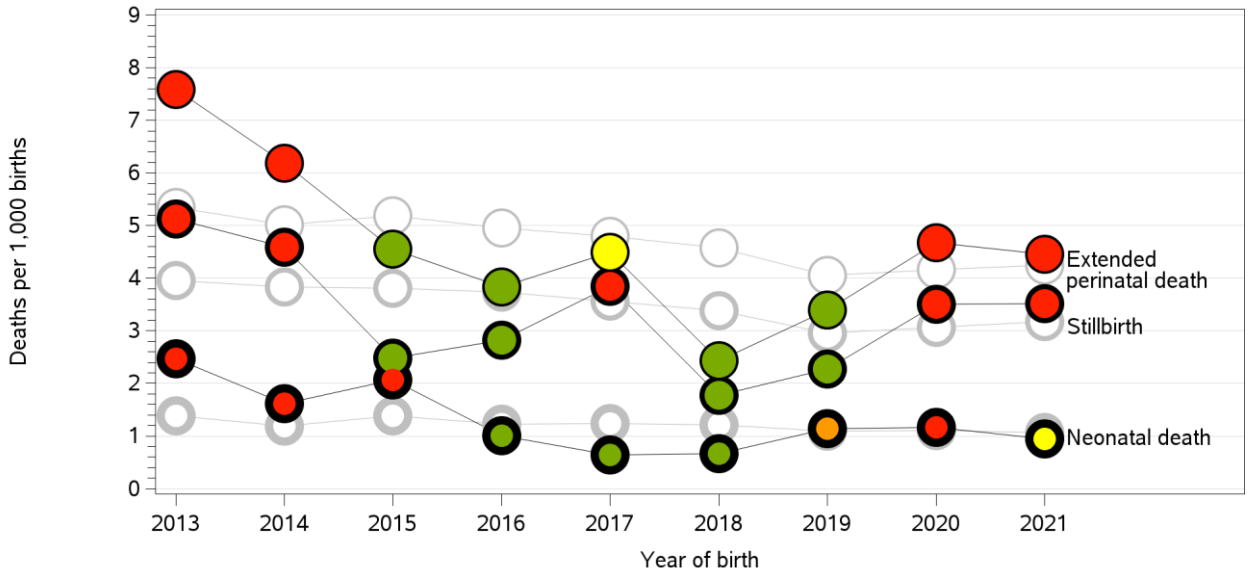
Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

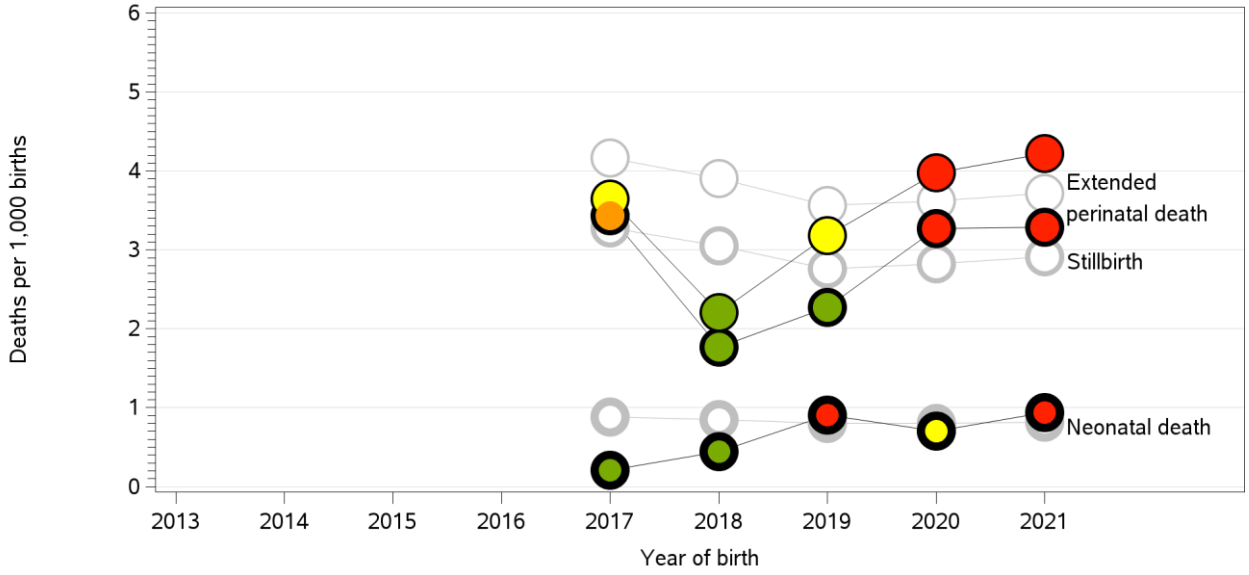
Due to updates to the data, these results might differ slightly from those in previous reports.



Crude mortality by year of birth (excluding deaths due to congenital anomalies)

Crude mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

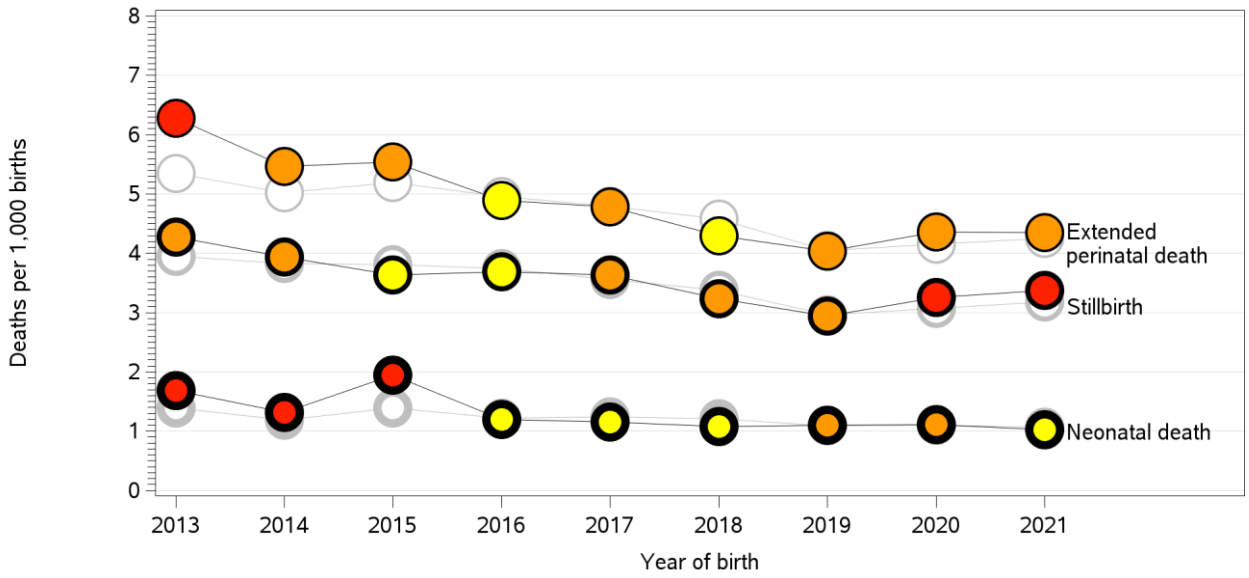
Due to updates to the data, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (excluding deaths due to congenital anomalies)

Stabilised & adjusted mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

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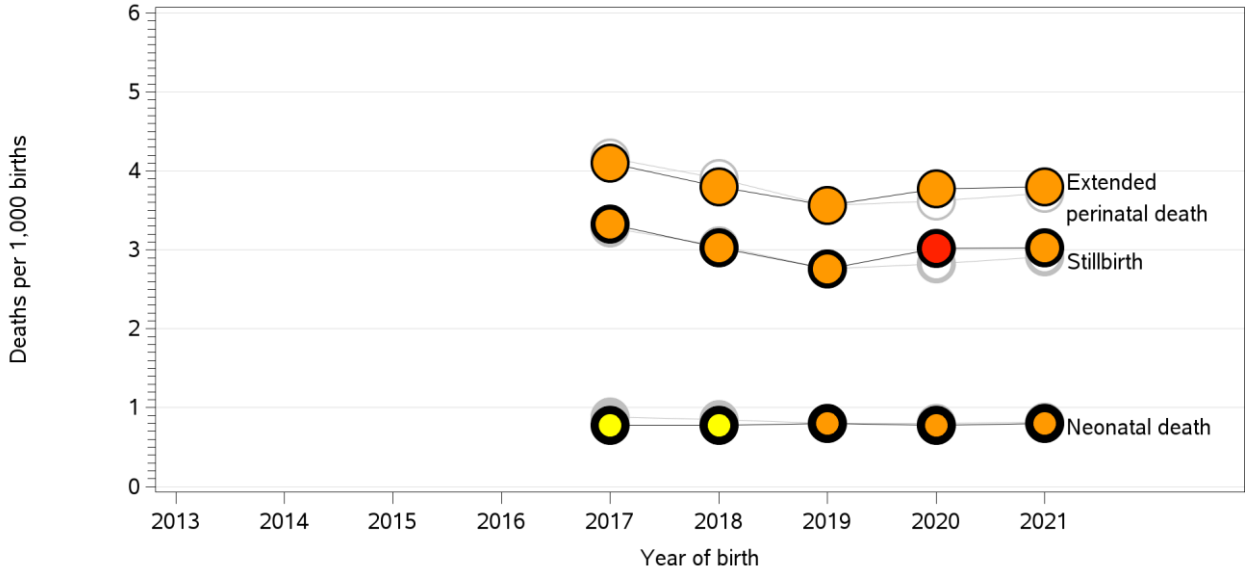


3. Your perinatal deaths

Deaths of babies born within your Trust

The crude mortality rates reported here are for babies born within your Trust, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 2 which provide more reliable estimates of the underlying (long-term) mortality rates for your Trust.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your Trust	*Rate (N)*	2.3	(10)	0.2	(1)	0.9	(4)	0.9	(4)	0.0	(0)	4.5	(19)
UK-wide	*Rate*	3.1		0.2		0.2		1.1		0.5		5.2	

The rates of extended perinatal death for your Trust, by gestational age at delivery, are shown below. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		$\geq 42^{+0}$	
Your Trust	*Rate (N)*	285.7	(4)	35.7	(1)	20.2	(6)	2.2	(8)	0.0	(0)
UK-wide	*Rate*	338.9		113.2		21.7		1.9		1.9	

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	6.7%	(1)	6.7%	(1)	6.7%	(1)
	UK-wide	%	4.5%		1.7%		1.3%		9.3%		4.0%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	100%	(4)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	7.7%		44.3%		2.2%		32.6%		3.8%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	*% (N)*	13.3%	(2)	46.7%	(7)	0.0%	(0)	20.0%	(3)	0.0%	(0)
	UK-wide	%	4.7%		33.2%		3.9%		33.3%		4.2%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	0.1%		3.0%		0.3%		4.5%		1.5%	

Your perinatal deaths *continued*

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		24^{+0} – 27^{+6}		28^{+0} – 31^{+6}		32^{+0} – 36^{+6}		37^{+0} – 41^{+6}		≥ 42^{+0}	
Within your Trust	*% (N)*	50%	(1)	0%	(0)		(0)	0%	(0)		(0)
Outside your Trust	*% (N)*	50%	(1)	100%	(1)		(0)	100%	(1)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere.

For births within your Trust, a post-mortem was offered for 100% of stillbirths and 100% of neonatal deaths, compared with 98% and 92% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your Trust	*% (n/N)*	100%	(15/15)	100%	(1/1)
Outside your Trust	*% (n/N)*			100%	(3/3)
UK-wide	*%*	98%		92%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You should ensure that the cause of death on the MBRRACE-UK data reporting system is updated once the post-mortem results are known.

		Post-mortem			
		Offered		Consent obtained	
Unknown cause of death	*% (N)*	100%	(3/3)	67%	(2/3)

Babies born at 22 to 23 weeks gestation

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is vital that your Trust ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Trust for babies born in 2021 was 6. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

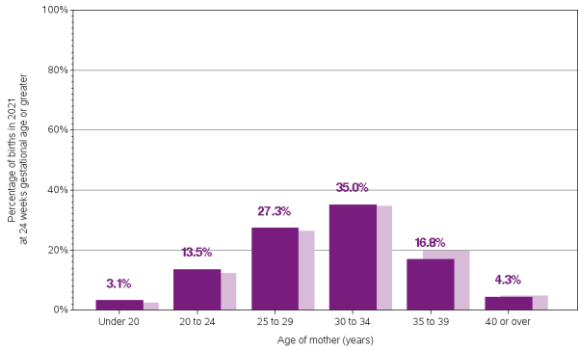
		Deaths at 22^{+0} to 23^{+6} weeks gestational age	
		Late fetal losses	Neonatal deaths
Your Trust	*N*	6	1

4. Your births

Age of mother

The proportion of mothers under 25 years of age was higher than that of the UK as a whole: 16.6% versus 14.5%.

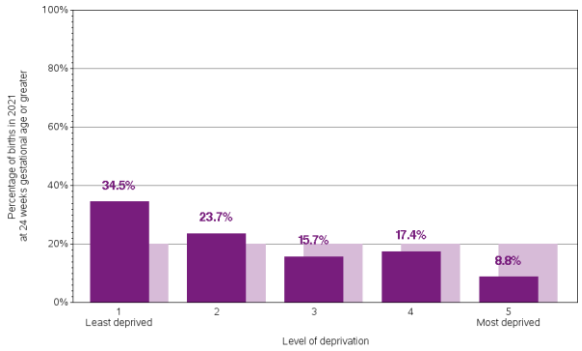
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

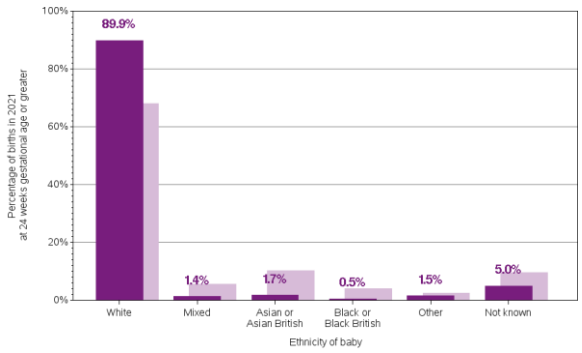
The mothers giving birth in your Trust were considerably less likely to live in areas of high deprivation than those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 5.2% versus 22.3%.

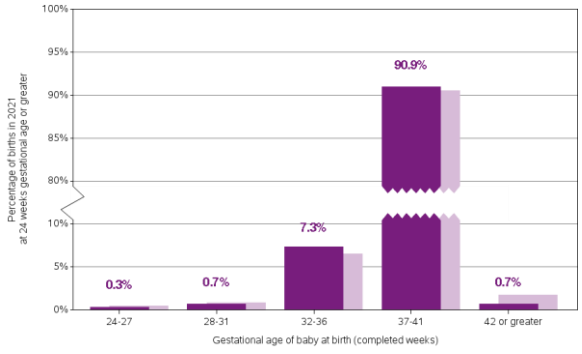
Across the UK the babies were of the following ethnicities: 68.1% White; 5.7% Mixed; 10.2% Asian or Asian British; 4.0% Black or Black British; 2.4% other; 9.7% not known.



Gestational age

In your Trust, 14 babies (0.3%) were born at 24 to 27 weeks gestational age, similar to the 0.4% seen in the UK as a whole. The percentage of babies born at 28 to 31 weeks was also similar to the national average: 0.7% versus 0.8%.

In addition, 28 babies (0.7%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.8%.

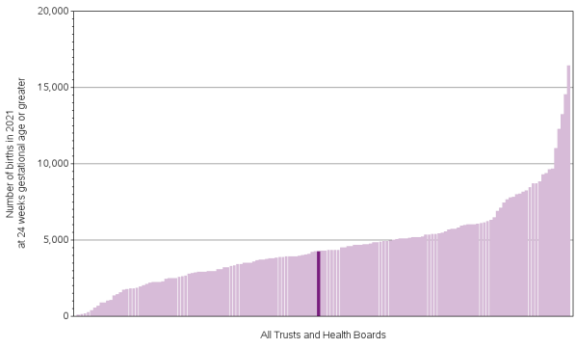


Your births *continued*

Number of births

There were 4,262 births in your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy.

The purple line in the graph opposite shows that the number of births in your Trust puts you in the middle third of all Trusts and Health Boards in the UK.



Percentage of births taking place in your Trust by commissioning organisation

The table below provides the percentage and number of births in your Trust at 24 weeks gestational age or later from each of the commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Trust. These organisations are Sub-Integrated Care Boards (Sub-ICBs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

In total, the births from these organisations accounted for 99.3% of your births at 24 weeks gestational age or later in 2021.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. NHS Humber and North Yorkshire ICB - 03Q	89.3% (2772)	2. NHS Humber and North Yorkshire ICB - 42D	29.3% (1027)
3. NHS Humber and North Yorkshire ICB - 02Y	18.1% (433)		

5. Data reporting

Completeness of key data items for DEATHS AT YOUR TRUST

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2021, we received 95% of information on key data items for the deaths which occurred within your Trust.

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Trust, these tables show the overall completeness of data for **deaths at your Trust no matter where they were born**. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- ♦ less than 70.0% complete
- ♦ 70.0% to 84.9% complete
- ♦ 85.0% to 96.9% complete
- ♦ 97.0% to 99.9% complete
- ♦ 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Trust. For those items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.

Mother's details	Completeness	
Name	100.0%	♦
UK-wide	100.0%	
Postcode of residence	100.0%	♦
UK-wide	99.9%	
Ethnicity	100.0%	♦
UK-wide	96.3%	
Age	100.0%	♦
UK-wide	100.0%	

Birth	Completeness	
Type of onset of labour	100.0%	♦
UK-wide	99.0%	
Actual place of birth	100.0%	♦
UK-wide	99.4%	
Date and time of birth	100.0%	♦
UK-wide	98.6%	
Final mode of birth	100.0%	♦
UK-wide	99.5%	

Booking and antenatal care†	Completeness	
Smoking	88.8%	♦
UK-wide	97.5%	
Body mass index	100.0%	♦
UK-wide	100.0%	
Intended type of care at booking	88.8%	♦
UK-wide	96.2%	
Estimated date of delivery	83.3%	♦
UK-wide	97.0%	

Baby's outcome	Completeness	
Date death confirmed‡	100.0%	♦
UK-wide	100.0%	
Whether alive at onset of care‡	73.3%	♦
UK-wide	95.1%	
Whether admitted to NNU§	100.0%	♦
UK-wide	99.9%	
Main cause of death	100.0%	♦
UK-wide	96.7%	

Baby's characteristics	Completeness	
Birth weight	94.4%	♦
UK-wide	98.6%	
Gestational age at birth	88.8%	♦
UK-wide	98.9%	

† excluding mothers reported as never booked; ‡ this data item is collected for stillbirths only; § this data item is collected for neonatal deaths only.

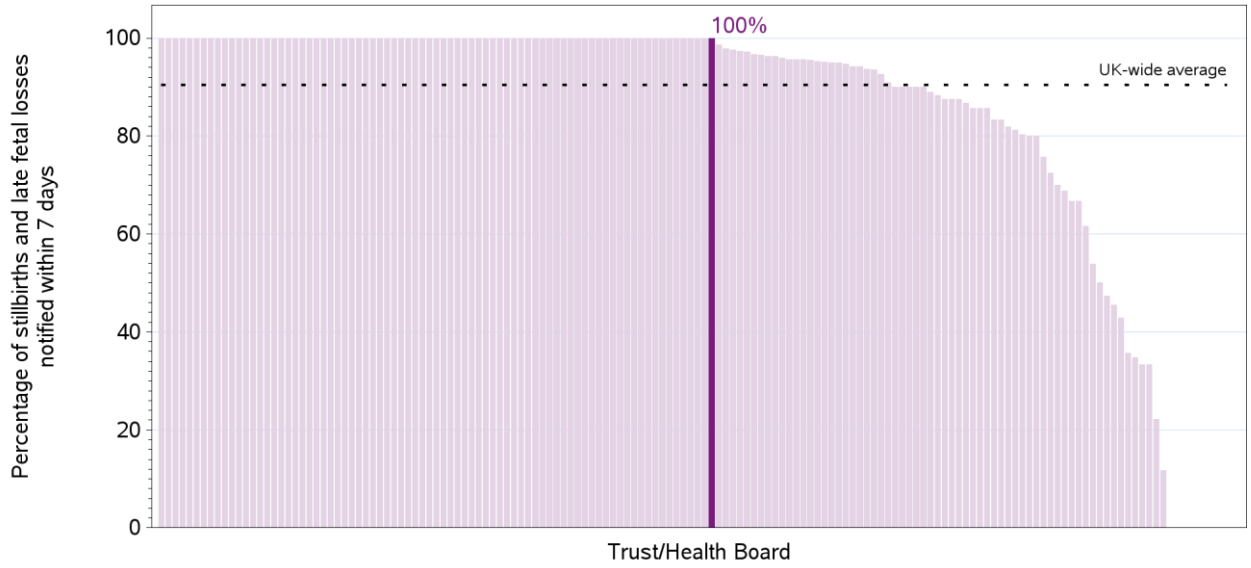
Percentage of deaths notified by your Trust within 7 days

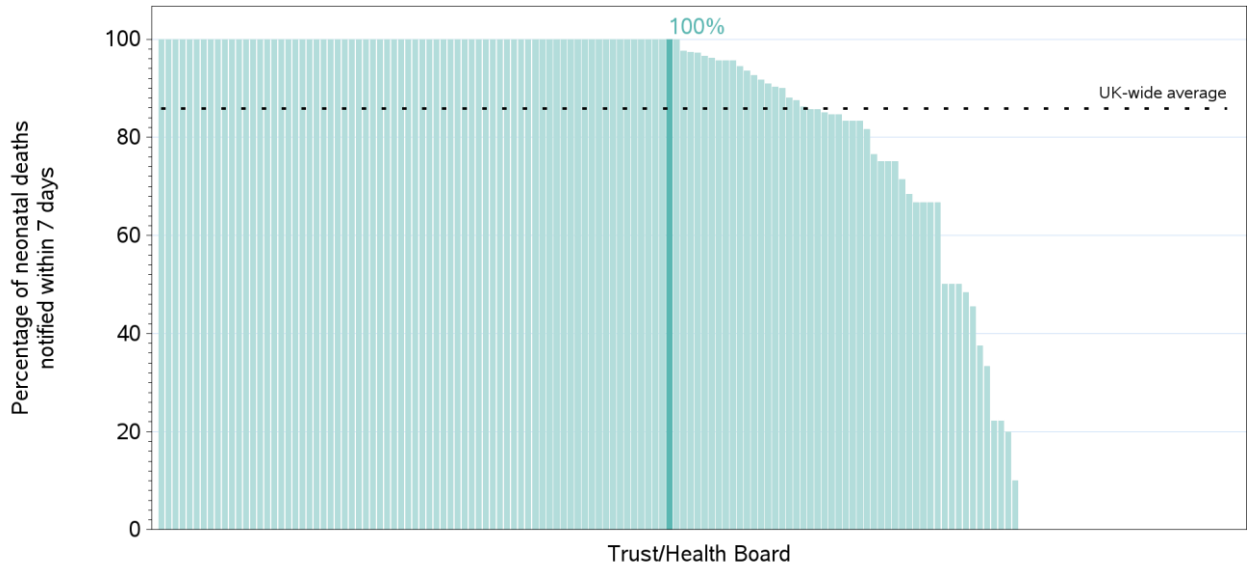
The MBRRACE-UK timeliness benchmarks for the notification of deaths and completion of surveillance data are:

1) All deaths should be **notified** to MBRRACE-UK within 7 days of the death occurring. The full data does not have to be complete at this point.

2) Trusts and Health Boards should aim to **complete** data entry for each death within 90 days of the death occurring.

The graphs below show the percentage of stillbirths & late fetal losses and neonatal deaths notified by your Trust within the 7-day benchmark period.





About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford with members from the University of Leicester (who lead the perinatal aspects of the work), University of Birmingham, Bradford Institute for Health Research, The Newcastle upon Tyne Hospitals NHS Foundation Trust and Sands (Stillbirth and neonatal death charity).

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, NHS Wales, the Scottish Government Health and Social Care Directorate, the Northern Ireland Department of Health, Social Services and Public Safety, the States of Guernsey, the States of Jersey, and the Isle of Man Government.

Data sources

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics, Personal Demographics Service, National Records of Scotland, Public Health Scotland, Northern Ireland Maternal and Child Health, States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2022.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other local or national reported rates as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards. Further details on the methods we have used are included in the Technical Document available at https://www.npeu.ox.ac.uk/mbrrace-uk/reports.

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Report to:	Quality and Safety Assurance Committee
Date of Meeting:	18th July 2023
Subject:	MBRRACE – Supplementary report to the MBRRACEUK perinatal mortality report 2021
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Caroline Alexander, Associate Chief Operating Officer, Family Health Care Group

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

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

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

Summary of Report and Key Points to highlight:

The purpose of this report is to present the Trust's MBRRACE-UK perinatal mortality report for 2021 to the Trust Board. The report concerns stillbirths and neonatal deaths among the 4,262 babies born at the Trust in 2021, excluding births before 24 weeks gestational age and all terminations of pregnancy.

The report provides an overview of the cases where the mothers receiving service and care from the Trust experienced stillbirth and neonatal death and a review of the common themes explored for organisational learning purposes.

The report also aims to provide assurance to the Trust Board that the maternity service have reported perinatal mortality to MBRRACE within the expected timeframes and that each case has been subjected to appropriate scrutiny either by local investigation, via HSIB (Healthcare Investigation Branch) and/or via the PMRT (Perinatal Mortality Review Tool).

There were 15 stillbirths and four neonatal deaths in 2021.

The stabilised & adjusted stillbirth rate, neonatal and perinatal mortality rates excluding deaths due to congenital anomalies for the Trust are around the average for similar Trusts & Health Boards.

The 2021 report identified that the Trust rate of stillbirths per 1000 births reduced from 2020 to 2021 from 3.51 to 3.03.

The 2021 report identified that the Trust rate of neonatal death per 1000 births reduced from 2020 to 2021 from 1.11 to 0.8.

The 2021 report identified that the Trust rate of perinatal death per 1000 births reduced from 2020 to 2021 from 4.36 to 3.8.

In 2021 the rate of perinatal deaths <28 weeks gestation reduced from 2020 to below the national rate.

In 2021 was an increase in the rate of deaths at term [>37 weeks gestation] (2.2) and this is above the national rate of 1.9 per 1000 births.

As in 2020 the Trust have had no deaths for post-term births in 2021.

Recommendation:

The Committee is asked to receive the 2021 MBRRACE report for the Trust and to note the reductions in stillbirth, neonatal and perinatal death rates per 1000 births from 2020 to 2021, and the 2021 Trust rates are around the average for similar Trusts & Health Boards.

In line with the national ambition to reduce stillbirths, the Trust is committed to implement, embed and sustain all elements of the Saving Babies Lives care bundle version 3. Compliance against all five elements will be reported through the internal governance structures of the care group and bimonthly to the Quality and Safety Committee and Trust Board.

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

York and Scarborough Teaching Hospitals NHS Foundation Trust Maternity Department supplementary report to the MBRRACE-UK perinatal mortality report 2021

A note of acknowledgement

The information contained within this report is sensitive in nature and contains demographic details and some potentially identifiable details of our women who have had the extremely sad experience of stillbirth and neonatal death.

The women mentioned within the report will be referred to as mothers and all baby losses will be referred to as their babies.

Definitions

Late fetal loss:	A baby delivered between 22+0- and 23+6-weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death

1. Introduction and Background

The purpose of this report is to present the Trust's MBRRACE-UK perinatal mortality report for 2021 to the Trust Board. The report concerns stillbirths and neonatal deaths among the 4,262 babies born at the Trust in 2021, excluding births before 24 weeks gestational age and all terminations of pregnancy.

The data is presented in deaths per one thousand births. The crude mortality rate is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for births in 2021. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high-risk pregnancies.

The stabilised & adjusted mortality rate provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within the Trust in 2021.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups:

(i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision;
(ii) Level 3 NICU;
(iii) 4,000 or more births per annum at 22 weeks or later;
(iv) 2,000-3,999 births per annum at 22 weeks or later;
(v) under 2,000 births per annum at 22 weeks or later.

The Trust are included in the comparator group with 2,000-3,999 births per annum.

The data is split between all deaths and deaths excluding those due to congenital abnormalities.

The report provides an overview of the cases where the mothers receiving service and care from the Trust experienced stillbirth and neonatal death and a review of the common themes explored for organisational learning purposes.

The report also aims to provide assurance to the Trust Board that the maternity service have reported perinatal mortality to MBRRACE within the expected timeframes and that each case has been subjected to appropriate scrutiny either by local investigation, via HSIB (Healthcare Investigation Branch) and/or via the PMRT (Perinatal Mortality Review Tool).

2. MBRRACE-UK Perinatal mortality report: 2021 births

2.1 National Data

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 to 1.0 per 1000 births and to half the 2010 stillbirth rate by 2025 to 2.6 per 1000 births.

The national MBRRACE-UK report for 2021 births is due for publication in September 2023, however 2021 data from the Office of National Statistics (for England) are

- Stillbirth – 4.1 per 1000 births an increase from 3.8 per 1000 births in 2020
- Neonatal deaths – 1.4 per 1000 births

2.2 Trust Data for 2021

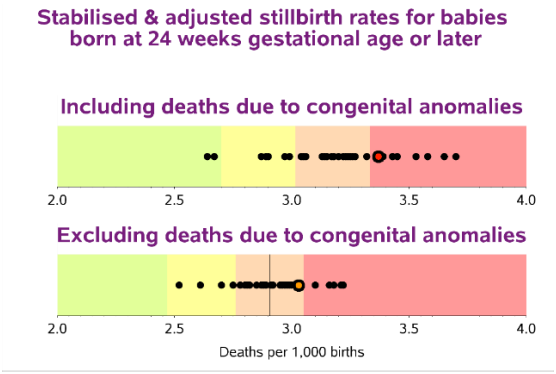
The senior maternity leadership team have reviewed the mortality rate data for the 2021 period on behalf of the Trust and confirmed that this data is valid and aligned to the data reported internally through the maternity governance and perinatal lead.

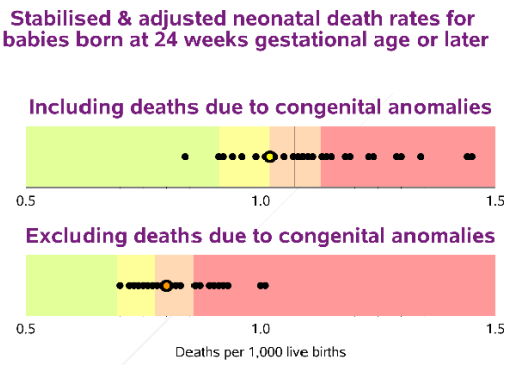
All deaths:

1. The stabilised & adjusted stillbirth rate is **3.37 per 1,000 total births**. This is more than 5% higher than the average for similar Trusts & Health Boards.
2. The stabilised & adjusted neonatal mortality rate is **1.02 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. The stabilised & adjusted extended perinatal mortality rate is **4.35 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Deaths excluding those due to congenital abnormalities:

1. The stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **3.03 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. The stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.80 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. The stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.80 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.





Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	15	3.52	3.37	(2.60 to 4.40)	More than 5% higher
Neonatal	4	0.94	1.02	(0.63 to 1.57)	More than 5% and up to 15% lower
Extended perinatal	19	4.46	4.35	(3.54 to 5.65)	Up to 5% higher or up to 5% lower

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	14	3.29	3.03	(2.38 to 3.79)	Up to 5% higher or up to 5% lower
Neonatal	4	0.94	0.80	(0.53 to 1.19)	Up to 5% higher or up to 5% lower
Extended perinatal	18	4.22	3.80	(3.26 to 4.80)	Up to 5% higher or up to 5% lower

2.23 Trust Data for 2020

In 2020, MBRRACE-UK presented data for stillbirth as all deaths rather than including and excluding congenital abnormalities, the stabilised and adjusted rate for 2020 was,

- Stillbirth – 3.51 per 1000 births
- Neonatal death – 1.11 per 1000 births
- Extended perinatal death – 4.36 per 1000 births

It should be noted that nationally the data collected in 2020 dataset is not an exact comparator to 2021 data but the Trust has compared the rates.

The 2021 report identified the Trust as a having a more than 5% higher than average for stillbirths in similar comparator Trusts before the data is adjusted to exclude deaths due to congenital abnormalities. However, there has been a decrease in the rate per 1000 births from 2020 to 2021 from 3.51 to 3.03.

The 2021 report identified that the Trust rate of neonatal death per 1000 births reduced from 2020 to 2021 from 1.11 to 0.8.

The 2021 report identified that the Trust rate of perinatal death per 1000 births reduced from 2020 to 2021 from 4.36 to 3.8.

2.3 Mortality Rate by Gestational Age

Nationally almost three-quarters of both stillbirths and neonatal deaths (including babies born at 22-23 weeks' gestational age) were preterm births (<37 weeks' gestational age): 73% and 71% respectively.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		$\geq 42^{+0}$	
Your Trust	*Rate (N)*	285.7	(4)	35.7	(1)	20.2	(6)	2.2	(8)	0.0	(0)
UK-wide	*Rate*	338.9		113.2		21.7		1.9		1.9	

The rate of perinatal deaths <28 weeks gestation in 2021 has reduced from 2020 to below the national rate.

However, there has been an increase in the rate of deaths at term (2.2) and this is above the national rate of 1.9 per 1000 births.

As in 2020 the Trust have had no deaths for post-term births in 2021.
The Trust had 28 live babies (0.7%) born post-term (42 weeks or greater), a lower percentage than the UK average of 1.8%.

2.4 Effect of Ethnicity and Deprivation on Perinatal Mortality

Nationally, the MBRRACE findings of the effect of ethnicity and deprivation on perinatal mortality are as follows:

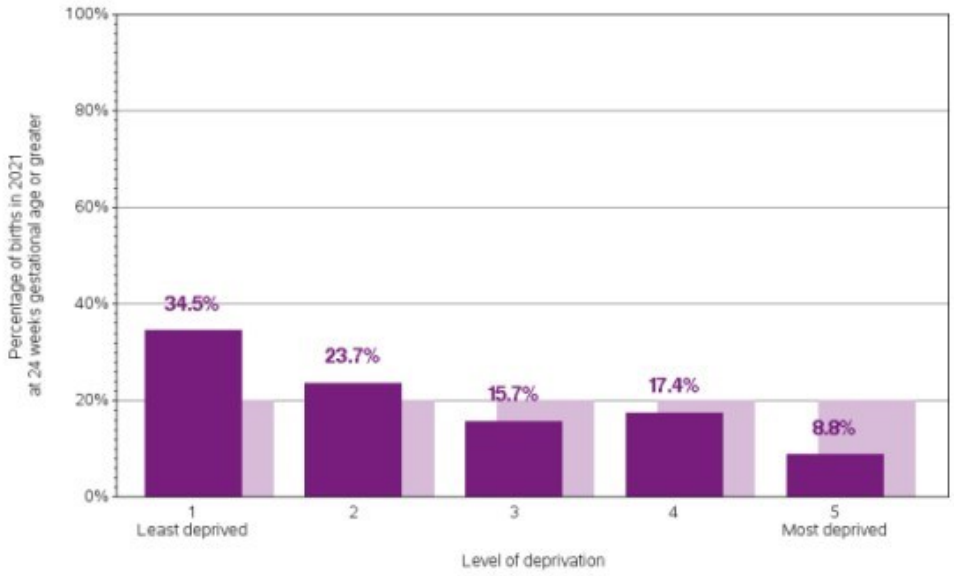
- Stillbirth and neonatal mortality rates increased with deprivation across all ethnic groups.
- Stillbirth and neonatal mortality rates were lowest for babies of White ethnicity from the least deprived areas (2.78 stillbirths per 1,000 total births and 1.26 neonatal deaths per 1,000 live births).
- The multiple impact of ethnicity and deprivation is highlighted by a stillbirth rate of 8.10 and 7.96 per 1,000 total births for babies of Black African and Black Caribbean ethnicity respectively from the most deprived areas.
- Neonatal mortality rates were over 3 per 1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas.
- Due to considerably higher proportions of babies of Black African, Black Caribbean, Pakistani and Bangladeshi ethnicity being from more deprived areas, they are

disproportionately affected by the higher rates of stillbirth and neonatal death associated with deprivation.

2.41 Deprivation – Trust data

This graph below shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

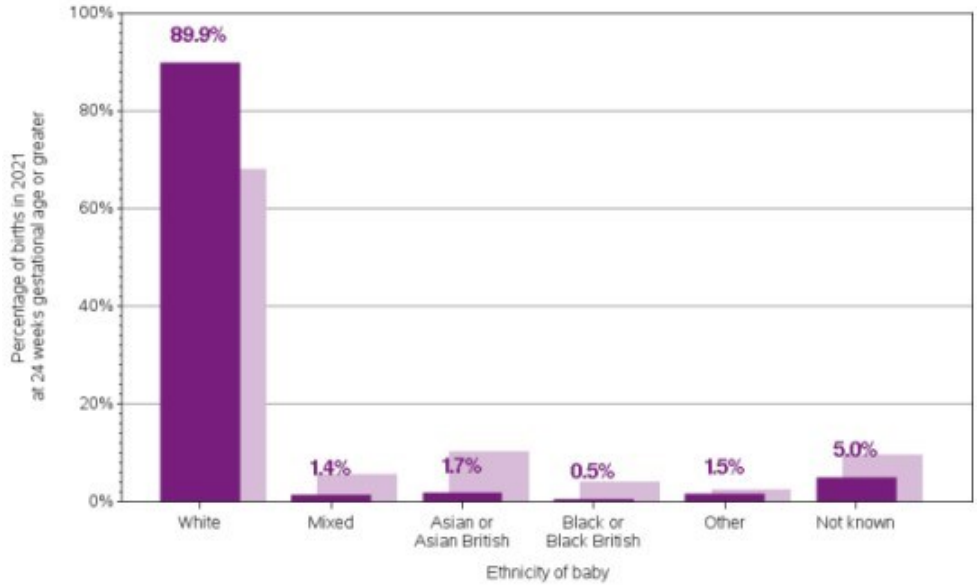
The mothers giving birth at the Trust were considerably less likely to live in areas of high deprivation than those giving birth across the UK as a whole.



2.42 Ethnicity – Trust data

Across the UK the babies were of the following ethnicities: 68.1% White; 5.7% Mixed; 10.2% Asian or Asian British; 4.0% Black or Black British; 2.4% other; 9.7% not know.

The proportion of babies of non-White ethnicity was considerably lower at the Trust than that of the UK as a whole: 5.2% versus 22.3%.



3. Perinatal Mortality cases in 2021

There were 15 stillbirths and four neonatal deaths in 2021.

The Yorkshire and Humber Maternal & Neonatal Clinical Network undertook the first network-wide review of the 303 stillbirths in 2021 across 11 of the 13 Trusts in the network.

They identified the following care areas where issues were present which were likely to or may have changed the outcome of some of the stillbirths:

- Inadequate growth surveillance
- Inadequate investigation and/or management of reduced fetal movements
- Inadequate management of significant obstetric/ medical/ surgical/ social problems
- Inadequate triage

4. Conclusion

In line with the national ambition to reduce stillbirths, the trust is committed to implement embed and sustain all elements of the Saving Babies Lives care bundle version 3. Compliance against all five elements will be reported through the internal governance structures of the care group and bimonthly to the Quality and Safety Committee and Trust Board.

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Reducing admission of full-term babies to Neonatal Unit

Report on Q4 2022/23 and Q1 2023/23

Bev Waterhouse and Georgina Rowe
Friday 7th July 2023

Background

This report allows us to share our position from the past year across our Trust. It is recognised that improvements in mother-infant separation may be made by understanding preventable factors leading to full-term babies being admitted to neonatal units.

To reduce avoidable separation of mother and baby in the early days of life of it is a national target that no more than 5% of all live births should be admitted to a Neonatal unit (NNU) if born at term (≥37+0 week gestation). York and Scarborough Teaching Hospital NHS Foundation Trust (YSTHFT) achieved an admission rate below the national target of less than 5% term admission to the neonatal unit. The overall rate is 4.1% Q4 and 2.9% Q1. A a robust review panel has been convened monthly involving an MDT approach. The panel will include a neonatal lead, neonatal matron, obstetric lead, obstetric matron, labour ward managers and maternity and neonatal clinical educators.

The maternity service working on a number of initiatives including information posters for the maternity unit, development of a teaching package and building strong relationships between maternity and neonatal teams, and the Local Maternity and Neonatal System (LMNS). As a result, we are starting to better understand the transitional care needs of our families and service.

The ATAIN panel members have reviewed all cases for the last year to address any incomplete reviews for that period. To ensure

The work aligns with national priorities including:

- The Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030
- Recommendations in Better Births, taken forward in the NHS England-led Maternity Transformation Programme
- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, team work and improvement capability within maternity units.

The ATAIN work programme focuses on four key areas relating to term admissions:

- hypoglycaemia,
- jaundice at > 24 hours of age,
- respiratory conditions
- hypothermia

and the factors leading to these admissions

NHS Improvement has identified that over 20% of admissions of full term babies to neonatal units could be avoided and requested all maternity services to work

together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so. (NHS England » Maternity Transformation Programme)

YSTHFT has reviewed the data of all of the term admissions to neonatal unit across both sites during Q4 2022/23 and Q1 2023/24. The panel has developed a bespoke data collection tool to capture themes and trends gathered via paper records and the Badgernet informatics system. The tool asks the reviewer to identify the primary reason for admission and if any changes in the Antenatal/perinatal or postnatal management could have prevented admission.

Objectives

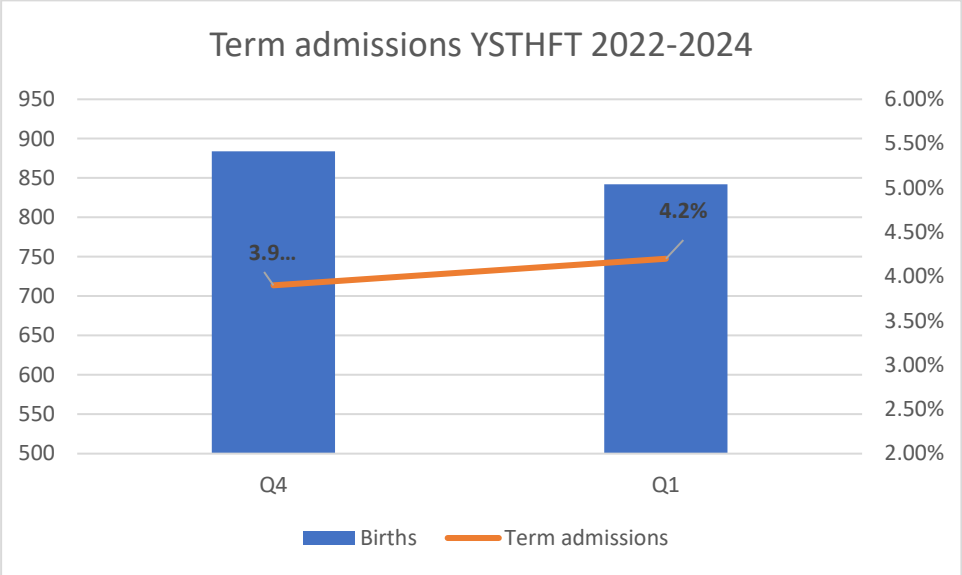
The number of unexpected admissions to neonatal units is seen as a proxy indicator that preventable harm may have been caused at some point along the maternity or neonatal pathway. Additionally, admission to a neonatal unit can lead to unnecessary separation of mother and baby. There is overwhelming evidence that separating mother and baby at, or soon after, birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health. (NHS England » Reducing admission of full term babies to neonatal units). It is therefore and should be an area of focus for improvement.

Admissions to Neonatal Wards.

Babies who have spent at least one day on the neonatal unit split by site

	York Term admissions	York Term admissions as a percentage of all term births at York	Scarborough Term admissions	SGH Term admissions as a percentage of all term births SGH
Q4 22/23	11	(1.9%)	24	(8.2%)
Q1 23/24	16	(2.65%)	19	(8%)

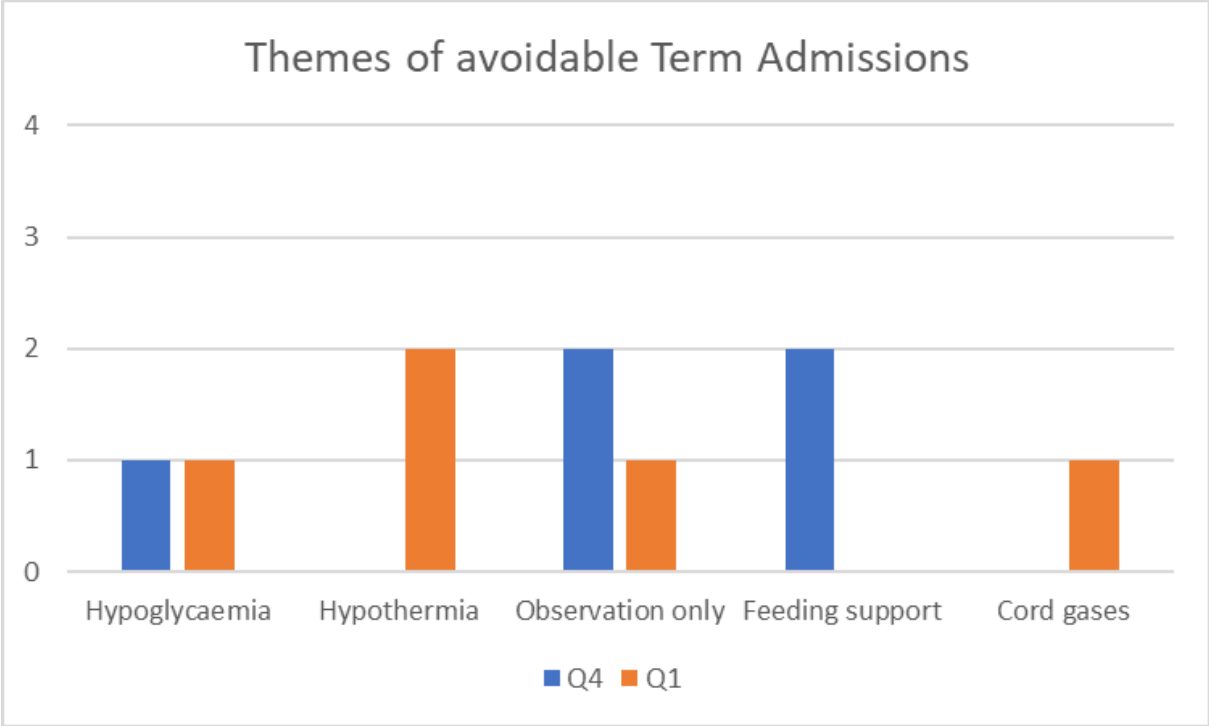
YSTHFT Q4 2022/23 – Q1 2023/24 Findings



(YSTHFT Term admissions 22-24)

YSTHFT achieved an admission rate below the national target of less than 5% term admission to the neonatal unit. **The overall rate is 3.9% Q4 and 4.2% Q1.**

Reason for Admission



Observation

Observation only is the leading cause of admission to the neonatal unit at York and Scarborough. This will be a leading focus of our work in the coming year and will aim

to identify any themes or trends where improvement may be made. See appendix 1 for Action Plan.

Hypothermia
Two cases were identified in quarter 1 where hypothermia was a factor in term admission. In these cases the panel felt achieving normothermia may have prevented the admission. See appendix 1 for Action Plan.

Feeding support
Two cases were identified in quarter 1 where feeding support was a factor in term admission. The panel agreed that improvements should be made to the offer of infant feeding support as infants should not be separated from parent for this reason. See appendix 1 for Action Plan.

Hypoglycaemia
Quarter 4 and quarter 1 both featured an avoidable admission with infants with hypoglycaemia. See appendix 1 for Action Plan.

Cord gases
In quarter 1, 1 case was reviewed where interpretation of cord gases may have aided assessment. See appendix 1 for Action Plan.

Conclusions and Actions Plan

Scarborough and York have noticeable differences in term admission rates. There are currently no clear themes emerging from the ATAIN panel reviews per site, but this will continue to be a key line of enquiry.

All term admissions to the neonatal unit should have a DATIX registered on the system as per DATIX Trigger List. Further work is needed to improve the governance and maintain the records for all term admissions to the neonatal unit; this will include consideration for Duty of Candour when an admission is deemed avoidable.

All admission notes were reviewed by Maternity and Neonatal colleagues as part of the ATAIN Panel meeting for Q4 (2023/23) and Q1 (2023/24) and action plans generated accordingly for learning and continued improvement. Monthly meetings are in place, which will ensure timely review of all term admission. Actions plans will be discussed monthly at the cross site, MDT ATAIN panel.

Concerns and escalations will be shared at Maternity and Child Health Governance meetings on a quarterly basis.

Appendix 1.
Scarborough ATAIN Action Plan Q4 22/23

No.	Recommendation	Lead	Embedded /Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q4 2022 - Carried forward									
1	Improve feeding support to ensure babies are not admitted to SCBU for feeding support	Susie Kinsella (Inpatient Matron Scarborough) and Julie Stone (Infant Feeding Lead)		In Q4, 2 babies were admitted for feeding support	1.1	Review of workforce model to support TC offer in Scarborough. Consider extended scope of B3/4.	Sal Katib (Head of Children's Nursing)	31/08/2023	
					1.2	Implement recommendations from the Workforce Review	Sal Katib (Head of Children's Nursing)	31/08/2023	
					1.3	Review training offer available to staff of infant feeding and provide update to ensure close monitoring of mother and baby separation.	Julie Stones (Infant Feeding Lead)	31/08/2023	
2	Improvement of Clinical Supervision	Jo Mannion (Care Director)		In Q4, 1 baby was admitted to the Neonatal Unit for observation only	2.1	Trust Neonatal Lead required	Jo Mannion (Care Group Director)	31/08/2023	
					2.2	Any cases identified with the ATAIN Panel will be identified to the neonatal lead for clinical supervision	Jo Mannion (Care Group Director)	28/07/2023	
					2.3	Neonatal teams to consider Workforce Model to support supernumerary status of staff to improve support on labour ward/Hawthorne	Pam Toas (Neonatal Matron)	29/12/2023	
3	Understand and agree governance process for recording Term Admissions	Sarah Gallagher (Governance and Safety Lead)		Governance process around term admissions to be standardised	3.1	Consideration to be given when delivering DoC where an admission has been deemed inappropriate	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	
					3.2	Review DATIX trigger list to clarify if term admission remains recommended practice	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	
					3.3	DATIX to be completed for any cases inappropriate	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	

Scarborough ATAIN Action Plan Q1 23/34

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q1 2023									
1	Improve thermoregulation of babies post delivery	Hanna Harness (Inpatient Matron York)		Q1, 1 cold baby	1.1	Hanna Harness to produce a Temperature Management Flow Chart and take to Governance for sign off on 13/06/23 then share with SGH.	Hanna Harness (Inpatient Matron York)	13/07/2023	
					1.2	Ensure staff are sighted on the Temperature Management Flow Chart, displaying them in visible areas	Hanna Harness (Inpatient Matron York)	31/07/2023	
					1.3	Hanna to review draft presentation to adapt for York Teaching Hospitals approval	Hanna Harness (Inpatient Matron York)	31/08/2023	
					1.4	Learning from ATAIN to be featured in Training Needs Analysis	Lois Bennett (Practice Development Midwife York) Cara Hayes (Practice Development Midwife Scarborough) and Kelly Ann-Dobbin (Practice Development Nurse)	31/08/2023	
2	To review and develop QI Projects around the use of antibiotics for Neonates	Kelly Ann-Dobbin (Practice Development Nurse)		Q1, 1 baby had Inappropriate use of antibiotics	2.1	Engage with QI to review problem and develop project	Kelly Ann-Dobbin (Practice Development Nurse)	31/08/2023	
					2.2	Kelly Ann-Dobbin to review Bev Waterhouse' ATAIN lessons learnt powerpoint slide	Kelly Ann-Dobbin (Practice Development Nurse)	31/08/2023	
3	Relaunch of Trust Sepsis Bundle	Hanna Harness (Inpatient Matron York)		Further understand our compliance with the Sepsis Bundle	3.1	Revist the Trust Sepsis Bundle	Hanna Harness (Inpatient Matron York)	31/08/2023	
					3.2	Idenitfy Sepsis Lead Trust wide	Hanna Harness (Inpatient Matron York)	31/08/2023	
					3.3	Hanna to liaise with Governance Lead Midwife regarding sharing Lessons Learnt	Hanna Harness (Inpatient Matron York)	31/08/2023	

Scarborough ATAIN Action Plan Q1 23/34 continued

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
4	To ensure all staff are compliant in CTG Mandatory Training	Rachel McCormack (Fetal Monitoring Lead), Miss Ghsoh (Obstetric Fetal Monitoring Lead York), and Miss Jordan (Obstetric Fetal Monitoring Lead Scarborough)		Q2 review identified 2 cases where fresh eyes had not been completed in a timely manner	4.1	Weekly review of staff training compliance	Karen Hind (Maternity Admin Coordinator)	31/08/2023	
					4.2	Managing staff non-compliance	Midwifery and Neonatal Managers and Matrons	31/08/2023	
					4.3	Monthly audit of Fresh Eyes compliance	Rachel McCormack (Fetal Monitoring Lead)	31/08/2023	
5	Improved Governance around ATAIN and 30+0 and 36+6 Admissions to the Neonatal Unit	Bev Waterhouse (Deputy Head of Midwifery) and Georgina Rowe (Deputy Programme Manager)		Monthly meetings arranged and cascaded to all leads	5.1	Develop a ToR. 05/07/23: Completed.			
					5.2	Agree ToR. 05/07/23: Completed.			
					5.3	Set up monthly meetings 05/07/23: Completed.			
					5.4	Develop an action and theme collection tool			

York ATAIN Action Plan Q4 22/23

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q4 - Carried Forward									
1	Improve compliance with Hypoglycaemia Policy	Hanna Harness (Inpatient Matron York)		In Q4, 1 infant was found to not have temperature recorded at time of glucose	1.1	Conduct audit on the hypoglycaemia guideline	Audit midwife/Infant feeding team	29/12/2023	
					1.2	Nominate ATAIN Champions	Hanna Harness (Inpatient Matron York) and Susie Kinseller (Inpatient Matron Scarborough)	31/08/2023	
					1.3	Ensure all infants who require a blood glucose measurement, have their temperature monitored through a monthly audit	Hanna Harness (Inpatient Matron York)	29/12/2023	
					1.4	Bev W to share existing ATAIN Training package template	Bev Waterhouse (Deputy Head of Midwifery)	05/07/2023	
					1.5	To develop an ATAIN Training package	Bev Waterhouse (Deputy Head of Midwifery)	31/08/2023	
					1.6	To develop a Temperature Management Flow Chart	Hanna Harness (Inpatient Matron York)	13/07/2023	
					1.7	Ratify the ATAIN Training package and Temperature Flow Chart at the ATAIN Monthly Review Group	ATAIN Panel	06/09/2023	
					1.8	Share training package and Temperature Management Flow Chart with Clinical Governance for sign-off	Bev Waterhouse (Deputy Head of Midwifery)	29/09/2023	
					1.9	Ensure both Clinical Governance meeting series are shared with the ATAIN Panel	Faye Blood (PA to Senior Management Team CG5)	28/07/2023	
					1.1	To add training package to Learning Hub and circulate to all staff including medical teams	Lois Bennett (Practice Development Midwife York) Cara Hayes (Practice Development Midwife Scarborough) and Kelly Ann-Dobbin (Practice Development Nurse)	29/12/2023	
					1.11	Display the Temperature Management Flow Chart in visible staff areas as promps	Hanna Harness (Inpatient Matron York)	31/07/2023	

York ATAIN Action Plan Q4 22/23 continued

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q4 - Carried Forward									
2	Improving thermoregulation immediately after birth	Hanna Harness (Inpatient Matron York)		in Q4, a trend of respiratory distress and hyperthermia was identified	2.1	Ensure staff are aware and trained to monitor and maintain the thermoregulation of a new-born.	Lois Bennett (Practice Development Midwife York) Cara Hayes (Practice Development Midwife Scarborough) and Kelly Ann-Dobbin (Practice Development Nurse)	13/07/2023	
					2.2	To ensure there is sufficient hot-cot capacity to meet demand by reviewing cases at the monthly ATAIN meeting	Rosie Pease (Labour Ward Manager Scarborough) and Carly Creasy (Labour Ward Manager York)	02/08/2023	
					2.3	To check babies temperature on arrival to elective bay and make sure flow chart (as mentioned above) followed	Debbie Sharp (Maternity Ward Manager York) and Debbie Hollingsworth (Maternity Ward Manager Scarborough)	13/07/2023	

York ATAIN Action Plan Q4 22/23 continued

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q4 - Carried Forward									
3	Improvement of Clinical Supervision	Jo Mannion (Care group Director)		In Q4, 1 infant was identified who required observation only	3.1	Identify area on Labour Ward York for Neonatal Care	Carly Creasy (Labour Ward Manager York)	13/07/2023	
					3.2	Neonatal teams to consider Workforce Model to support supernumerary status of staff to improve support on labour ward/G2.	Pam Toas (Neonatal Matron)	29/12/2023	
					3.3	Trust Neonatal Lead required	Jo Mannion (Care Group Director)	31/08/2023	
					3.4	Any cases identified with the ATAIN Panel will be identified to the neonatal lead for clinical supervision	Jo Mannion (Care Group Director)	28/07/2023	
4	Understand and agree governance process for recording Term Admissions	Sarah Gallagher (Governance and Safety Lead)		Governance process around term admissions to be standardised	3.1	Consideration to be given when delivering DoC where an admission has been deemed inappropriate	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	
					3.2	Review DATIX trigger list to clarify if term admission remains recommended practice	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	
					3.3	DATIX to be completed for any cases inappropriate	Sarah Gallagher (Governance and Safety Lead)	31/08/2023	

York ATAIN Action Plan Q1 23/34

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
Q4 - Carried Forward									
Q1									
1	Ensure all staff are trained and aware of the importance of Cord Gases	Lois Bennett (Practice Development Midwife York) and Cara Hayes (Practice Development Midwife Scarborough)		In Q1, a case was identified where cord gases would have aided assessment	1.1	Practice Development Midwives to develop a programme of training around the management of cord gases	Lois Bennett (Practice Development Midwife York) and Cara Hayes (Practice Development Midwife Scarborough)	29/09/2023	
					1.2	Delivery Cord Gases Management training to staff	Lois Bennett (Practice Development Midwife York) and Cara Hayes (Practice Development Midwife Scarborough)	29/12/2023	

Appendix 2.
York and Scarborough Transitional Care Action Plan Q4 22/23 and Q1 23/24

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
1	Improve co-location of TC and SCBU	Pam Toas, Bev Waterhouse, Donna Williams and Sal Katib		TC is in G2 making it hard for the Nurse in Charge to have oversight of both TC and SCBU	1.1	Ongoing discussions to move SCBU to G3. TC will be incorporated in the move to ensure they are co-located.	Pam Toas, Bev Waterhouse, Donna Williams and Sal Katib discussing with Estates	06/09/2023	In progress
					1.2	Estates are currently costing up location improvement prices	Sarah Kew	06/09/2023	In progress
					1.3	Update regarding scoping review of the relocation of SCBU and Rainbow Ward to Oak Ward in SGH	Sal Katib	06/09/2023	Not started
2	To have a registered staffing workforce of B4 and above in TC and SCBU	Sal Katib		B3 recruited but recognise the need for a B4 registrant. This results in B3 requiring supervision from the B5. If there is high acuity on SCBU the B5 staff are moved from TC to support which puts TC at risk of closing. This is inline with the esclation plan.	2.1	B3s are currently being offered the opportunity to become a Nursing Associate (2Y course). 2x staff are in cohort 1 (in progress, 1Y complete) 2x staff on cohort 2 (due to commence in Jan 24) Further work ongoing to understand how many more staff must be put through the course to understand staff B4 deficit.	Sal Katib, Gail Lindley, Jeanette Butterworth, Pam Toas and Kelly Dobbin	06/09/2023	In progress
					2.2	Further discussion with HR around Workforce model for B3/4.	Sal Katib	01/11/2023	Not started
					2.3	A full Workforce Review has taken place	Sal Katib	06/09/2023	Complete
					2.4	Recruitment of B4 following staffing review and skill mix as vacancies occur	Gail Lindley, Jeanette Butterworth, Pam Toas and Laura Banks	01/11/2023	In progress
					2.5	Monthly budget meetings to review staffing and budget. 2x B4 posts have been created and are going out to advert in August 23.	Gail Lindley and Jeanette Butterworth	31/08/2023	In progress

York and Scarborough Transitional Care Action Plan Q4 22/23 and Q1 23/24 continued

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
3	Appoint a Supernumery Nurse in Charge for every shift	Sal Katib		The Nurse in Charge is running TC, SCBU, has her own case load and is expected to attend deliveries which results in SCBU being left unsafe, no senior oversight of TC and deliveries being unattended	3.1	A full Workforce Review has taken place. Awaiting recommendations. Update required by August 23.	Sal Katib	31/08/2023	Not started
4	TC admission criteria to consider if mum is well enough to care for baby at time of admission	Hanna Harness and Susie Kinseller		Mum may not be fit enough to care for baby on TC at time of birth, resulting in separation of mother and baby	4.1	Review and update TC guideline to ensure there is clarity around eligibility of mothers condition.	Gail Lindley, Jeanette Butterworth, Kelly Dobbin, Hanna Harness, Susie Kinsella and Sunny Sundeep	06/09/2023	Not started
					4.2	Share updated TC guideline with Paeds and Maternity Governance	Gail Lindley, Jeanette Butterworth and Sunny Sundeep. Susie Kinsella and Hanna Harness	06/09/2023	Not started
					4.3	Educating midwives as to what TC offers	Kelly Dobbin, Cara Hayes and Lois Bennett	06/09/2023	Not started

York and Scarborough Teaching Hospitals NHS Foundation Trust

Transitional Care Q1 2023 Report

Introduction

Reducing admissions of babies born at 37 weeks gestation and over to neonatal units is an NHS Improvement priority. The neonatal transitional care pathway supports mothers to act as primary care givers for babies who have care requirements greater than those of normal newborn care, thereby removing the need for admission to the neonatal unit. For York and Scarborough Teaching Hospital Foundation Trust (YSTHFT) maternity services, the provision of transitional care is delivered by the neonatal team on the Special Care Baby Unit (SCBU).

Background

The maternity clinical negligence scheme for Trusts (CNST) aims to deliver consist, safe, effective maternity and neonatal care throughout the NHS. The purpose of this report is to demonstrate YSTHFT maternity and neonatal services compliance with the standards set out in Maternity Incentive Scheme year 5, Safety Action 3 for the delivery of transitional care services.

In year 5 Maternity Incentive Scheme introduced the collection and recording of secondary data to inform future capacity management for late preterm babies who could potentially be cared for in a Transitional Care setting. This data captures babies between 34+0 – 36+6 weeks gestation at birth, who were neither transferred or had surgery during admission, and to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

Review Systems

All admissions to transitional care are audited and reviewed to ensure compliance against the agreed transitional care pathway. Any learning identified from this process is categorised into themes and shared with the wider team through our 'Safety Briefing'. To improve the robustness of our review process, we are developing a multidisciplinary approach to monitor findings and ensure shared learning through the nursing and medical teams.

No formal Transitional Care facilities at the Scarborough site. This is currently being reviewed in terms of location and staff in terms of being able to support.

Findings

There was a total of 3 babies admitted to transitional care in York in Q1. 17 babies went to transitional care following a SCBU admission.
There was a total of 2 babies on a transitional care pathway in Scarborough in Q1.

Themes and learning

A full refresh of the auditable standards in relation to transitional care are currently being reviewed which will include reason for admission into transitional care, length of stay and will provide some rich data which will be shared in the next report. This will also demonstrate the required need to enhance the services on the Scarborough site.

5 babies were not admitted to the neonatal unit, keeping mum and baby together.

Action Plan

No.	Recommendation	Lead	Embedded/ Delivered	Current position	Action No.	Further Action required	Action Owner	Target date	RAG
1	Improve co-location of TC and SCBU	Pam Toas, Bev Waterhouse, Donna Williams and Sal Katib		TC is in G2 making it hard for the Nurse in Charge to have oversight of both TC and SCBU	1.1	Ongoing discussions to move SCBU to G3. TC will be incorporated in the move to ensure they are co-located.	Pam Toas, Bev Waterhouse, Donna Williams and Sal Katib discussing with Estates	06/09/2023	In progress
					1.2	Estates are currently costing up location improvement prices	Sarah Kew	06/09/2023	In progress
					1.3	Update regarding scoping review of the relocation of SCBU and Rainbow Ward to Oak Ward in SGH	Sal Katib	06/09/2023	Not started
2	To have a registered staffing workforce of B4 and above in TC and SCBU	Sal Katib		B3 recruited but recognise the need for a B4 registrant. This results in B3 requiring supervision from the B5. If there is high acuity on SCBU the B5 staff are moved from TC to support which puts TC at risk of closing. This is inline with the esclation plan.	2.1	B3s are currently being offered the opportunity to become a Nursing Associate (2Y course). 2x staff are in cohort 1 (in progress, 1Y complete) 2x staff on cohort 2 (due to commence in Jan 24) Further work ongoing to understand how many more staff must be put through the course to understand staff B4 deficit.	Sal Katib, Gail Lindley, Jeanette Butterworth, Pam Toas and Kelly Dobbin	06/09/2023	In progress
					2.2	Further discussion with HR around Workforce model for B3/4.	Sal Katib	01/11/2023	Not started
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No.	**Recommendation**	**Lead**	**Embedded/ Delivered**	**Current position**	**Action No.**	**Further Action required**	**Action Owner**	**Target date**	**RAG**
3	Appoint a Supernumery Nurse in Charge for every shift	Sal Katib		The Nurse in Charge is running TC, SCBU, has her own case load and is expected to attend deliveries which results in SCBU being left unsafe, no senior oversight of TC and deliveries being unattended	3.1	A full Workforce Review has taken place. Awaiting recommendations. Update required by August 23.	Sal Katib	31/08/2023	Not started
4	TC admission criteria to consider if mum is well enough to care for baby at time of admission	Hanna Harness and Susie Kinseller		Mum may not be fit enough to care for baby on TC at time of birth, resulting in separation of mother and baby	4.1	Review and update TC guideline to ensure there is clarity around eligibility of mothers condition.	Gail Lindley, Jeanette Butterworth, Kelly Dobbin, Hanna Harness, Susie Kinsella and Sunny Sundeep	06/09/2023	Not started
					4.2	Share updated TC guideline with Paeds and Maternity Governance	Gail Lindley, Jeanette Butterworth and Sunny Sundeep. Susie Kinsella and Hanna Harness	06/09/2023	Not started
					4.3	Educating midwives as to what TC offers	Kelly Dobbin, Cara Hayes and Lois Bennett	06/09/2023	Not started

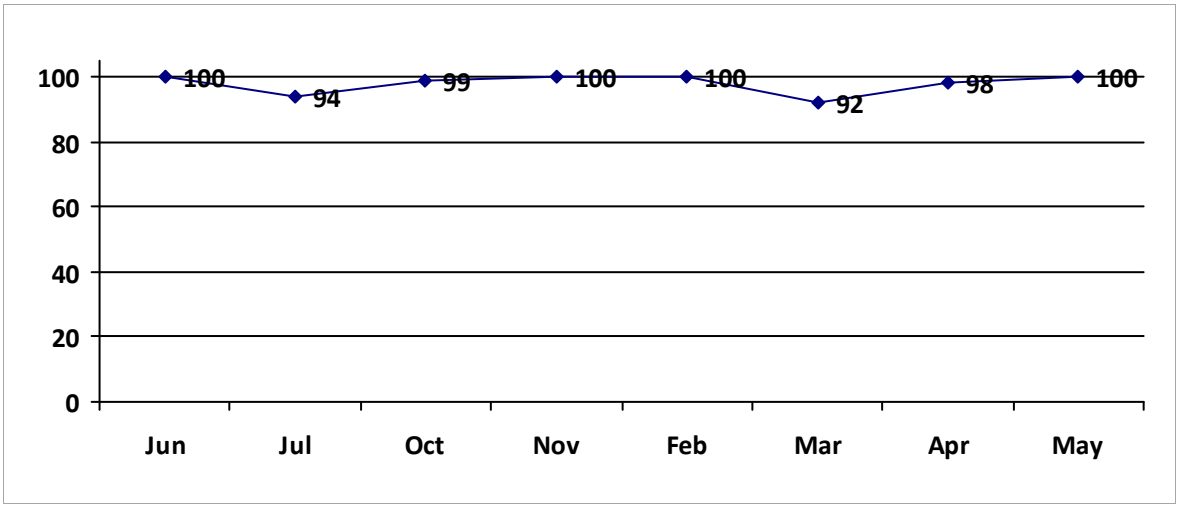
Friends and Family Test Results
G2 May 2023

We aim to give each inpatient a comment card (or send each patient a txt message).

Overall, how was your experience of our service?

100 % of patients rated their experience as Very Good or Good.

Percentage Very Good or Good for this ward by month:



This month, there were 3 responses.

Percentage of patients treated with kindness always or sometimes: 70

Patient Comments

The table below shows what patients said about this ward:

Rating	Comments
1. Very good	From induction to discharge, the staff were incredible. I couldn't have wished for better.
2. Good	Majority of care was great just some areas let it down
2. Good	Midwives and nurses were really helpful and friendly, but overworked, so when asked for pain medication, it came hours later.

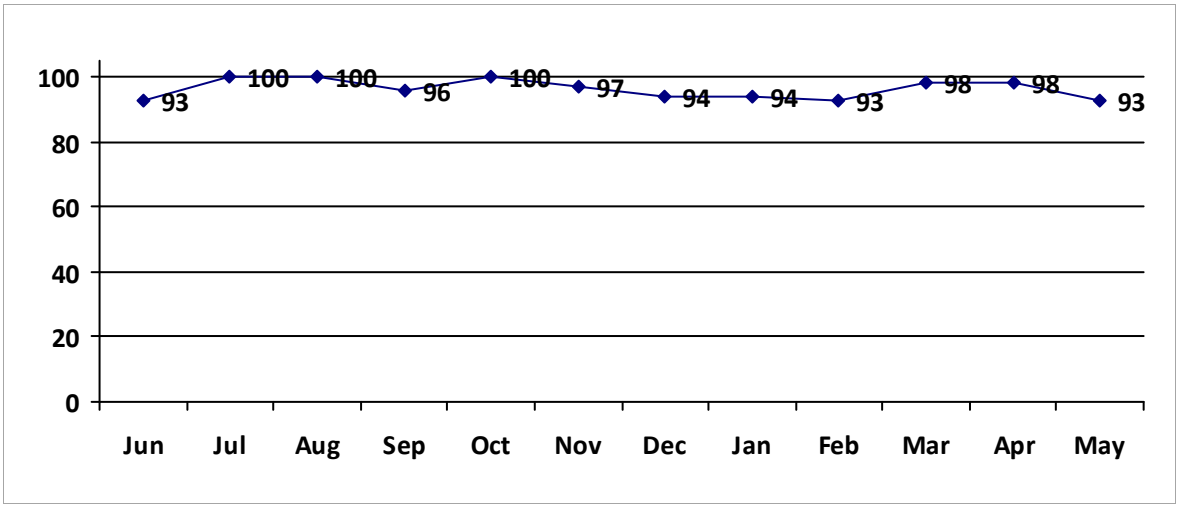
Friends and Family Test Results
Labour Ward Scarborough May 2023

We aim to give each inpatient a comment card (or send each patient a txt message).

Overall, how was your experience of our service?

93 % of patients rated their experience as Very Good or Good.

Percentage Very Good or Good for this ward by month:



This month, there were 100 responses.

Percentage of patients treated with kindness always or sometimes: 95.58

Patient Comments

The table below shows what patients said about this ward:

Rating	Comments
1. Very good	My section was brilliant from start to finish. I would especially like to mention [name removed] who was there for me and [name removed] every step of the way! Thank you!
1. Very good	Everyone is so caring and can't help you enough.
1. Very good	The team were very supportive of me. Particularly as it was a very stressful time for me. Couldn't be more grateful for the whole team!
1. Very good	Midwives were brilliant and caring.
1. Very good	Again - the staff were amazing. [Names removed] were so helpful in keeping me calm and I felt we were so well looked after. I couldn't have done it without [name removed]. She was amazing.
1. Very good	I wasn't the best behaved with being so anxious but they treated me well and kept calming me down. Nothing bad to say, couldn't thank them enough.
1. Very good	Very helpful, fast, encouraging, supportive team. Great doctors. Very caring.
1. Very good	Really reassuring. Helpful.
1. Very good	A massive thank you to [names removed], my amazing midwives. You both were so amazing and gave me the birth I really wanted, felt so happy and supported throughout and after, can't thank you both enough. Also a thank you to [name removed] for all the support.
1. Very good	Staff could not have been more helpful and caring. Very good experience.
1. Very good	The most amazing care and support throughout the hardest physical challenge of my life. Couldn't be happier with my experience!
1. Very good	All staff and nurses were very kind, helpful and professional.
1. Very good	Support was amazing. Maybe more fans.
1. Very good	Kind, friendly.
1. Very good	[Names removed] were outstanding from start to finish. As was every member of staff who assisted them.
1. Very good	Friendly, helpful and very supportive.
1. Very good	Fantastic staff and care before and after birth.
1. Very good	The midwives are incredible. [unreadable comment]
1. Very good	All the midwives and doctors were amazing!
1. Very good	Everybody was helpful and kind.
1. Very good	Staff very kind and made you feel as comfortable as possible. Very supportive.

1. Very good	Everyone was lovely and made the whole process very special. The elective section was fantastic.
1. Very good	Everyone was super lovely and friendly.
1. Very good	Staff lovely and attentive.
1. Very good	Couldn't fault a single thing. Our circumstances are so sad and I've been treated with such compassion during the whole labour and afterwards. I couldn't have asked for a better experience bringing my beautiful daughter into the world. I am beyond grateful.
1. Very good	Great labour experience, superb and professional staff.
1. Very good	Everyone was amazing. I was made to feel so relaxed and comfortable.
1. Very good	Felt at home. Made to feel happy.
1. Very good	Everything was discussed and explained, all staff were kind, caring and encouraging. The students were excellent. A massive thank you to all.
1. Very good	Lovely staff, was taken well cared of.
1. Very good	Recommend all staff during my time on labour ward especially [names removed] midwives these were both here from start to finish of my c-section. Explained everything.
1. Very good	Calming at a distressing time. Lovely staff.
1. Very good	Service from all the staff fantastic.
1. Very good	Couldn't have asked for a better experience, my midwife was amazing throughout the whole labour.
1. Very good	Staff were brilliant, professional, kind and helpful. Deserve a pay rise!
1. Very good	Attentiveness of staff made my stay/birth brilliant with baby.
1. Very good	Best team of confident professionals. I've been treated so well by both doctors and midwives that I never doubted any of their decisions. Highly experienced professionals so devoted to their duties. You all always treated so well with so much patience and nice manners. Operation team was very superb. Appreciate all team effort and thanks for safely delivering my baby.
1. Very good	Quick response when baby was distressed during labour. Kept me calm after when needed.
1. Very good	Overall lovely midwives. I loved all mine.
1. Very good	Everyone introduced themselves and made me feel calm and at ease. Made my c-section experience a great one - thank you.
1. Very good	Friendly. Caring.
1. Very good	The level of care we received for our newborn daughter was exceptional. Kind, courteous and compassionate. Staff made our experience special. We will be forever grateful to Scarborough Hospital. Support from midwives throughout was first rate.
1. Very good	Amazing, [name removed] was an absolute superstar and I wouldn't have got through labour without her, so encouraging and reassuring. We were so impressed. Thank you.

1. Very good	All staff made our birth experience so much easier and always treated us with kindness. We were amazed with the level of care and work they put into our stay. We couldn't thank them all enough for everything they did for us and we will never forget that.
1. Very good	Caring, informative, supportive and helpful, even though really busy.
1. Very good	They were very friendly and patient with me. Looked after me very well.
1. Very good	The staff gave exceptional care. They were very polite and encouraging.
1. Very good	Lovely staff, very helpful and supportive.
1. Very good	Level of care from start to finish was exceptional.
1. Very good	Staff were excellent. Very calm, and they coached me through the process of labour.
1. Very good	I felt very supported, and like I could talk or ask for help at any time and someone would be there instantly.
1. Very good	Staff very helpful in explaining best 'method' for pushing during labour. Great stamina - shouting out words of encouragement. Kind and approachable throughout.
1. Very good	Really quick response and reassuring during emergency. All staff friendly and went above for aftercare. It was lovely for us to have our midwife [name removed] for the birth.
1. Very good	All midwives were very caring - handled us with care. Very excellent service.
1. Very good	Reacted straight away to events. Provided constant reassurance and explained procedures thoroughly and explained why they were doing so at that particular time. Midwives and staff were great.
1. Very good	Support! Absolutely fantastic. Lizzie you're amazing. Thank you.
1. Very good	Everyone involved in my care was lovely, professional and caring.
1. Very good	Care was amazing and the response was quick.
1. Very good	I had a prolonged stay on Delivery Suite (Room 3). I found the staff extremely friendly and attentive. They literally couldn't do enough for me and my baby.
1. Very good	All amazing.
1. Very good	The ward from which I can remember was very clean and tidy. The staff were lovely. The room however was stifling at one point it reached over 28 degrees April. But we coped.
1. Very good	[name removed] was amazing yesterday delivering my baby and throughout the whole process.
1. Very good	Looked after really well. Everyone very kind and caring!
1. Very good	My midwife made my labour enjoyable.
1. Very good	Staff are friendly and caring. They are very knowledgeable about everything.

1. Very good	The whole team could not have been anymore helpful, informative and friendly the whole time. Even though they were visibly understaffed they were there when I needed anything, helping to make the whole experience a lot better than it could have been.
1. Very good	Amazing care from start to finish, thank you for following my birth plan and giving me advice and encouragement when I needed it to help everything go smoothly. You're all amazing!
1. Very good	Labour Ward was a very supportive experience, however in Hawthorne I felt the care was lacking, and the wait after ringing for help could be a very long wait.
1. Very good	Made me feel very reassured during my c-section.
1. Very good	Brilliant care for myself, partner and baby once arrived.
1. Very good	[name removed] was really attentive but also good with the tough love which was needed to get me through. Everything was well explained and she clearly knew what she was talking about and was very thorough with everything. She was there when I arrived at midnight then on again to take me through labour at 8 pm. In between I was looked after well while [unreadable comment].
2. Good	Overall experience good, maybe a little more support/info during labour but it was very quick so maybe not enough time!
2. Good	Epidural could have been earlier but all staff helpful.
2. Good	Very supportive student during labour on my own. Very calm and encouraging.
2. Good	I was very happy with the care I got from [name removed] (daytime staff) but when [name removed] came on I found myself getting stressed as she wasn't listening to how I felt and didn't find her much help. The people who did my section were very helpful and kind.
2. Good	All of the staff are very polite and took care of us well, just the time issue as everyone was busy so we kind of got overlooked.
2. Good	Lovely staff, shame they're so understaffed/overworked. Things could have been explained better.
2. Good	Always had a smile even when stressed and showed good care towards patients.
3. Neither good nor poor	Bad: [names removed] and a couple others made me feel scared, like I was failing and extremely helpful. I was often made to feel like the lowest priority and fobbed off or just a check list. They did not listen and made me feel like I wasn't doing anything right. Throughout my experience I did not feel like I was given options and the options presented were fear mongering and not explained fully and considerately. I'd ask to be seen or to talk to someone or would be told I'd be attended to in x hours or in a certain amount of time and I'd see the team doing nothing and be left for long periods.

3. Neither good nor poor	Had good care from main midwife. However the beginning did not go well having a clip attached to my cervix and not the baby's head. Very stressful situation and painful, and not a lot of communication on what had happened and what they were going to do.
3. Neither good nor poor	The staff are all lovely. Just so rushed off their feet.
3. Neither good nor poor	Short staffed. Poor communication. Long delays. At times felt like inconvenience.

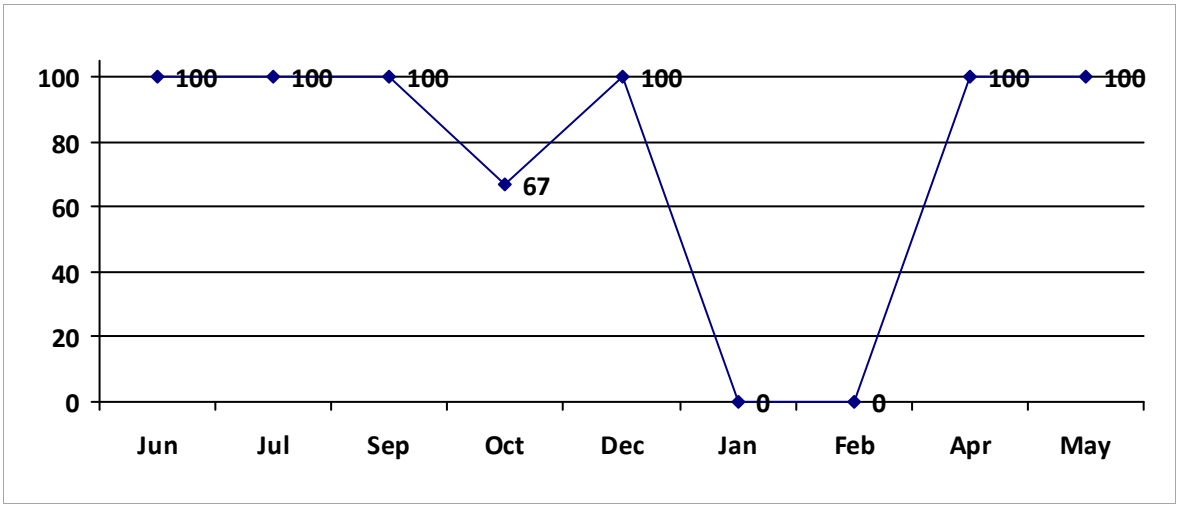
Friends and Family Test Results
Obstetrics YDH May 2023

We aim to give each inpatient a comment card (or send each patient a txt message).

Overall, how was your experience of our service?

100 % of patients rated their experience as Very Good or Good.

Percentage Very Good or Good for this ward by month:



This month, there were 2 responses.

Percentage of patients treated with kindness always or sometimes: 55

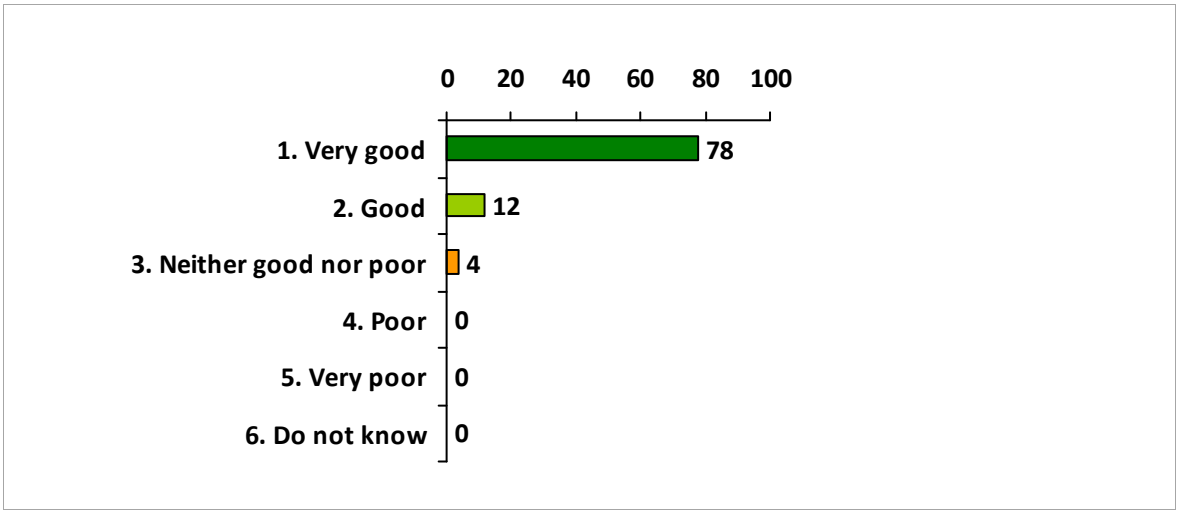
Patient Comments

The table below shows what patients said about this ward:

Friends and Family Test Results
Hawthorne Ward May 2023

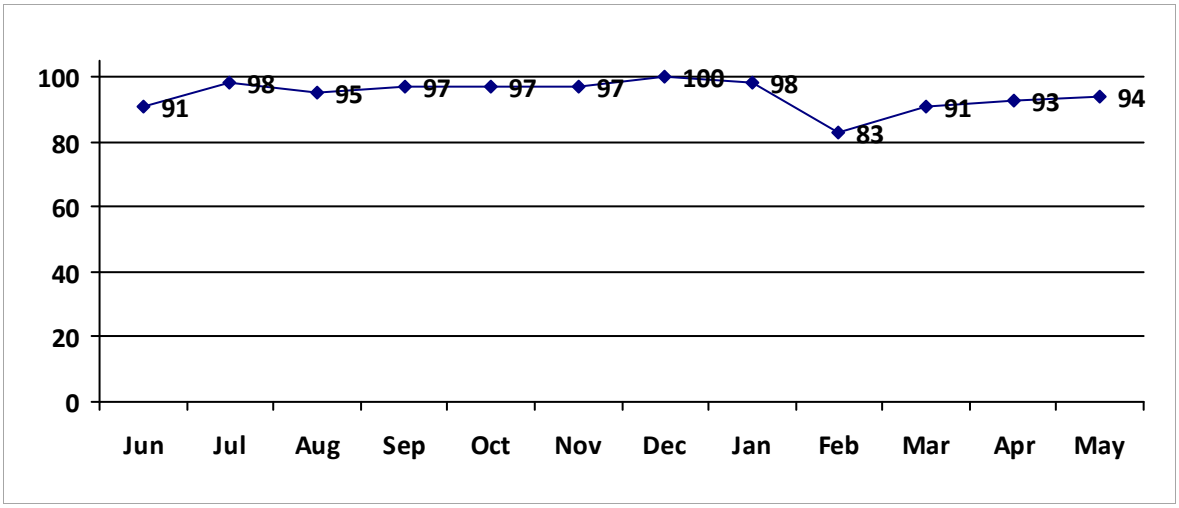
We aim to give each inpatient a comment card (or send each patient a txt message).

Overall, how was your experience of our service?



94 % of patients rated their experience as Very Good or Good.

Percentage Very Good or Good for this ward by month:



This month, there were 94 responses.

Percentage of patients treated with kindness always or sometimes: 95.20

Patient Comments

The table below shows what patients said about this ward:

Rating	Comments
1. Very good	Overall care fantastic. Only issue is the birthing partner situation. Only been able to possibly see them on visiting hours is ridiculous gives partners high anxiety which isn't great. Birthing partners should be able to stay.
1. Very good	The staff couldn't have been more helpful and caring. Very good experience.
1. Very good	Everyone, even though really busy and hardworking very friendly, helpful, just lovely. Thank you to them all for support and help.
1. Very good	[Name removed] was brilliant - so helpful. And [name removed] who helped me deliver was so lovely.
1. Very good	All staff were attentive and helpful when needed. Made the long stay more comfortable and easy.
1. Very good	All care amazing. Always help and advise when needed. A massive thank you to my midwives [names removed]. Couldn't have done it without you both. Also a big thank you to [name removed], gave me so much advice and support.
1. Very good	Really impressed by how attentive and friendly all the staff are and the amount of information given.
1. Very good	Staff always helpful and friendly. Made me feel at home. Very supportive. Staff did very well to care for everyone and quick as possible under staff issues.
1. Very good	[Name removed] - thank you for being so friendly and lovely!
1. Very good	Great support from everyone looking after me. Very thankful to have been under the care of such a brilliant team!
1. Very good	Staff supporting my wife in my absence. Thank you everyone!
1. Very good	The food!
1. Very good	The team were very helpful in all and more ways. Thank you.
1. Very good	Very helpful and considerate ward overall.
1. Very good	Very attentive and helpful staff, all lovely.
1. Very good	All staff were amazingly friendly and kind, and always willing to help.
1. Very good	Excellent, everyone was helpful, available and knowledgeable. [Name removed] went above and beyond to ensure I was happy and confident with breastfeeding/gave tips from experience.
1. Very good	Followed all my requests. Were really good. Just a bit busy and hectic sometimes.

1. Very good	Friendliness and helpfulness of all staff. I felt very safe and well looked after/cared for.
1. Very good	Very good, the support was so goo, from breastfeeding advice to other hints and tips. All staff responded to calls almost instantly, which was so nice.
1. Very good	Everything was explained well.
1. Very good	Thank you for everything.
1. Very good	All the staff are lovely, very helpful. Can't be faulted at all.
1. Very good	Incredibly kind and personalized care. Very sensitive to our circumstances. Just a beautiful experience. So grateful, thank you!
1. Very good	Everybody was helpful, kind and very understanding.
1. Very good	Excellent standard of care, dedicated staff.
1. Very good	Staff and nurses was exceptional. Very helpful and caring.
1. Very good	Very friendly and accommodating. Nothing was an issue to anyone, no matter how busy. Thank you.
1. Very good	What can I say - my whole experience here has been amazing! Thank you for everything over the last 4 weeks. The care I have received has been incredible. I feel very lucky to have been in your care - thank you!
1. Very good	Midwives very friendly and assertive. Also really supportive.
1. Very good	All staff friendly, explained everything and answered call bells within seconds.
1. Very good	Service from all staff fantastic.
1. Very good	Super lovely and friendly.
1. Very good	Amazing staff, super supportive.
1. Very good	All staff lovely and friendly, felt very relaxed.
1. Very good	Always friendly. Really helpful.
1. Very good	Everyone friendly and put you at ease.
1. Very good	Amazing team of professionals. So loyal to their job and doing so much extra work. It is very impressive. Amazing bedside manners, best treatments. They are all so kind and nice you never feel forgotten even if there is lack of resources you don't feel it as everything is on time. This is my best hospital experience in my life. Will never find enough words to express my appreciation.
1. Very good	Very understandable. Friendly. Caring.
1. Very good	All staff so helpful with me and baby. Everyone was lovely!
1. Very good	Level of care from start to finish was exceptional. The aftercare during day and night was very reassuring for a first time mum.
1. Very good	Everyone on Hawthorne Ward have been so lovely and helpful!
1. Very good	Staff were friendly and helpful on the ward.

1. Very good	Great support for any questions and breastfeeding. Everyone was non-judgemental so I felt I could ask anything I needed to, especially as a first time mum.
1. Very good	All very nice, very welcomed and looked after. Great advice - detail.
1. Very good	All the staff are incredible, especially to say it's very busy, all the midwives are so lovely and supportive. My experience was a very good one, nothing to be improved but could do with more staff, they all work so hard to be there for everyone.
1. Very good	Always answered questions, listened to my concerns. Very friendly and caring. Sensitive to my feelings. Happy and funny.
1. Very good	Staff were lovely, caring and attentive, even under very busy times. The ward was always kept very clean and tidy.
1. Very good	Everyone has been very helpful and kind and professional.
1. Very good	Staff all extremely helpful and supportive. They were happy to help with everything.
1. Very good	All staff very friendly and approachable. Available for help or advice at any time required. Felt listened to and treated with kindness and respect at all times.
1. Very good	Amazing care, felt very well looked after and supported, and feel well prepared to go home. Thank you for the great experience and looking after me and baby!
1. Very good	Everyone was approachable, friendly and very helpful. We were made to feel comfortable and supported.
1. Very good	Lovely staff members.
1. Very good	I was informed on what was going on at all times. I was helped when in pain the midwives helped me to the best they could.
1. Very good	Every time I needed someone they'd come quickly. Staff all lovely and friendly. All my questions were answered.
1. Very good	HCA went above to support on first few days after c-section for both baby and myself. Midwives all really helpful and supportive.
1. Very good	Staff were amazing and listened to me always.
1. Very good	Everyone has been wonderful on here. It's such a beautiful team of people and they help and care I have received has been amazing!
1. Very good	The ward was busy but the staff were very attentive and [unreadable comment].
1. Very good	The most wonderful staff who couldn't be kinder day or night. [Name removed] in particular during the nights gave so many helpful tips, she was invaluable.
1. Very good	Kind, caring and supportive midwives. Couldn't ask for more.
1. Very good	All the ladies on the ward are amazing. Made you feel comfortable and relax and if help is needed they are more than happy to assist.

1. Very good	Very helpful. Very supportive. Always around. Great knowledge about babies and care.
2. Good	Night team were brilliant, helped me with breastfeeding, helped me with cluster feeding and encouraging her to sleep so that I could - checked pain regularly and were helpful with everything. Day staff also super helpful and lovely but so busy forgot multiple times to return with pain meds - ended up in tears but generally fantastic and helpful in other ways. More staff needed.
2. Good	The aftercare was really helpful and the service was reassuring.
2. Good	[Name removed] the Anaesthetist was super chatty and made me feel at ease.
2. Good	Midwives all did a fab job looking after us through our speedy delivery and also being COVID+. Couldn't fault any of them.
2. Good	I am pleased with the care I got from midwives on Hawthorne apart from one woman who I found quite rude. Felt like I couldn't ask for help as when I did she'd always say she's busy and felt like she was being [unreadable comment] with me. [Name removed] was lovely, so kind and would always help me.
2. Good	Treated kindly.
2. Good	Everyone made me feel very welcome during my stay, and would always make sure I understood what was happening.
2. Good	Very kind and helped a lot with everything, just the timing was not great.
2. Good	The staff were very attentive even though they were short staffed.
2. Good	Was often left in the dark for plans, hence why my stay was so long.
2. Good	Theatre team were amazing at keeping me calm in a scary situation. Very helpful staff after my c-section.
3. Neither good nor poor	Good. There were some midwives that were attentive and supportive and understanding of not only my preferences and wishes but of my concerns and helped facilitate my comfort and my aims. There were some midwives who made me feel [unreadable comment] and cared for and empowered. [Name removed] from York, [name removed] and another midwife from York, who was just working a shift for cover. All really made me feel seen and heard and helped.
3. Neither good nor poor	Night staff were lovely. Some staff throughout the day were rude and not very understanding. Personally felt neglected and not cared for during my induction.
3. Neither good nor poor	Staff were really nice and polite. Although they left me with bad contractions after me explaining to them I couldn't handle them.
3. Neither good nor poor	Short staffed. Ward dated and bathroom unclean.

Report to:	Board of Directors
Date of Meeting:	26 July 2023
Subject:	CQC Section 31 Update
Director Sponsor:	Dawn Parkes - Interim 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 (S31) of the Health and Social Care Act 2008 to impose conditions on the Trust registration in respect of maternity and midwifery services. This Trust updates the CQC monthly on the 23rd of the month with progress against the S31.

Recommendation:

The Board of Directors are asked to receive and approve the July S31 submission to the CQC.

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.

The Service is progressing the training of midwives on the 'Maternal Aims and PROMPT Care of the Critically Ill Pregnant or Postpartum Woman' course. Two training days have been facilitated at York, on the 28th of March and 4th July 2023 with a total of twenty-two attendees who all passed the course. A training day is planned for the 18th of July at Scarborough with ten midwives booked onto the training.

A.2 Fetal Monitoring and CTG

A.2.1 CTG Machines

There have been no reported incidents of CTG shortages on any of the wards or reported incidents where there has been a delayed CTG undertaken because of lack of availability of CTG machines in June 2023. The status is reviewed daily at handover and the Labour Ward Coordinators have been reminded to complete this section daily on the handover sheet and the Antenatal, Postnatal and Triage areas are developing a process of review.

York Hospital Area	No of CTG Machines (SOP Requirement)	Actual (10 July 2023)
Labour Ward	10	11
Triage	3	4
G2	6	4
Antenatal Day Unit	2	2
In repair		2
Floating	2	

Scarborough Hospital Area	No of CTG Machines (SOP Requirement)	Actual (10 July 2023)
Labour Ward	11	11
Hawthorn Ward	4	4
Antenatal Day Unit	2	2
Floating	0	0

The CTG machines are moved around the unit's dependant on acuity, the number of CTG monitors in each area is recorded on the production boards in each ward area for oversight of the ward managers and labelled to support oversight of location.

A.2.2 CTG Training

The Director of Midwifery has contacted the LMNS regarding the situation with training at the Trust in the absence of the Fetal Monitoring Lead and Harrogate have offered support in joining their fetal monitoring training days in July and August. The Medical Fetal Monitoring Lead at this Trust is able to facilitate the two planned training days in July, in York on the 19th of July and Scarborough on the 13th of July with the support of the Practice Development and Clinical Skills Midwives and there are plans in sending staff to join Harrogate for their training in August.

Harrogate have not yet implemented the updated nice guidance as wished to understand how this would link into the implementation of BadgerNet. The Director of Midwifery will discuss with the Associate Director of Midwifery at Harrogate to understand if there are any difference to training that could pose a risk when practising to the York and Scarborough Fetal Monitoring Guideline.

The Trust Fetal Monitoring Guideline has been updated to reflect national guidance and shared for comments and will be ratified at a virtual Extraordinary Specialty Governance by the end of July. The new national guidance has been incorporated in the training sessions since January 2023, and has been promoted by posters in ward areas, social media posts and fetal monitoring boards in the handover areas,

A rolling year action tracker is in development where both elements of the fetal monitoring training to include face to face training and the competency assessment will be included with a sign off for the competency assessment completed on the same day of training. This will provide assurance of monthly training figures and will be monitored at the Labour Ward Forum,

Following reviews of fetal monitoring training figures there has been a focused approach through May and June and during the week of the 26th of June support was provided to clinicians and midwives who had undertaken face to face training but were not compliant with their fetal monitoring assessment to complete. There were daily updates provided to the Clinical Director and Director of Midwifery and staff were informed that if at the end of the five-day period of monitoring they were still not compliant they would be unable to practise until compliance received.

Current Fetal Monitoring compliance figures by site at the end of June are outlined below.

	York	Scarborough
Midwives	92%	86%
Consultants	71%	100%
Obstetric medical staff	82%	91%

Staff that are due for fetal monitoring updates have been booked onto one of the training days in July and the projections for training compliance on the 31st of July are outlined below.

	York	Scarborough
Midwives	96%	97%
Consultants	100%	100%
Obstetric medical staff	100%	100%

A guideline is in development to sit alongside the training needs analysis that will outline responsibilities for training for both management and employee with a clear pathway if a member of staff is not able to attend training to ensure clear oversight of compliance across the Department.

A.2.3 Fresh Eyes Audit

In the November CQC inspection eleven patient records were reviewed and 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's was not in line with NICE guidelines.

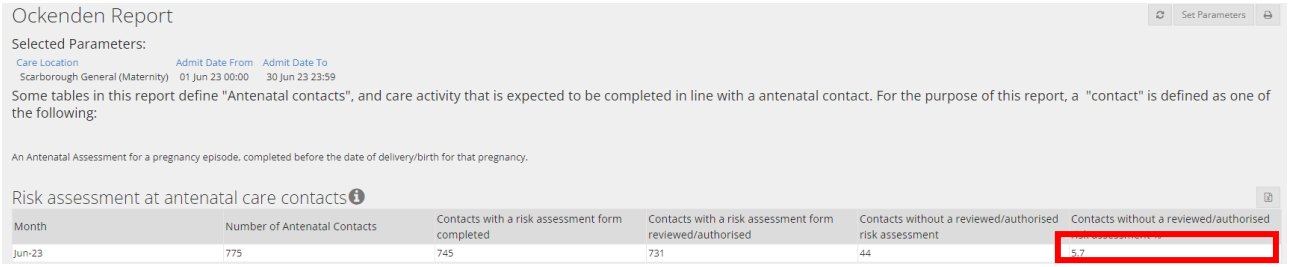
Ward Managers are reviewing fresh eyes on a weekly basis and reviewing via their production boards. A process for reviewing data has been developed with our new digital lead, as it is recognised that the reporting / data entry on Badgernet is not yet robust enough. Transition to Badgernet in May 2023 has necessitated a change in the way we audit and review our compliance with Fresh Eyes. The BadgerNet lead is working with all team staff to ensure all CTGs are reviewed as peer intrapartum reviews, which will enable audit. Average compliance is 75.8% with completed Intrapartum Peer review on Badgernet. There is evidence of CTG reviews being completed but assigned as "antenatal review " on Badgernet which skews compliance data as these reviews do not save as an intrapartum peer review. The digital lead and managers are working with staff to educate importance of correct assignment of review.

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.

All antenatal risk assessments are recorded on BadgerNet.

As the user works through the contact, the system uses prompts and mandated boxes to ask the user to complete the relevant risk assessments, a care plan is then produced on the left-hand side that can be added to the patient records.



Ockenden Report

Set Parameters

Selected Parameters:

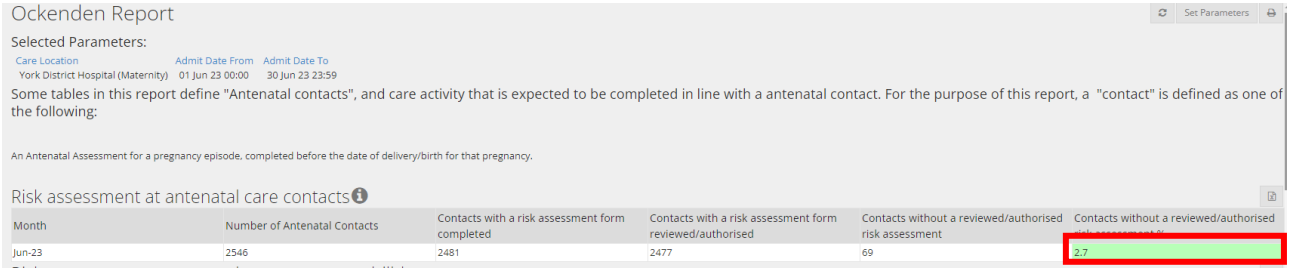
Care Location	Admit Date From	Admit Date To
Scarborough General (Maternity)	01 Jun 23 00:00	30 Jun 23 23:59

Some tables in this report define "Antenatal contacts", and care activity that is expected to be completed in line with a antenatal contact. For the purpose of this report, a "contact" is defined as one of the following:

An Antenatal Assessment for a pregnancy episode, completed before the date of delivery/birth for that pregnancy.

Risk assessment at antenatal care contacts

Month	Number of Antenatal Contacts	Contacts with a risk assessment form completed	Contacts with a risk assessment form reviewed/authorised	Contacts without a reviewed/authorised risk assessment	Contacts without a reviewed/authorised
Jun-23	775	745	731	44	5.7



Ockenden Report

Set Parameters

Selected Parameters:

Care Location	Admit Date From	Admit Date To
York District Hospital (Maternity)	01 Jun 23 00:00	30 Jun 23 23:59

Some tables in this report define "Antenatal contacts", and care activity that is expected to be completed in line with a antenatal contact. For the purpose of this report, a "contact" is defined as one of the following:

An Antenatal Assessment for a pregnancy episode, completed before the date of delivery/birth for that pregnancy.

Risk assessment at antenatal care contacts

Month	Number of Antenatal Contacts	Contacts with a risk assessment form completed	Contacts with a risk assessment form reviewed/authorised	Contacts without a reviewed/authorised risk assessment	Contacts without a reviewed/authorised
Jun-23	2546	2481	2477	69	2.7

The data shows for May was that 10.3% of risk assessments were not completed at Scarborough and 3.9% were not completed at York. In June, the compliance has improved to 2.7% at York and 5.7% at Scarborough where risk assessments were not completed. There is ongoing support provided to the clinical teams by the BadgerNet project team and the digital midwives to provide support and improve compliance.

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 and the SOP has been updated by the Maternal Medicine Lead with a plan for ratification in July's Clinical Governance meeting. The SoP was discussed in the July meeting but not all attendees had managed to review, this will be reviewed virtually in August as there is no Specialty Clinical Governance Meeting and shared in the September Report.

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 Local Maternity and Neonatal System (LMNS) Perinatal Quality, Safety and Assurance Group meeting on 25 April 2023. A system wide approach to addressing the safety recommendations has been undertaken with an initial meeting to discuss the recommendations was held on 30 June 2023. This meeting was attended by representation from across the LMNS, further development of the action plan will continue in July 2023.

The Trust Consultant Obstetrician alongside the Maternity Improvement Advisor have been approached to undertake an audit of the categorisation of caesarean section which had been planned for June and will proceed in July when they are on site. There have been no concerns raised from any internal or external reviews of care about the categorisation of caesarean section.

A.4 Assessment and Triage

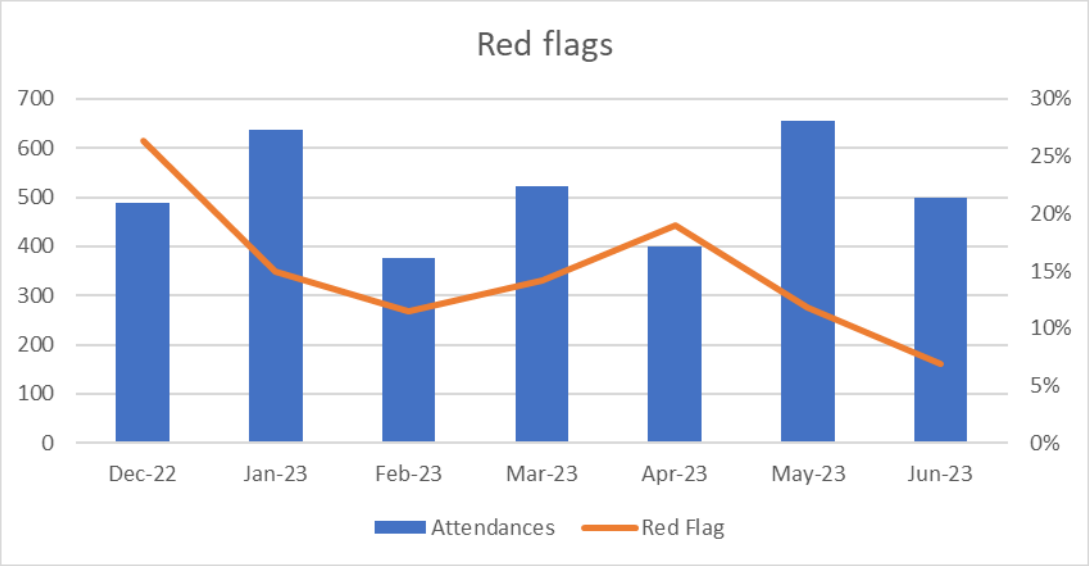
On the 12 May 2023, the Birmingham Symptom Specific Obstetric Triage System (BSOTS) Triage system went live at York Hospital and from 3 July 2023 at Scarborough. The triage system is part of the Badgernet software, the system facilitates the prioritisation of women based on needs.

The Maternity Triage Unit Manager undertakes a weekly audit to measure the effectiveness of the BSOTS system on the clinical review times and waiting times of women attending the unit.

The results for June show that on average 95% of women received a rapid review with 94% within 15 minutes.

Triage Rapid Review	05/06/23	12/06/23	19/06/23	26/06/23
Number of women admitted to triage	143	127	128	140
Number of women receiving rapid review in triage	137	115	123	134
% women where rapid review complete	95.80%	90.50%	96%	96%
Rapid review complete <=15 minutes	86.8% (119)	100% (115)	95.1% (117)	91.7% (123)
Women receiving rapid review (within 15mins) as a % of all women receiving review.	86.70%	90.50%	91.40%	87.80%

The introduction of BSOTS in January 2023 is demonstrating a steady reduction in the number of red flags reported which are outlined in the NICE safe midwifery staffing for maternity settings (2015). These will continue to be monitored as a key safety metric for our service in demonstrating safe staffing.



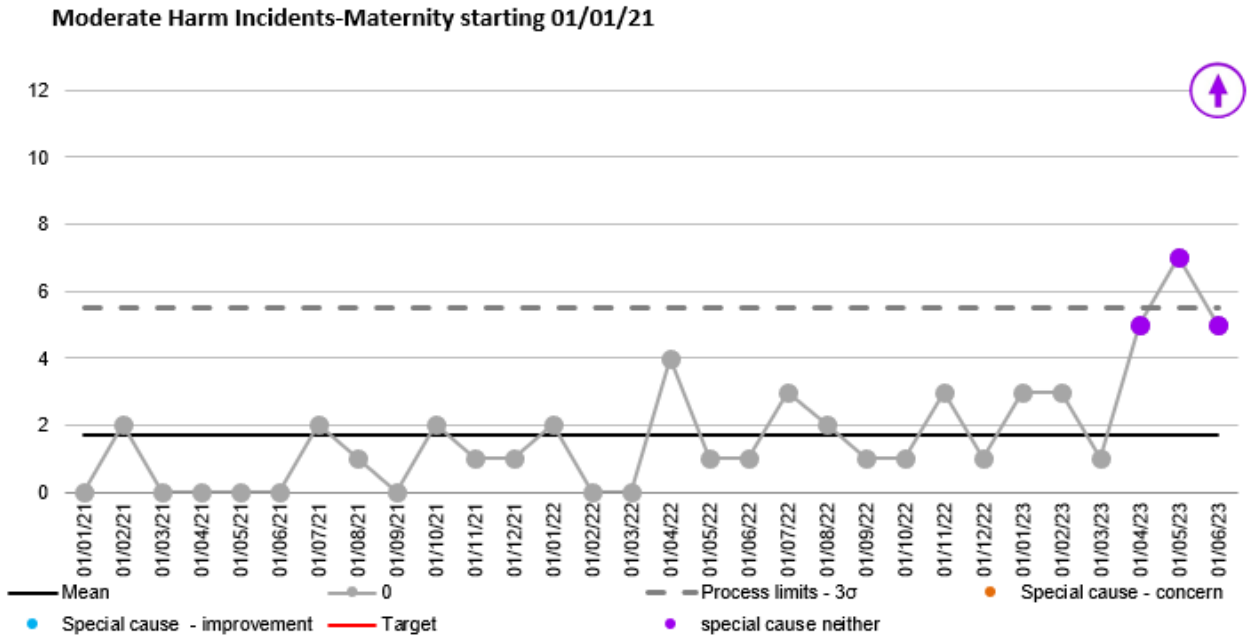
B. Governance and Oversight of Maternity Services

B.1 Post-Partum Haemorrhage

B.2 Incident Reporting

Moderate harm incidents are discussed weekly with the Triumvirate by the Quality and Governance Lead and are shared with the Trust Board as part of the Maternity and Neonatal Quality Report. The moderate harms reported for June are outlined below.

Datix Number	Incident Category	Outcome/Learning/Actions
WEB186402	3.3l blood loss	PSIR completed and awaiting review
WEB186712	Missed antenatal appointment.	PSIR completed and awaiting review
WEB186077	Unexpected admission to SCBU	To be reviewed at ATAIN meeting
WEB185839	Missed Fragmin administration	PSIR completed and awaiting review
WEB186521	Postnatal readmission requiring ITU	Joint investigation with ED
WEB187032	Delay in histology receiving placentas	PSIR completed and awaiting review
WEB186950	Delivery at 23+3 weeks gestation	To be reviewed at ATAIN meeting



The Department has support from the MIA's to accurately review and grade incidents and ongoing review of incidents and assurance from MIA's that these are robust.
Increased reporting figures is a positive and reflective of an open culture and incidents are reported on Datix. PPH < 1.5l are reviewed by the PPH Scrutiny Panel.

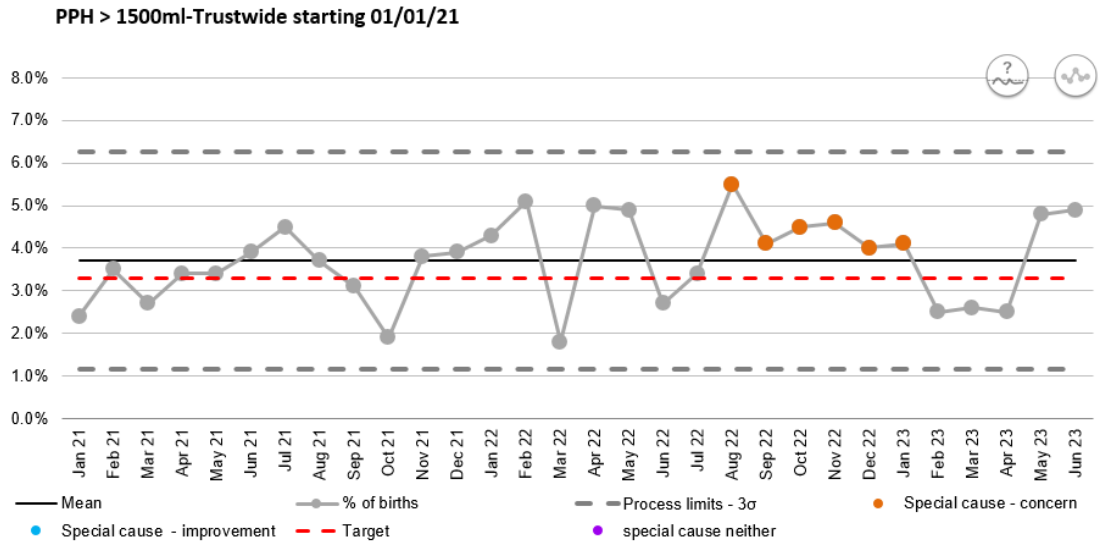
B.1.1 PPH Data

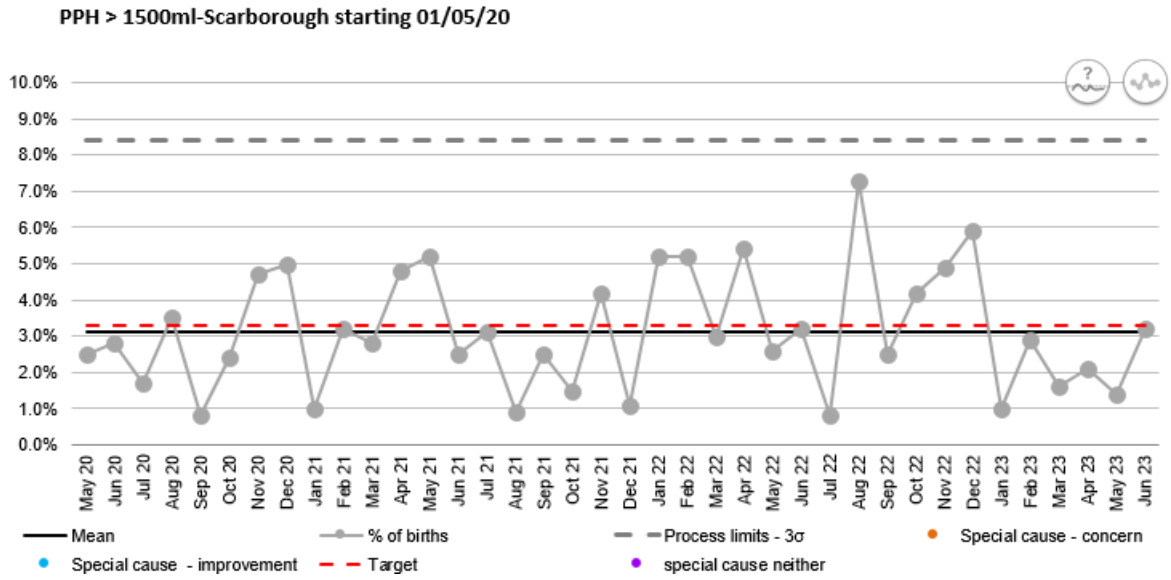
PPH over 1.5 litres

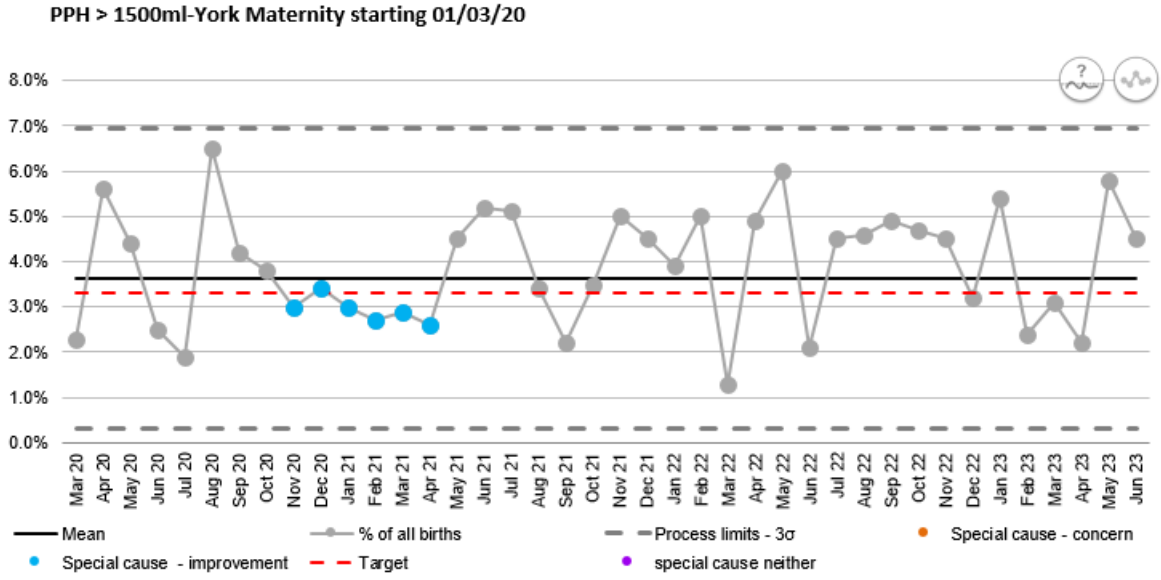
There were 12 incidents of PPH > 1500ml reported as having the potential for moderate harm in June 2023. This is a reduction from May 2023 where there were fourteen incidents identified following data quality review.

Blood Loss	Number in June 2023
1.5l – 1.9l	9 (range 1.5l – 1.8l)
2l – 2.4l	2 (range 2l – 2.2l)
> 2.5l	1 (range 3l – 3.08l)

A cluster review was undertaken in June by the Obstetric MIA regarding 14 cases reported in May and initial findings indicated there was no one identified cause for this increase in relation to PPH >1500 ml.







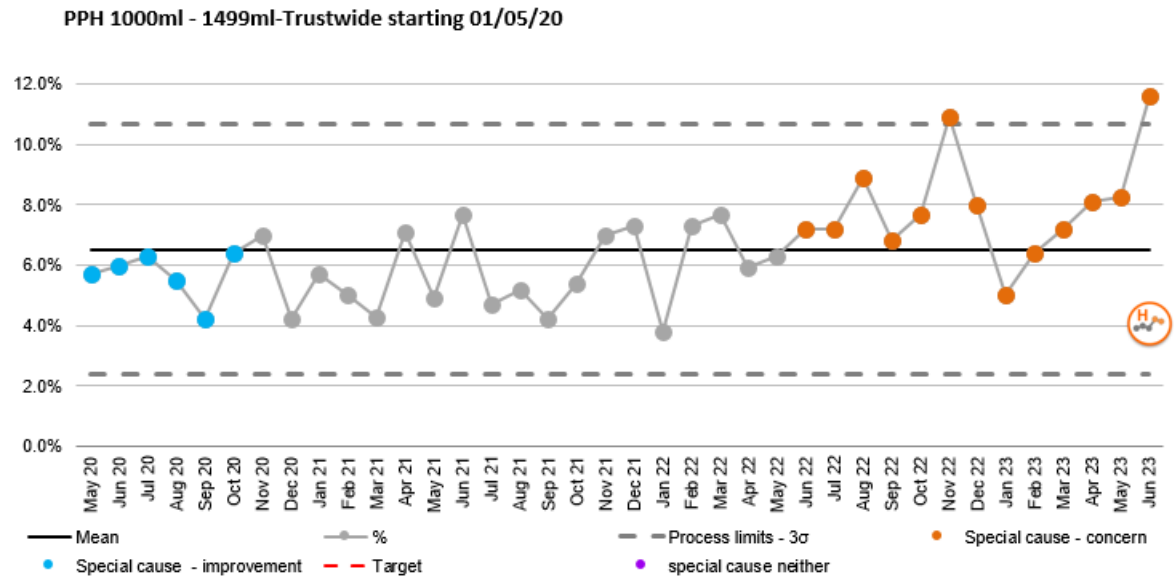
PPH Below 1500ml

All PPH under 1500ml are reviewed by the cross site PPH Scrutiny Panel and the monthly snapshot audit overseen by the panel. Weighing scales were introduced into delivery rooms following a previous snapshot audit to accurately weigh blood loss, the clinical teams report that whilst these are useful, they do not consider they have made a difference in accurately assessing blood loss.

The snapshot audit in May 2023 identified that the PPH proforma had not been used in all of the ten cases audited at York and in one of the seven cases audited in Scarborough, this was highlighted on the weekly safety brief dated the 12th of June and the importance to be reaffirmed through PROMPT training. Feedback from staff is that the introduction of BadgerNet has caused some confusion about how and where the proforma should be stored and completed, the safety brief explained the use of the paper proforma was acceptable which can be scanned to BadgerNet. A cross site audit was undertaken in June where this use of the proforma was to be reaudited and will be discussed at the July Panel. The date for the July panel meeting has been delayed due to a clash with the Speciality Clinical Governance meeting and the junior doctor and consultant strikes. A date will be arranged for later in the month. Due to capacity and staffing challenges the audit has not been fully completed. Audit results will be provided in August 2023.

The service is planning to trial new lithotomy drapes with pockets that measure ongoing blood loss as the panel have identified that following audit and case review that there is a delay in identifying blood loss due to collecting behind the green drapes or on the sheets behind the woman. The drapes, expected in June now have a delivery date the week of the 10th of July and will record the blood loss accurately with the sticker changing to red when the blood loss reaches 500mls, this is demonstrated in the attached photograph.

The panel have also identified that increased blood loss can be as a result of the suturing skills and confidence of the midwife and can lead to delays in closing the perineum with an associated increased blood loss, this is more prevalent at the Scarborough site. There has been an absence of a Practice Development Midwife at Scarborough but now recruited and in post and a Clinical Skills Midwife has been recruited and waiting to be released from their current position. They have a keen interest in teaching perineal suturing and attending a one-day training course in London run by Peri health and will be planning a structured training programme for the midwives when in post. In York training sessions have commenced , all newly qualified midwives and international midwives working on labour ward attended a workshop on the 12th of June. In addition, workshops were held on the 31st of January with thirteen midwives attending and, on the 16th, May with four midwives attending, more workshops will be planned.



There has been an increase in the number of PPH rate between 1000ml and 1499ml, this is monitored through the PPH Scrutiny Panel.

Modified Early Obstetric Warning Score (MEOWS) Compliance:

The CQC identified occasions where the MEOWS was not completed in line with Trust policy. Prior to the introduction of BadgerNet, MEOWS was calculated and recorded on paper records and compliance was monitored via the Business Intelligence platform Signal. BadgerNet does not allow monitoring of MEOWS completion in the same way as CPD and Signal, in that it does not provide a retrospective data set of observations not completed in time. The service has approached CleverMed who have advised the software is unable to provide like for like data for assurance. The service will be working with the Digital and Information Team and met in June to build a report that will allow for retrospective audit, this has proved complex and while it may be possible to produce this, there is no current date when this will happen.

Each ward manager completes a daily MEOWS audit of two records to provide assurance of compliance in recognising women who may have a deteriorating condition. MEOWS compliance is shared with all staff on the Ward Production Boards, newly implemented from the 26th of June to encourage improved and sustained compliance and is encouraging conversations and discussions between the teams. The Digital Midwife, with MEOWS as one of their key priorities oversees training compliance of the staff and the admin teams

and recruitment and retention midwives will oversee new starters to ensure they receive training. The Digital Midwife is looking to provide a log in to Badgernet for all agency and locum staff which will support the completion of MEOWS. In addition, all Labour Ward Coordinators (LWC) will become local administrators of Badgernet once they have completed the Caldicott forms, currently 50% of LWC can perform this across site. Local administrators can then in addition create accounts for all staff including agency and locums. A SOP will be developed to ensure the process is standardised to be ratified in September.

Three out of the five clinical areas achieved over 90% compliance with MEOWs completion in June and ongoing plans to improve / maintain performance is highlighted below.

- Ward mangers share and monitor weekly position with teams via production boards.
- Any learning from non-compliance is shared with the teams or individuals.
- Ongoing work with Business Intelligence team to resolve reporting deficits.
- Tables being built within data warehouse.
- Digital lead midwife recruited – MEOWs reporting one of key priorities.

Area	June 2023 (target 90%)
Labour Ward York	91%
G2 York	100%
Triage York	87.2%
Labour Ward SGH	92%
Hawthorn SGH	81.1%

B.3 Management of Risks

B.3.1 Fire Safety and Security

B.3.1.2 Project Updates York

- The video intercoms are in place and are working.
- The upgrade of the X tag baby security system will be undertaken from 12/7/23 to 21/7/23 before full testing, staff training and refresh of security SOP and business continuity plans before going live in the first week of August (current target date 31/7/23)
- Maternity Theatres Refurbishment **–** the works schedule for the Theatre refurbishment is agreed and final costings from the contractor will be confirmed by 14/7/23 to inform the ITT to go out on a framework to tender by the 31/7/23 with a 4-week tender period. Scoring and awarding will be undertaken in the first week in September. The planning for the decant of maternity theatres can progress once a start date for all work has been confirmed with the successful contractor.
- Nurse Call Replacement – the new system is now in place on G2 as of 10/7/23. The wireless system has been transferred to G3 and the work to install the permanent system on G3 has commenced with contractors on site in the week commencing 17/7/23.

- Security support – there continues to be the provision of 24/7 security guard cover in the maternity G2/G3 reception area to support security of the unit while the system work continues.

B.3.1.3 Project Updates Scarborough

Upgrade to the system has been planned aligned to the York upgrade programme of protective security. The new fire doors have been placed in the corridor between the delivery suite and Hawthorn Ward in June and this now supports the work progressing on the full security upgrade in line with York. Final programme costs and timelines are to be confirmed further to a full site inspection by the swipe access contractor and Baby X tag contractor teams together. A date for this is to be confirmed by the 17/7/23. These doors are no longer used as a throughway for staff or families unless clinically appropriate.

Any issue with security or estates are escalated at the daily bronze meetings with the Trust estates and facilities programme lead for maternity in attendance.

- The video intercoms are in place and are working.
- Maternity Theatres Refurbishment – final arrangements to be agreed, plan to be then agreed for delivery of works by August 2023.
- Nurse Call Replacement – Ongoing works in G2, progressing slowly due to access (which is being managed in live area) and new components being manufactured. Works expected to be completed by August 2023

The senior midwifery team continue to work with the Corporate Team in looking to improve the Tendable audit tool to support maternity specific issues, this includes baby tags and the location of CTG monitors, there is no update for this report.

B.3.2 Scrub and Recovery Roles

The ability to identify shift fill rates for scrub practitioners was escalated to the Director of Workforce and a separate roster is being built to identify these shifts, this is planned for July and will enable better oversight of shift vacancy and will be overseen by the Maternity Theatre Manager.

The Director of Midwifery has discussed with the Labour Ward Managers and asked that all shifts are sent to bank at the time of creation of the rosters, this is now being actioned and will provide a more transparent overview of fill rate. There is a discussion at the daily staffing huddle re the availability of a scrub midwife per shift in the absence of a dedicated scrub practitioner.

There are up to three available scrub shifts on each site per day (early, late, night).
In June 2023, 68% of advertised scrub shifts were filled at Scarborough and 51% at York.

Care Group 3 also now offer scrub shifts in addition to the midwives. In Scarborough 7 shifts were offered with an uptake of three. In York 18 shifts were offered with an uptake of six. The reason only a few shifts are offered is because the majority of theatre staff have never been to the maternity theatres and by offering shifts during elective lists, those who are interested in doing over time but do not have the experience, have the opportunity to have exposure and learn how to scrub in maternity under “controlled” circumstances, where if anything happens, they will have the right support. For the first three months these shifts are offered, so staff have the chance to learn with the appropriate support. After three months there will be a plan to offer Tuesday and Thursdays to build up confidence when support is available, following this period weekend shifts will be offered

and then finally night shifts. This provides a robust mechanism to ensure the right people are in the right place and appropriate support is available.

The phased training plan is continuing through June and July 2023.

In June 2023 one whole time equivalent scrub practitioner was appointed to both York and Scarborough Theatre Teams which in turn will support maternity theatres following induction and training. There is a current advert for a band six for York and Scarborough, two posts each site which will support the fill rate in maternity theatres.

Report to:	Board of Directors
Date of Meeting:	26 July 2023
Subject:	Guardian of Safe Working Hours 2023-2024 Q1 report
Director Sponsor:	Dr Karen Stone
Author:	Dr Ruwani Rupesinghe

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

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

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

Summary of Report and Key Points to highlight:

Despite a successful recruitment drive there is evidence showing persistent challenges with staffing levels across general and elderly medicine (York). This is impacting working hours including access to rest breaks and leave. Trainees also report difficulty in meeting their portfolio requirements all of which is negatively impacting morale.

Significant progress has been made in creating a pathway of escalation for leave requests and establishing timescales in which they should be managed.

We are unable to guarantee provision of emergency rest facilities to doctors at the end of a night shift, which is a contractual requirement. It is a consequence of check-in times for Travelodge, with the earliest being midday. The item has been escalated.

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

No ☒ Yes ☐

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

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

Board report: Guardian of Safe Working Hours 2023-2024 Q1 report

1. Introduction and background

This is the 2023/2024 Q1 report to the Board from the Guardian of Safe Working Hours (GoSWH) as required by the 2016 terms and conditions for doctors and dentists in training. The quarterly report is for 1st April 2023 to 30th June 2023 and summarises key findings from the Junior Doctor Forum (JDF), Exception Reporting and Agency/Bank shift data.

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

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

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

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

2. Current position/issues

2.1 *Guardian funds*

Six Guardian fines were levied in Q1.

- In April 2023, 2 fines were levied against Care Group 3 for a Dental Core Trainee placement in ENT at York Hospital. The doctor worked a 16-hour shift against a maximum shift length of 13 hours. It meant the trainee did not achieve the minimum 11 hours rest before their next shift causing a further breach of 3 hours. Immediate TOIL was not given as the doctor did not report this until 6 days after the event. The total Guardian fine for these joint breaches was £715.50. This was split as per the TCS as follows: £268.32 to the trainee and £447.18 to the Guardian.

A very detailed review was carried out by the doctor's educational supervisor. The doctor needed to remain in theatre and assist with a complex two-team operation. A plan has been put in place to ensure juniors get adequate rest between shifts if a similar situation is to arise, although this is felt to be unlikely.

- In May 2023, 2 fines were levied against Care Group 3 for a FY1 Doctor working in Anaesthetics but doing a weekend urology shift at York Hospital. The doctor worked a 14.5-hour shift and much like the aforementioned breach, did not achieve the minimum 11 hours rest between shifts. Immediate TOIL was not given as the doctor did not report this until 2 days after the event. The total Guardian fine for these joint breaches was £225.96. This was split as per the TCS as follows: £84.71 to the trainee and £141.26 to the Guardian.

  In May 2023, 1 fine was levied against Care Group 3 for a FY1 Doctor working in Anaesthetics but doing a weekend urology shift at York Hospital. The doctor worked a 14.5-hour shift meaning a breach of 1.5 hours in total. The total Guardian fine for this breach was £130.62. This was split as per the TCS as follows: £48.96 to the trainee and £81.66 to the Guardian.

  Despite several reminders and offers of extra support these reports were not reviewed by the doctor's supervisor. It is unclear whether the excess hours stem from doctors working outside of their usual area out-of-hours or a lack of sufficient staff despite the increase (as stated in the report) or indeed a combination of both.

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

  The junior made it very clear in their report that the shift was unusually busy and despite everyone pitching in there was a delay in being able to commence handover. It does not appear that any further action is required.

The current balance from fines received is £1,433.02. However, £700.00 has been ringfenced as below.

Guardian funds levied from fines

Detail	**+/-**	**Balance**
Opening balance on 1 April 2023		**£856.24**
(+) Guardian fines	+£683.71	£1,539.95
(-) JDF meeting catering	*-£96.93*	*£1,433.02*
Closing balance on 31 March 2023		**£1,433.02**

Ringfenced funds	**+/-**	**Available Balance**
Games console for York Doctors' Mess	*-£500.00*	*£943.02*
Parasol for area outside York Doctors' Mess	*-£100.00*	*£843.02*
Catering for JDF meetings	*-£100.00*	*£743.02*
Available funds at 31 March 2023		**£743.02**

2.2 *Exception reporting trends*

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

The GMC *State of medical education and practice in the UK: workplace experiences 2023* report highlights that 70% of respondents worked beyond their rostered hours on a weekly basis with 68% having difficulty taking breaks. Extrapolating those figures, we should receive significantly more exception reports than we do. We are constantly encouraging doctors to submit exception reports and rising numbers should be viewed in a positive manner. 67 reports were received in this quarter compared to 51 in Q4 22/23.

Whilst the trend of most reports coming from Foundation Year 1 doctors continues there was a mild upturn in submissions for other grades. It is important that all our doctors, irrespective of department and grade, feel safe to utilise the system. Their needs, challenges, insight and suggestions for improvement will differ. As such this is also a positive change which will hopefully be sustained.

The majority of reports were received from Care Groups 1 and 3, 21 (31%) and 23 (34%) respectively. This corresponds with the previous quarter.

In Care Group 1 all but 5 originated from general and elderly medical wards. They often cite low staffing as a reason/major contributing factor. The reports from the Emergency Department in contrast mention clinical need such as making urgent referrals and breaking bad news.

In Care Group 3 there is greater variation with most originating from Urology (York). The written content does not point towards a singular reason, with doctors citing episodes of low staffing (per roster), unplanned sickness and days of high workload with good staffing. As detailed in the 22/23 Q4 report the department implemented a variety of actions to improve the situation. A further increase in staffing has been arranged from August 2023 changeover onwards. It remains an area of heightened interest.

In 22/23 Q4, 49% of exception reports were reviewed within 7 days; we expected the implementation of automatic reminders to improve this figure. A newsletter with individualised covering letter was sent to all supervisors emphasising their role in the exception reporting pathway and seeking their assistance in meeting the timescale. Despite these interventions only 51% met the target in this quarter, a much smaller rise than anticipated. The junior doctor strikes may have contributed with consultants needing to cover acute and unplanned care on top of their usual administrative, and in some cases clinical, duties.

2.3 *Summary of rota gaps and locum usage*

Internal locums (bank) are managed via the Patchwork application and external locum (agency) shifts are through Medacs. Data for Q1 is included in Appendices 2 and 3.

Most locum shifts – for all grades of doctor including consultant – were requested due to staff vacancies (2,906 bank, 4,305 agency).

2,152 shifts went unfilled (1,708 bank, 444 agency) contributing the low staffing levels.

2.4 *Junior Doctors' Forum (JDF)*

The agenda and discussion topics at JDF are led by junior doctors. Meetings are cross-site with the option of joining in person or virtually. As we approach the end of this academic year for many of our juniors, it is important to maintain and grow attendance by having representatives. It has been recommended that recruitment into the roles occurs at induction for maximal uptake. Positive outcomes from JDF will be shared in the Guardian's induction session and the option for hand-written and electronic sign-up will be trialled at the GoSWH stall at this year's main July/August changeover. The presence of an information stall proved useful for engagement at the smaller February changeover. Plans are in place to ensure visibility on both Scarborough and York site across the changeover period.

2.4.1 Management of leave requests and queries from doctors

This item was discussed at length in the 22/23 Q4 report. Junior doctors continue to report delays in leave - getting a response to their request and a high volume of them being declined due to staffing levels. Members of the Forum worked together to draft a simple pathway. It includes guidance for the deployment team on escalating situations whereby they cannot approve leave due to minimal staffing levels. It also lays out time frames in which doctors can expect to receive a response at each stage. The presence of a Trust standard will allow the process to be audited. The pathway has been circulated for comment and consultation prior to final approval.

2.4.2 Workplace based assessments

Postgraduate doctors in training are expected to complete several assessments to pass their annual review of performance and to progress. They need regular contact and support from senior colleagues, the ability to attend specialist clinics and time to complete non-clinical activities. Doctors inform us they are finding it incredibly difficult to access some of these learning opportunities; increased workload and low staffing mean they cannot leave ward areas. Similarly, senior clinicians are stretched and find it difficult to make time for their trainees. I expect to see a steady rise in educational reports if we do not find ways to turn the tide. The Medical Education Team is working closely with postgraduate trainees via their recently introduced Junior Education Forum to address these issues.

3. Review of Junior Doctor staffing – General, Elderly and Acute Medicine (York)

This piece of work is closely linked to items 2.4.1 and 2.4.2.

The Medical Deployment Team circulates a summary of staffing levels for the week ahead in General and Elderly Medicine (York). It includes minimum staffing levels for each area – a number established by clinicians utilising RCP guidance on patient numbers and acuity.

An initial review of the data demonstrated that despite a lot of hard work going into a successful campaign of recruitment last summer most shifts run at, or below, minimum staffing levels. Feedback via the JDF is that they are exhausted because of constantly working at maximum capacity and leave requests being declined. Similarly, poor staffing means they are unable to leave the wards to access Self-Development Time and other core learning objectives. It may be beneficial for the organisation to complete a full review of this data in the context of medical workforce planning and operations across the Trust.

4. Emergency rest facilities

The contract states doctors should be provided with a place to rest if they feel too tired to drive after a long/late/night shift. Alternatively, the Trust should arrange safe transportation home and back for their next shift or to collect their vehicle.

Despite a review of the pathway within the last two years a further failed attempt at accessing emergency rest facilities was escalated to the Guardian.

The Estates and Facilities Manager has liaised with the Travelodge Contract Manager. Unfortunately, they are unable to provide a room before midday (early check-in). This poses a bigger challenge in York as the hospital does not own any accommodation. However, there does not appear to be an accessible, robust pathway to manage the recently renovated on call rooms in Scarborough. The accommodation team is not available on weekends and bank holidays which leaves a gap in being able to access a room 365 days/year. This matter has been raised with the Director of Workforce and Medical Director as other attempts to resolve the matter have been exhausted.

5. Summary

Despite a successful recruitment drive there is evidence showing persistent challenges with staffing levels across general and elderly medicine (York). This is impacting working hours including access to rest breaks and leave. Trainees also report difficulty in meeting their portfolio requirements all of which is negatively impacting morale.

Significant progress has been made in establishing a pathway of escalation for leave requests that cannot be immediately approved by the medical deployment team.

We are unable to guarantee provision of emergency rest facilities to doctors at the end of a night shift. This primarily affects, but is by no means limited to, the York site. It is a consequence of check-in times for the Trust's current agreement with Travelodge, with midday being the earliest. The relevant teams have been advised to offer doctors the late check in and arrange transport home if they decline.

Date: 18 July 2023

Appendix 1: Exception reporting data for 2023-2024 (Q1)

Table 1: Exception reports by department			
Care Group/ department	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions open**
CG1			
Cardiology	4	0	4
Elderly/rehab medicine	9	9	0
Emergency Medicine	5	5	0
Gastroenterology	2	2	0
Renal Medicine	1	1	0
CG2			
Acute Internal Medicine	3	3	0
Diabetes and Endocrinology	2	2	0
Gastroenterology	1	1	0
CG3			
Anaesthetics	4	2	2
General Surgery	3	3	0
Surgery: Colorectal	2	0	2
Surgery: Vascular	3	3	0
Oral & Maxillofacial Surgery	1	1	0
Urology	10	7	3
CG4			
CG5			
Obstetrics & Gynaecology	1	1	0
Paediatrics	8	6	2
CG6			
Trauma & Orthopaedics	8	8	0
Total	**67**	**54**	**13**

Table 2: Exception reports by grade				
Grade	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
F1	38	75%	42	63%
F2	5	10%	9	13%
CT1-2 / IM1-2/ ST1-2	6	12%	14	21%
IMT3/ ST3+	2	4%	2	3%
Total	**51**	**100%**	**67**	**100%**

Table 3: Exception reports by type				
Type	No. exceptions in **previous quarter**	Proportion of reports **previous quarter**	No. exceptions raised **this quarter**	Proportion of reports **this quarter**
Late finish	28	55%	48	72%
Late finish & early start	1	2%	0	0%
Missed breaks	3	6%	6	9%
Late finish and missed breaks	7	14%	3	4%
Difference in working pattern	3	6%	0	0%
Missed breaks & Difference in working pattern	1	2%	0	0%
Inadequate supervision	0	0%	2	3%
Inadequate clinical exposure	1	2%	0	0%
Inadequate supervision & unable to achieve breaks	0	0%	0	0%
Unable to attend scheduled teaching/training	3	6%	2	3%
Unable to attend scheduled teaching/training & late finish	0	0%	2	3%
Unable to attend clinic/theatre/session & late finish	0	0%	1	1%
Teaching cancelled	4	8%	1	1%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience	0	0%	1	1%
Difficulty completing workplace-based assessments (WPBAs) & Inadequate clinical exposure/experience & Inadequate supervision & Lack of feedback	0	0%	1	1%
Total	**51**	**100%**	**67**	**100%**

Table 4: Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY1	13	9	23	8
FY2	6	1	4	0
CT1-2/ST1-2	2	3	5	5
IMT3/ST3+	0	0	2	0
Total	**21**	**13**	**34**	**13**

51% addressed within 7 days (49% in previous quarter)

Appendix 2: Locum booking (bank) data

Table 5: Locum bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine SGH	218	161	2,228	1,568
Acute Medicine YH	911	439	9,297	4,336
Cardiology YH	9	1	42	7
Cellular Pathology (SHYPS Network)	11	11	55	55
Community In Patient Units	20	19	152	147
Community Rehabilitation - Selby	5	5	40	40
Elderly Frailty Unit RAFA ED YH	1	0	12	0
Elderly Medicine SGH	1	0	8	0
Elderly Medicine YH	104	79	1,025	808
Emergency Department SGH	577	368	5,788	3,723
Emergency Department YH	881	706	8,252	6,721
Endocrine YH	5	5	40	40
ENT YH	38	38	480	480
General Medicine SGH	850	443	7,924	4,162
General Medicine YH	132	70	1,320	664
General Surgery SGH	57	53	658	614
General Surgery YH Consultants	12	11	194	170
General Surgery YH Juniors	142	105	1,520	1,169
Home First Unit (HFU) SGH	334	269	3,218	2,705
Maxillo Facial YH	108	105	1,376	1,344
Obstetrics & Gynaecology SGH	117	110	1,324	1,256
Obstetrics & Gynaecology YH	147	112	1,467	1,090
Occupational Health YH	4	4	32	32
Oncology YH	33	16	234	115
Ophthalmology SGH	9	8	72	61
Ophthalmology YH	28	23	246	226
Orthodontic YH	3	0	29	0
Paediatrics SGH	211	190	2,548	2,364
Paediatrics YH	191	180	1,814	1,726
Radiology YH	19	19	80	80
Respiratory YH	72	70	671	651
Stroke/Rehab Senior YH/SGH	10	10	56	56
Theatres, Anaesthetics and Critical Care SGH Consultants	119	119	1,705	1,708
Theatres, Anaesthetics and Critical Care SGH Juniors	62	62	723	725
Theatres, Anaesthetics and Critical Care YH Consultants	3	3	50	50
Theatres, Anaesthetics and Critical Care YH Juniors	14	11	151	113
Trauma & Orthopaedics SGH	70	36	663	278
Trauma & Orthopaedics YH	186	145	1,804	1,422
Urology YH	6	6	72	72
Total	**5,720**	**4,012**	**57,364**	**40,777**

Table 6: Locum bookings (bank) by shift grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Anaesthetic ICU different base cover	39	39	659	659
Anaesthetic Juniors & SAS	67	67	778	780
Anaesthetics General different base 24 hr on-call gap	13	13	298	298
Anaesthetics General different base Mon-Fri on-call gap	19	19	245	246
Anaesthetics General same base Mon-Fri on-call gap	3	3	62	62
Anaesthetics ICU same base Mon-Fri on-call gap	2	2	29	29
Anaesthetics ST3+/Specialty Doctor/SAS	1	0	12	0
Consultant	331	317	2,610	2,496
Consultant WE/Bank Holiday/Discharge	160	148	1,806	1,735
CT/GPStR/ST1-2	2,451	1,822	23,955	18,117
FY1	241	100	2,345	1,039
FY2	754	188	7,446	1,803
On-call consultant	34	34	595	595
On-call ST1+/SD	50	41	582	481
ST3+	1,158	899	12,238	9,387
ST4+	351	278	3,388	2,766
T&O ST3+/Specialty Doctor/SAS	46	42	320	285
Total	**5,720**	**4,012**	**57,364**	**40,777**

Table 7: Locum bookings (bank) by reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Agency Locum Cancelled	13	12	141	130
Annual Leave	87	82	829	785
Bank Holiday	199	102	2,174	1,121
Bed Pressure	25	11	253	120
Compassionate Leave	9	7	114	89
COVID-19 (Additional demand)	6	0	36	0
COVID-19 (Staff sickness/isolation cover)	26	21	281	227
Extra Clinic	46	40	466	417
Extra Weekend Support	6	5	59	47
Induction	9	9	71	71
Industrial Action	157	60	1,767	655
Maternity Leave	10	5	120	65
On-call cover	128	122	1,668	1,626
Paternity Leave	3	3	29	29
Service Requirement	1,641	1,153	15,348	10,659
Sick Leave	392	250	3,759	2,363
Sickness - Long Term	35	23	377	239
Sickness - Short Term	12	8	125	79
Special Leave	10	9	95	86
Vacancy	2,906	2,090	29,654	21,972
Total	**5,720**	**4,012**	**57,364**	**40,777**

Appendix 3: Locum booking (agency) data

Table 8: Locum bookings (agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Accident & Emergency	484	429	3,898	3,437
Acute	137	137	1,105	1,105
Anaesthetics	0	0	0	0
Cardiology	7	0	61	0
Community Paediatrics	5	0	41	0
Dermatology	0	0	0	0
Ear Nose & Throat	130	130	1,056	1,056
Gastroenterology	41	0	349	0
General Medicine	1,450	1,364	11,672	10,954
General Surgery	478	473	3,860	3,819
Geriatric Medicine	150	150	1,216	1,216
Haematology	92	71	750	571
Hepatology	11	11	90	90
Histopathology	36	0	302	0
Obstetrics & Gynaecology	400	373	3,260	3,025
Oncology	133	133	1,064	1,064
Ophthalmology	0	0	0	0
Oral & Maxillofacial	166	160	1,334	1,285
Orthopaedics & Trauma	243	243	1,961	1,961
Paediatrics	4	1	38	13
Paediatrics & Neonates	791	691	6,394	5,548
Renal Medicine	41	0	343	0
Respiratory Medicine	6	0	56	0
Rheumatology	0	0	0	0
Stroke Medicine	150	145	1,210	1,169
Total	**4,955**	**4,511**	**40,059**	**36,312**

Table 9: Locum bookings (agency) by grade				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Consultant	2,670	2,467	25,574	19,828
Specialty Doctor	480	423	4,382	3,415
FY2	147	147	1,188	1,188
ST1-ST2	1,065	1,034	11,595	8,331
ST3+	593	440	6,019	3,550
Total	**4,955**	**4,511**	**48,757**	**36,312**

Table 10: Locum bookings (agency) by reason				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
<unspecified>	426	225	3,538	1,798
Annual Leave	0	0	0	0
COVID-19	0	0	0	0
Deanery Gap in Rota	0	0	0	0
Increased Capacity Need	8	8	64	64
Other	213	213	1,703	1,703
Sickness	0	0	0	0
Site Pressures	3	3	24	24
Staff Shortages	0	0	0	0
Target Provision	0	0	0	0
Vacant Post	4,305	4,062	34,730	32,723
Winter Pressures	0	0	0	0
Total	**4,955**	**4,511**	**40,059**	**36,312**

Minutes

Quality and Safety Assurance Committee
23 May 2023

Members in Attendance:

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

Attendees:

Sue Glendenning (SG), Louise Brown (LB), Amanda Pearson (AP), Ben Adekanmi) (BA) Sally Light (SL) – Public Governor for York and governor that observes this committee, David Thomas (DT) – Associate COO Medical Care Group, Scarborough, Jerry Robins (JR) – Care Group Director of the Medical Care Group, Scarborough

19-23/24 Apologies for Absence

There were no apologies.

20-23/24 Declaration of Interests

There were no declarations provided.

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

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

22-23/24 Matters arising from the minutes and outstanding actions

MT stated that the action to have a Board Assurance Framework workshop with the Board has been discussed with the new Interim Chair and will be planned for future.

KS noted that the action on outlier patient processes from care groups 1 and 2 remained to be concluded.

LB said that the committee has not met since the last nurses' strike and enquired what the impact was on safe care and waiting lists.

HM stated that all wards were covered but did not know about any impact on waiting lists. The majority of staff came in for their night shift some at midnight. Another strike is planned for about 4 weeks' time.

SH referred to outpatient utilisation data The concern was that the outpatient booking service didn't allow patients to be allocated to the correct clinic due to the practicalities of the system. This subject had been covered during the Data Quality Group and the outpatient booking

service does not have any standardisation as it is too complicated. Action to be closed in having been escalated to the Digital, Performance and Finance Committee.

23-23/24 Escalated Items

There were no escalated items.

24-23/24 Risk Management Report

MT presented the Risk Management Report involving the Corporate Risk Register (CRR) for May which has been through the Risk Committee at the start of the month. This contains the Care Group risks that are escalated to the CRR including an update of current mitigations in place.
Section 2 on the report listed specifically those risks that are under the responsibility of this committee ranging from IPC down to speech language therapy delays. A lot of work is ongoing with regards to the Care Groups. The Board papers contains a revised CRR format that is now more user-friendly.

MT confirmed that the 6 risks were the only risks on the CRR that are under the responsibility of the Quality Assurance Committee.

SH commented that there must be other risks that had a significant impact on quality or safety. MT said that it is for members to consider when looking through this if there were points that should be considered by this Committee.

JM commented that although the CQC report is currently in draft it would be good to triangulate the information with the CQC to ensure risks are not missing.

Action:

- **The risks of the CRR not assigned to the committee are to be delved into to measure the level of risk and feedback by the committee members at a future meeting**

25-23/24 Care Group 2 Assurance Report

Freya Oliver (FO) and Louise Brown (LB) joined from CG2 and JR and DT presented the report with a summary of the key risks and assurances. There was general discussion amongst members on CG2 activity with C-Difficile being a particular area of concern.FO commented that the C-Diff risk is high with15 cases which exceeds expected. Initiatives have not made any headway but a Rapid Improvement Programme with the IPC and Quality Improvement team to try and move forward is in place.

Violence and aggression incidents have resulted in 2 members of staff resigning with another 2 being injured.

It was noted in discussion that Care Groups have their own quality templates to report against which could be considered in future assurance reporting to the Committee. There was also a discussion around the sustainability of some specialised services on the Scarborough site. Cardiology and gastroenterology were specifically referenced

Action:

- **Escalate concerns to the Board the fragility of the service in SGH, i.e. cardiology, gastroenterology and IPC element.**

26-23/24 CQC Compliance Update Report

HM presented the report and highlighted discharge performance with both sites working together on the correct communication with care homes and families.

The review of the audit of the mental health assessment was underway

The dashboard was proving challenging. The Committee again discussed the fact that while a great deal of work had been completed, there were still areas where assurance of sustainable change needed to be stronger

27-23/24 Maternity Update Report

Amanda Pearson – National Maternity Improvement Advisor and Director of Midwifery presented the report. Amanda has been working alongside the York and Scarborough team with Sue, Sarah, Caroline and Heather for the last 4 weeks and hopes to streamline some of the systems and processes around the safety agenda within the organisation.

Perinatal Clinical Quality Surveillance Update

AP stated that she planned to develop the MEA Safety Report over the next few months so the committee have clearer sight of where the gaps are in assurance and the work that has been undertaken to provide the assurance.

SG explained that the paper that is currently known as the Perinatal Clinical Quality Surveillance Update but as of next month it will be referred to as the Quality Report.

Key points:
Reasons for consultants' attendance – SG agreed that the data did not clearly identify where problems might exist. The data reveal where attendance is needed and from next month the data will be more accurate.

BA also confirmed that there is always a consultant on site.

Feedback from the CQC is a request for the Dashboard to be changed and this is being worked on

Home Birth Service – currently we are not offering a home birth service and this is being monitored closely. Funding is available for recruitment for the home birth service and the training.

CO Monitoring The problem of carbon monoxide monitoring at 36 weeks is still being flagged which is part of saving babies lives. The outpatient data will enable the team to report back in July on the progress of this.

Theatre Capacity – commented on this paper is elective capacity, there was a business case for an elective Caesarean list in York, but more work was required to demonstrate full utilisation of current capacity.

LB stated that this is an important element on our Safety Champions Walk Around that is an issue that has been flagged. Scarborough Labour Ward highlighted increasingly women booked for elective care are being delayed.

HM agreed but Badgernet will be a better source of data around this.

SH summarised that this remained a problem which creates a possible safety issue and commented that we are looking to the Maternity team to provide assurance to the committee on utilisation of theatre sessions.

SG commented further on the report at page 18, on the non-compliance of Saving Babies Lives.

CJ commented on the 'unable to demonstrate compliance', is this because we don't have the figures or because we are below the target. When are we expected to get to the target and how and the path to compliance. SG has supported the transformation midwife with a template, and she will do a paper audit to give a clear benchmark of where the gaps are and what needs to be undertaken to get the trajectory to 80%. On the Saving Babies Lives element 4, BA to put narrative around as to how that is going to be implemented and reviewed by the organisation.

It was commented in conversation by members in needing assurance that the staff that are working in the labour environment have the updated skills and competency to be able to interpret CTG as this is a theme that comes through a lot of the incidents at the moment.

E-roster Team – it is hard for the Managers to be held accountable as there is one large roster for 3 – 4 Managers. A specific project is being created for this issue.

Training – KS aired concerns for the medical leadership as the confidence is low that the staff are all fully trained and the consequences of this.

The is a need to require recording of training with local records and the relevant Manager should hold accountability. IPC team are working on practical assessments for appraisal purposes.

Ultrasound – this is of significant concern as in February there was a 15-day delay.
SH asked if it was a shortfall in capacity or scanning the wrong people.BA confirmed that it is a capacity issue and the Outpatient Matron is working with CJ on this.

The consensus was that it is not a problem with equipment but that more sonographer hours are required. Need an extra 30 hours to operate over 7 days.

Scarborough – high number of babies being admitted to special care at SGH. Cross site learning is looking to improve, and ongoing work is being reviewed.

AP to pull together a more comprehensive report for the next meeting.

SH commented on the reference made to formal In Postpartum Haemorrhage (PPH) is there a programme in place to secure this improvement. BA reported that the risk assessment on PPH has been tightened and clear about the change identified belonging to a programme of work. If risk assessment helped drive down PPH this is useful to track and a way of checking quality.

Action:

- **SG to provide an update on the theatre capacity in 2 – 3 months**
- **AP to pull together a comprehensive report**
- **Escalate to Board progress and some additional specific items**

Maternity CQC Update Report

A broad overview of the report was presented by AP and confirmed that the information is being captured in the risk register. A previous request from HM regarding the information required has been included.
The information previously discussed in the meeting has covered the Maternity CQC report.

HM added that if the CQC were to look at our minutes and cross reference the information needs to be consistent as it is a factual document. The CQC report needs to be an accurate reflection of where we are.

Monthly reports will be submitted for six months and thereafter quarterly.

28-23/24 Quality and Patient Safety Escalation Report

CG1 highlighted the increase in developed and deteriorated pressure ulcers. At the end of the financial year CG1 had an increase of 31%. In addition to the mattress replacement programme there has been a request for a pressure pump for every bed in the elderly wards. This will be monitored and further actions put in place if required.

Community Nursing – asking for more information and 16% increase in referrals from community nursing. QPaS requested further detail in relation to the quality impact and mitigations.

CG2 highlighted that during the doctors strikes the data surrounding performance has identified continuing gaps in the Vocare service provision.

Area of concern from CG3 around mixing paediatrics and adult patients in the day unit. Could be escalated to the CQC if the report being prepared by the Q&S and Risk Committee reveals further issues.

CG4 highlighted the lack of pull cords in some disabled toilets – this has been escalated through the Non-Clinical Risk Group for action.

CG5 chose not to escalate anything in maternity. SH commented that he was surprised that the CG had nothing to report and feels that its voice is outside of the CG structure.

CG6 reported safety issues in relation to admin processes when booking Ophthalmology appointments although this is a Trust wide issue rather than just this department. A task and finish group will address these issues. SH commented that all these issues have been reported before.

Infection Prevention and Control – the issues with C difficile, MSSA and MRSA repeatedly escalated. HM commented that not just for patient safety but reputationally it is huge. Damien Mawer has highlighted issues to the Board but does not attend the QSAC and the escalation process should be reviewed.

29-23/24 Serious Incident Report (Including Maternity and Never Events)

Monthly
No comments on this report.

Quarterly
It was discussed in review of the report that a QI update in future be looked at overall in improvements across the SIs and outcomes as a result.

30-23/24 Quality and Safety Assurance Metrics (TPR)

There were no comments on the report.

31-23/24 Safeguarding Annual Report

HM in presenting the report would like to escalate that we are non-compliant with the staff that came over last July 2022. We do have a safeguarding nurse but we should have a named nurse for Safeguarding Adults and a named nurse for Looked after Children. There is a budget for these.

HM requested escalation to the Board of the non-compliance of the staff and the risk around compliance of the Mental Capacity Act.

32-23/24 Draft Trust 2022/23 Quality Report

It was commented by members that the Quality Report was written well and had a good flow of information in reading like a sole author had completed the report, rather than a collection of authors for the different parts. A few points were discussed and the Committee requested that mention was made of IPC challenges in the CEO Forward

This report would be issued to the Board for approval alongside the annual report and accounts to be submitted to NHS England.

33-23/24 Issues to escalate to the Board and/or other Committees

SH confirmed escalation of maternity with the particular points below and also some aspects of CG2, IPC and CQC report and safeguarding issues.

- Escalate to Board of the following from maternity;
  i) that we are an outlier for still births based on 2021 figures
  ii) flag theatre capacity is an ongoing risk
  iii) flag that we are non-compliant with all elements of Saving Babies Lives and that we are asking the maternity service for more information on next month's report
  iv) scanning capacity is an ongoing risk which appears to be due to sonographer time
  v) concerns about the levels of admission to neo-natal unit at SGH partly due to lack of a transitional care facility
  vi) CTG training/certification compliance

Further escalations:

- Progress against recommendations from CQC
- IPC performance
- Escalate concerns to the Board the fragility of the service in SGH, e.g. cardiology, gastroenterology and also concerns with IPC performance.
- Safeguarding was noted to be non-compliant. We do have a safeguarding nurse but we should have a named nurse for Safeguarding Adults and a named nurse for Looked after Children. There is a budget for these.

34-23/24 Issues to escalate for BAF and CRR consideration

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

35-23/24 Summary of Actions Agreed

This was covered previously on the agenda.

36-23/24 Any other business

There was no any other business

37-23/24 Date and time of next meeting

The next meeting will be held on 20 June 2023 2.00pm-5.00pm (extended following member feedback).

Minutes

Quality and Safety Assurance Committee
20 June 2023

Members in Attendance:

Stephen Holmberg (SH) (Chair), Karen Stone (KS), Dawn Parkes (HM), Caroline Johnson (CJ), Lorraine Boyd (LB), Jenny McAleese (JM)

Attendees:

Nicola Topping (NT), Debbie Bayes (DB) and Sunitha Daniel (SD) (for Item 46-23/24) Sue Glendenning (SG), Amanda Pearson (AP) and Ben Adekanmi (BA) (for Item 52-23/24), Sally Light (SL) – Public Governor for York and governor that observes this committee

38-23/24 Apologies for Absence

There were no apologies.

39-23/24 Declaration of Interests

There were no declarations provided.

40-23/24 Minutes of the meeting held on 23 May 2023

Minutes of the meeting were accepted as an accurate record of the meeting.

41-23/24 Matters arising from the minutes and outstanding actions

Q&S09 – Remains open with July the intended completion date at Board
Q&S10 – Remains open with capacity challenges, target date revised until September
Q&S15 – Remains open for the Committee to conclude
Q&S17 – Remains open

42-23/24 Escalated Items

There were no escalated items.

43-23/24 Risk Management Report

MT presented the Risk Management Report involving the Corporate Risk Register (CRR) for June which has been through the Risk Committee at the start of the month. This contains the Care Group risks that are escalated to the CRR including an update of current mitigations in place.

Section 2 on the report were specifically those risks that are under the responsibilities of this committee ranging from IPC down to speech language therapy delays and assessment intervention. A lot of work is ongoing with regards to the Care Groups. The Board papers contains a revised CRR format that is now more user-friendly.

MT confirmed that the 6 risks were the only risks on the CRR that are under the responsibility of the Assurance Committee. The Fragility of the Gastroenterology service had been reduced to a score of 12 and therefore removed from the CRR to be managed at a Care Group level.

In line with the CRR report there was an open action for the Committee members to delve into specific risks, this would take place more at a future meeting.

Action:

- **Q&S15 - the risks of the CRR assigned to the committee are to be delved into to measure the level of risk and feedback by the committee members at a future meeting.**

44-23/24 Care Group 4 Assurance Report

This item was removed from the agenda due to the apologies for absence of the presenters.

Action:

- **Care Group 4 Assurance Report to be added to the July meeting agenda.**

45-23/24 Operational Quality Group Escalation Report

KS explained due to the timing of the meeting the Committee hadn't received the report yet which would be looked into and addressed in the refining of the Quality governance structure in the coming weeks, but it could still be problematic. The written version would be provided the month after.

Escalations were received in the meeting regarding falls, pressures ulcers and IPC from various care groups dealt with individually under each heading. Issues persist of the gastroenterologists' availability but which will be managed in the new care group structure across the 2 sites as one service. The SSNAP stroke measure in care group one has increased from D to C which was pleasing to see with a further action plan in place asked for September's Committee.

Another area discussed was the failure of 3 CPAP devices at Scarborough Hospital. There has been no escalation to NPSA currently. Further investigation will understand whether these are the fault is in the devices themselves or whether it may be a training issue to bring back to the Committee. High dependency paediatric care at York Hospital was raised for information. Bed availability for this care has been challenging with paediatrics having significant increases in patient numbers as compared to pre-Covid. It waits to be seen if this is a permanent issue and if staffing levels need to be looked at further with available capacity.

IPC was presented going into further detail on these issues in being a national outlier with the group pushing the IPC team for improvements on particularly with MRSA and C-Difficile. Performance had been broken done by ward in for example MRSA screening of mothers and babies which should be happening regularly.

Pressure ulcers are always a concern and increases have been seen on patient admission as well as those acquired in the Trust. Partnership working is being expanded to manage care optimally Pressure Ulcers and Falls now have improvement leads as advanced clinical specialists in place and it is expected that these areas will start to see improvements in future. LB queried the Trust's Community Care around pressure ulcers with DP stating that there was a need for a more influential campaign in care homes to be done and the nursing

teams are being spoken to on this. In addition, there isn't currently a look at the risks of the patients that have no right to reside at the Trust and the associated harm that occurs with some work starting in that area. A further area to look at are the patients that are having stays in ED of greater than 12 hours and the subsequent impact with more to do. SH commented that this is an area that has troubled the Committee whilst patients have had delays in receiving treatment. LB commented that this can be a difficult issue in that who has the responsibility of patients in these circumstances requires complete clarity.

SH commented on the TPR with measures with no targets which was agreed by members and that these would be looked at with the details that effects the overall performance. An example of improvement was at Lilac ward who had used QI methodology to improve performance. It was agreed by the Committee to provide DP with the time to analyse the situation and inviting in future key services such as quality seminars at the end of the meeting.

KS continued with Mental Health which was also discussed in completion of the Mental Health Act paperwork, discharge medication in the three workstreams set up, medical examiner functions and training capacity of consultants to enable required assessments to be completed. Mixed sex breaches are still occurring impacting patient experiences with also breaching complaints timescales.

JM commented in summary that the agenda of the meeting formally known as QPAS is so large it must be challenging, which was agreed by KS with reductions in papers, moving the agenda around, care groups moving to a number of four, improving presenting and time management all now in place to improve the group's assurance.

Action:

- **The SSNAP stroke action plan to be presented to the Committee September's meeting.**

46-23/24 Palliative and End of Life Annual Report

DB - Lead Nurse for Palliative Care and SD - Lead Consultant in Palliative Medicine presented the annual report after reporting to QPAS in May pulling out key themes. The demand for palliative and end of life care is increasing with 52% cancer and 48% non-cancer diagnosis, high compared to national levels. The service does receive later referrals with a focus now on how they can get earlier recognition and how the home to hospital and hospital to home service can be improved. The Autumn project is a specific focus making end of life care everyone's business to educate hospital staff.

In addition, there is a 7-day service running from Scarborough Hospital and York Community but for two years now this hasn't been possible from the York Hospital site with a business case underway to ask for further funding of staff positions. A 7-day service would make a difference particularly at weekends in discharging to the the preferred place of care.

The Committee commented on the service and the good work that had gone into the annual report and what was needed to improve the service from a staffing perspective and for recognising patients approaching end of life. JM commented in her role working with the end-of-life service and the need for 7-day services on all sites which was fully supported by the Committee yet difficult to implement.

The work of the palliative care team was commended for its work. There was unfortunately no further funding available to increase the service at this time , but the service had the Committee's support in the work that it is undertaking. KS commented that a future nursing

review in DB and SD working with DP could potentially release the funding for the posts to be appointed with community district nursing also having gaps in support commented by LB.

47-23/24 Nurse Staffing Report

DP presented the report and commented on the new dashboard emerging which shows what are the gaps on staffing and the subsequent impact on quality. DP advised to take this with caution currently with the NHSE network staffing review paper providing opportunities to improve how data is collated in consistent way such as the nursing staffing tool. CJ commented on the manual processes currently which increases the risk of the data provided.

The vacancy and fill rates show for example wards where HCA fill rate is high with areas of concern identified in what would be in the HCA role such potentially as nutrition and hydration identified by CQC. Opportunities exist then in the HCA role and how the Trust prepares HCAs ready for the ward with many of these staff members having no experience of this environment. DP commented that the paper as a whole is lengthy which could be addressed further with key areas pulled out and how we assure ourselves that the staff have the capability to deliver on the wards in the experience that staff have had previously and address gaps.

LB commented on the difficulties of the dashboard presented with a small number of proxy measures needed to be focussed on which was agreed by the Committee in that too much detail is currently being presented. Tendable provides an opportunity to report key measures to action in future.

The Committee further commented on the governance of assurance needed to be provided to the Committee and overseen by the Executive team via the oversight and assurance meetings. KS added on the assurance work ongoing with Melanie Liley following the EY work concluding. JM commented on the lack on integration of the digital solutions with DP and CJ commenting on Badgernet for example now being used by the maternity team and other systems integrating across different services. The integration of these was key to providing quality data reporting in future.

It was agreed to bring back the report on a quarterly basis.

Action:

- **The Nursing Staffing report to be reported quarterly to the Committee.**

48-23/24 Infection Prevention and Control Update

DP presented the report with key areas identified as potentially the reliance of talking on the environment as a key cause of IPC concerns, but it is broader than that. There are opportunities to improve the basics such as hand hygiene, PPE usage, de-cluttering and assurance of cleaning. There are issues with the estate but there are other areas that we could focus on as mentioned.

A senior IPC practitioner is to join the Trust shortly to address the strategic challenge and to oversee the basics. SH commented on the discussion on these areas in the past to include the de-escalation of antibiotic prescribing. DP agreed and there was now an opportunity to engage and work with the ward managers in working with the matrons' handbook as the overall framework.

Discussion around the matrons' work ensued in the support that they require to be autonomous rather than being informed what to do with the resource constraints in staff and

the time available to conclude their duties. There is some good work ongoing and yet some areas that need support to deliver further quality of care. NT commented there are examples of wards really owning the IPC processes and championing their ideas to improve performance.

49-23/24 CQC Update

CJ presented the report as a different style to the approach to CQC improvements. The CQC actions are being worked though: approximately 90 must do and 40 should do, with a plan being developed to avoid duplication and the best way of concluding the actions. Two levels of assurance will then be achieved; firstly, are we delivering the actions and secondly what is the impact of those actions being delivered.

The Trust is expecting the final well-led report shortly from which the action plan is being developed to be submitted within two weeks. The Trust continues to receive requests from CQC on fundamentals of care and Tendable audits for actions to improve. The Quality and Regulations Group keeps the actions plans under review to be delivered.

DP commented that what we should have in future are the actions, which are on track and those that aren't providing the reasons why. The proposals to close actions can then be brought with the evidence providing assurance to the Quality and Safety Assurance Committee before these are reported to the CQC. SH commented that concerns in the past have focussed on whether the actions sustainable into the future and it was agreed that consistency of delivery was required to ensure the actions remain delivered in place.

DP enquired of the CQC action plan coming to Quality & Safety Assurance Committee before submission and it was decided that the plan be reported to the Executive Committee first before submission to then be reported back to the Quality & Safety Assurance Committee the next meeting. Members will be provided with the report in the interim before submission to CQC for any further comments.

Action:

- **The CQC action plan be provided to Committee members ahead of submission with the final plan reported to the July Quality & Safety Assurance Committee.**

50-23/24 Serious Incidents Report

KS presented the report with six investigations concluded with subsequent outcomes and invited questions with NT who carried out the investigations. SH asked if there was any assurance that could be provided to ensure learning was triangulated with other information to improve quality across the Trust. This was a work in progress and was underway across the Trust in sharing learning.

Ideally NT would like to see more evidence of Quality Improvement (QI) across the Trust with a more widespread culture of QI needed across all clinical areas. QI is a culture that can assist in providing learning across the Trust and KS noted the invitation for the Board members to attend the QSIR poster display to illustrate the work that has been underway at the Trust. KS has challenged the QI team with using Sepsis as a project to develop across the Trust to have a wide impact that could demonstrate improvement. The QI methodology would enable the Trust to do that in demonstrating the learning from each area to bring back to the Committee the assurance in embedding QI.

LB commented on the SPC chart in indicating consistency above target and will QI lower the overall line in time with CJ commenting that QI is changing the way that things are done

in learning differently. DP commented that the Trust Quality Strategy needs to provide further information on the quality priorities in sharing the learning in presenting to staff what the data is showing and spreading the messages.

JM commented on the internal audit on organisational learning and quality improvement and suggested the committee look at the recommendations and the learnings as a result.

51-23/24 Quality and Safety Assurance Metrics (TPR)

LB commented on the jump in moderate harm incidents over the reporting period for obstetrics and gynaecology and SH commented on the lack of targets on the mandatory measures. These are planned to be looked at in refining of the TPR.

52-23/24 Maternity Update Report

Perinatal Clinical Quality Surveillance Report

AP explained that the Perinatal Clinical Quality Surveillance report hadn't been concluded on time this month. This would be included with next month's paper to the July meeting of the Committee. The maternity incentive scheme year five had significant changes to the Board reporting requirements with the PCQS and the Maternity Safety Report being reported to Board every month. As many Trust Boards have meetings bi-monthly there is the possibility that derogation is put in place to the Quality and Safety Assurance Committee.

It was agreed by members of the Committee therefore that the PCQS and maternity safety reports would come to the Quality & Safety Assurance Committee on a monthly basis reporting into the Trust Board on a bi-monthly basis.

Maternity CQC Update

SG explained that a workforce review was underway to try understand the position since 2021. There has been an increase in PPH rate in York for last month but which is now coming down again currently in June with a review of those areas and AP provided further detail around the saving babies lives programme. AP explained that version 3 of the saving babies' lives was the proposal to undertake 36-week scans but this has been difficult to implement because of the workforce challenges.

SG continued that there is a current audit underway for Q4 on saving babies' lives. Further scan capacity has been required with a new machine ordered. SH commented that at the previous meeting of the Committee the issue was more of sonographers' capacity with which AP stated that their hours have been uplifted with an extra room which is intended to future proof the service. Student midwives' recruitment has appointed 18 in York and 6 in Scarborough. A series of CTG training and subsequent assessments are underway to ensure the workforce is compliant with their requirements with the potential of doing assessments on the day of training where possible as there have been challenges of the midwives' in meeting the required standard. The Committee agreed the target that all the midwives should be complaint in the next 3 months through the assessments as required so expectations are fully understood on training and immediate assessment.

AP continued that in May there were 15 PPH incidents which are being investigated to see if there are any themes to understand for staff support or further training needed. Work on the Scarborough site was underway with multidisciplinary reviews to identify where potentially avoidable admissions to SCBU were prevalent when only transitional care facilities were required not currently available in Scarborough. Regarding MIS year 5 the

Trust is complaint with 5 of the 10 standards with an ongoing plan to be fully compliant with risks around mandatory training and the remaining standards.

KS enquired about transitional care in Scarborough and is there an opportunity to provide special care with mothers rather than baby care elsewhere. AP replied that this could potentially happen within the footprint of the neonatal unit in being creative with the facilities and is being looked into. LB enquired about the PPH incidents in the collection of the data to be reported and were we now receiving a backlog of data with digital solutions, which AP stated could be the further reliability reporting of data from Badgernet rather than being paper based and we now maybe reported more than previously thought. LB enquired therefore in the PPH incidents how much of a multidisciplinary approach takes place with for example patient safety walkarounds to ensure the right treatment is provided to patients on a timely basis. BA commented that there is an escalation process in place to ensure that patients are not overly waiting where possible.

CNST Scorecard

SG commented that this is received on an annual basis and is presented in the meeting to raise awareness and the steps taken on the maternity improvement programme highlighting clinical and non-clinical risk. There will be a further scorecard in the Autumn to bring to the Committee around November. There were no questions from the Committee.

LB commented on the TPR in the rise of high dependency unit on the labour ward with SG stating this may be the language used around maternity enhanced care.

53-23/24 Patient Experience Report

DP presented the report of the National Maternity Survey results which would be taken through the Maternity Quality Surveillance meeting the actions and improvements. In particular, from other areas of patient experience was an area of concern of mixed sex accommodation breaches with the Committee needing assurance on the ongoing compliance to understand what has happened to mitigate these instances. Care Group 4 will be asked to come to the Committee as part of their ongoing attendance ask at the now July meeting.

The Committee agreed that mixed sex accommodation policies are needing to be looked at to understand more particularly in ICU and how to solve this issue.

54-23/24 Issues to escalate to the Board and/or other Committees

Mixed-sex accommodation breaches in Care Group 4 ICU were to be escalated to the next Board meeting.

55-23/24 Issues to escalate for BAF and CRR consideration

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

56-23/24 Summary of Actions Agreed

This was covered previously on the agenda.

57-23/24 Any other business

There was no any other business.

58-23/24 Date and time of next meeting

The next meeting will be held on 18 July 2023 2.00pm-5.00pm (extended following member feedback).

Item 15.3

Quality Committee – Chair's Assurance Report

Date of Meeting:	June & July 2023			**Quorate (yes/no):**	Yes	
Chair:						
Members present:	Stephen Holmberg (Chair), Lorraine Boyd (NED), Karen Stone (MD), Dawn Parkes (CN), Mike Taylor, Caroline Johnson		**Key Members not present:**	Jenny McAleese (NED)		
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**	
BAF Risks assured to Committee	**PR1 - Quality Standards**	x	**PR2 - Safety Standards**	x	**PR3 - Performance Targets**	
	PR4 - Workforce		**PR5 - Inadequate Funding**		**PR6 - IT Service Standards**	
	PR7 - Integrated Care System		**Comments:**			

Key Agenda Items	RAG	Key Assurance Points	Action
15 Maternity Services (Ockenden)		To inform the Board of on-going work to address concerns by CQC and to achieve compliance with Ockenden standards. There is evidence of improving assurance e.g. around training compliance but areas persist with variable performance and compliance e.g. PPH and Saving Babies' Lives	Information and escalation
11 CQC Compliance Report		To inform the Board of on-going work to address regulatory action imposed by CQC and to address additional recommendations for improvement in the Trust. Committee received new plan in response to latest CQC report	Information and 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

Quality Committee – Chair's Assurance Report

8 MD Report		Mixed sex accommodation breaches remain a concern. A major area for focus is step-down for ICU beds where long delays persist. The governance around non-registered prescribing has been identified as a concern and further work to provide assurance is in train. A TKR prosthesis used in significant numbers at Bridlington has been flagged by the NJR as experiencing higher than expected failure rates. This has triggered a recall programme for enhanced monitoring. This necessitates additional activity but, to date, harms are very low.	Information & Escalation
8 MD Report		It has previously been identified that only notes from paediatric ED attendances flagged for concern at that time are being reviewed subsequently as possible safeguarding concerns. This potential weakness continues to be reviewed but initial audits have not identified missed opportunities or harm	Assurance
6 CG4 Assurance Report		CQC has imposed regulatory action in relation to self-reported breaches of IRMER regulations. A number of patients have experienced low harm due to over-exposure during CT scans. These resulted from non-adherence to changed scanning protocols. HTA inspection is due next week. Although much work has been done to mitigate possible problems, weaknesses persist especially in relation to mortuary services and the condition of the body store. Progress with this has been delayed during main SGH rebuild. Diagnostic capacity and ageing equipment continue to represent major obstacles to addressing long diagnostic waits. The nuclear medicine service is especially fragile at present.	Information & 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

		Ward 31 is currently a concern with regard to ability to perform adequate cleaning and isolation due to number of side-rooms, lack of decant facilities and poor ventilation	

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

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	26 July 2023
Subject:	Chief Operating Officer's Report
Director Sponsor:	Claire Hansen, 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 June 2023 position for 78-week RTT waiters of 75 down from 163 at the end of May 2023. This progress is monitored on a weekly basis by the Chief Executive and NHSE.

The Trust is above trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 241 against a target of 179 for June 2023.

The June 2023 Emergency Care Standard position was 69.2%, below 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 out the operational update for Board oversight. The operational performance position is provided in the Trust Priorities Report.

2. Considerations

The Board notes the updated position and associated actions.

3. Current Position/Issues

The Trust is preparing for the industrial action by the British Medical Association Junior Doctors on the 13th to 18th of July and Consultant action on the 20th and 21st of July. During the previous industrial action on the 11th to 15th of April the Trust cancelled 1,013 outpatients and 217 elective procedures.

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 13% of ambulances having a handover time of over 60 minutes against the <10% target (down from 17% in April 2023).

Advise (2): The total number of patients waiting over 12 hours in ED reduced to 13.7% remained from 16% in April and May 2023 (target <8%), with those waiting more than 12 hours after a Decision to Admit also decreasing (495 against zero target, May 2023: 789).

Assure (1): The Trust did not achieve the Emergency Care Standard improvement trajectory with performance of 69.2% against the end of June 2023 ambition to achieve above 70.1%.

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.

4.1.1 UEC Performance

The June ECS position was 69.2%, against the planned trajectory of 70.1%.

The Care Group clinical and operational teams are working closely to ensure patients receive the care and treatment they need in a timely manner. In Scarborough there is a continued piece of work with YAS in relation to handover times, testing new processes. In York, the new Emergency Department is opening on 10th July with a new clinical model and pathways planned to run which are expected to have a positive impact on ECS. The new ED facility will provide state of the art resus and assessment facilities which will transform our emergency care offering at York. In addition, the OPEL escalation framework is being reviewed to provide more focused actions to each level of escalation.

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 and a new UEC Improvement Board for North Yorkshire and York Places including all system partners commenced in June.

The UEC Programme milestones for June 2023 included the requirement to understand the responsibilities of the Programme in terms of Health Inequalities and to scope the Mental Health project.

As part of the system improvement plan Mental Health is to be established as a workstream in relation to UEC pathways. The project will be established and will run across all three driver areas as health inequalities does. The initial meeting will take place in July 2023 to agree more details looking at alternatives to ED and integration of mental health pathways to support patients in the ED.

In terms of the health inequality theme running through the programme, further work is required to understand the responsibility of the programme in relation to health inequalities and correlation with the trust strategy. The focus at this point is related to high intensity users and understanding and developing appropriate alternatives to the ED for these patients, these include working with Children where a social prescriber is specifically focusing on this.

TRUST PRIORITY MEASURES	TARGET	ANNUAL TREND	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
Reducing average ambulance handover time:							
% within 15 mins	65%		44%	39%	43%	49%	55%
% within 30 mins	90%		67%	56%	65%	72%	70%
% within 60 mins	95%		82%	73%	83%	84%	88%
Percentage of all attendances having initial assessment within 15 mins	95%	↔	47%	45%	50%	48%	43%
Percentage of Type 1 ED attendances in ED longer than 12 hours	10%		20%	20%	16%	16%	14%
ECS (all Types)	76%	↔	70%	70%	73%	72%	69%
Mean time in department	Reduction throughout 23/24 to <380mins		406	415	367	359	356
Bed Occupancy (York and Scarborough, month average, 8am)	92%	↔	92.7%	92.9%	92.1%	91.9%	93.5%

4.1.2 UEC Programme update

Each project within the UEC Programme contributes towards the above performance 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 ED, 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 contributing to ambulance handover times, enabling improved response times.

Project	Impact	June	July plan
Urgent Care	To develop the Integrated Urgent Care Model to reduce unnecessary attendances in ED.	Additional workshops taken place in York, Selby and Scarborough and Strategic Board discussion taken place to inform business case.	To complete the business case for July Board including pathways, workforce models and full due diligence including financial evaluation.
Children and Young people Integrated Care and Assessment	To develop integrated models of care for C&YP to reduce paediatric ED attendances	Planning paused for public health summit, integrated care pathways developed within other projects i.e. virtual ward and SDEC.	Finalise the summit arrangements and expected outcomes with all partners.
Virtual Ward	To develop pan trust strategy on VW to enable a reduction in admissions & ED attendances and reduction in LOS across specialties.	Cross specialty virtual ward pathway assessment being completed to understand the resource requirements for a Virtual Hospital including digital requirements.	To agree priority use of existing VW resource and present impact schedule demonstrating what could be achieved with additional resource. Test VW pathways which can be achieved on small scale.
SDEC	To maximise the potential of SDEC pan trust to reduce ED attendances and LOS.	Planning work with all partners completed for YAS direct pathway for surgery SDEC. Review of 0 LOS pan-trust completed; pathway change to be reviewed and agreed with care groups for patients	Risk sharing and escalation protocol to be implemented including SDEC units to improve access for all patients as part of the revised OPEL framework. Surgical SDEC direct pathways implementation to be completed over summer, ahead of winter.

Project	Impact	June	July plan
		to attend SDEC directly rather than a pathway through ED and acute admission wards.	
Internal discharge processes	To reduce admissions and LOS.	Implementation plan for IPS (supported by ECIST clinical lead and Improvement Manager) completed. OPEL framework reviewed to ensure consistency in process.	IPS clinical workshop scheduled 6th July to agree assurance and escalation processes required to embed IPS.
7-day standards	Reduce LOS	Actions merged with above project as successful implementation and embedding of IPS will allow achievement of 7DS priority standards.	
Transfer of Care	Reduce LOS	Preparation work continued prior to the integration workshop, analysing current position, workforce and potential impact.	Workshop with all partners to take place 10th July to agree the scope of the Integrated Intermediate Care project and stages in relation to timescales.

4.1.3 UEC Project metrics

The UEC dashboard is awaiting development, however the following programme metrics can still be reported to evidence the impact of each individual project once they are implemented.

Urgent Care / Children and Young People	TARGET	ANNUAL TREND	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
ED attendances - total			19,085	19,716	20,196	19,625
Number / proportion of type 1 attendances			9,583 50.2%	9,174 46.5%	9,843 48.7%	
Number / proportion of type 3 attendances			9,075 47.6%	10,199 51.7%	9,915 49.1%	
Number / proportion of paediatric (0-18) attendances	TBC		2,224 11.7%	1,908 9.7%	2,117 10.5%	2,116

Discharge Framework/IPS	TARGET	TREND	FEB 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
Percentage of discharges before 12:00 on weekdays. (SAFER report – SAFER SPC Chart – York and Scarborough hospitals, select months)	33%	←→	18%	18.2%	18.6%	15.2%	14.7%
Percentage of discharges before 12:00 on weekends. (SAFER report – SAFER SPC Chart – York and Scarborough hospitals, select months)	33%	←→	22%	24%	23%	22%	20.7%
Percentage of discharges before 17:00 on weekdays. (SAFER report – SAFER SPC Chart – York and Scarborough hospitals, select months)	70%	←→	60%	62.5%	59.9%	56.6%	55.2%
Percentage of discharges before 17:00 on weekends. (SAFER report – SAFER SPC Chart – York and Scarborough hospitals, select months)	70%	←→	68.6%	69.8%	68.7%	62.1%	62.2%
Average LOS of pathway 0 patients at discharge	TBC						

7DS – priority standards	TARGET	MAR 2023	APR 2023	MAY 2023	JUNE 2023
Standard 2: Emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	100%	80%	79%	79%	80%
Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services (ultrasound, CT, MRI, ECG, endoscopy, microbiology). Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients	100%				
Standard 6: Hospital inpatients must have timely 24/7 access to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. Interventions would typically be: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy • Urgent radiotherapy • Stroke thrombolysis and thrombectomy • Percutaneous Coronary Intervention • Cardiac pacing (either temporary via internal wire or permanent)	100%	Achieved			
Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway. *(Last working day of the month)*	100%	-	52%	60%	68%

SDEC	TARGET	TREND	MAR 2023	APR 2023	MAY 2023	JUNE 2023
Percentage of patients streamed to SDEC within 30 mins of arrival at ED (SDEC Report – measures table tab – York and Scarborough)	30%		15%	24%	19%	14%
Percentage of Medical take seen in SDEC. (SDEC Report – measures table tab)	40%		Not available yet			
Percentage of Surgical take seen in SDEC. (SDEC Report – measures table tab)	40%		Not available yet			
Percentage of patients seen in SDEC transferred to a down-stream ward – ALL (Trust Priorities Report – Acute Flow)	30%		14%	15%	14%	19%
Proportion of patients with an ED attendance prior to SDEC = number of ED attenders seen in SDEC / total number seen in SDEC * 100	10%		1424/3564 = 40.0%	1262/3069 = 41.1%	1415/3498 = 40.5%	1311/3411 = 38.4%

Transfer of Care	TARGET	TREND	1st June 2023	12th June 2023	11th July 2023
Number of Pathway 0 patients who don't meet the criteria to reside.		-	78	45	46
Number of Pathway 1 patients who don't meet the criteria to reside.		-	45	53	49
Number of Pathway 2 patients who don't meet the criteria to reside.		-	36	44	33
Number of Pathway 3 patients who don't meet the criteria to reside.		-	37	32	34
Number of bed days lost each month.					

4.2 Board Priorities: Elective Recovery

Advise (1): Reduction seen in elective RTT long waiters over 78 weeks; Trust had seventy-five patients waiting at the end of June 2023. This position was in line with the revised trajectory that the Trust submitted to NHSE for the end of June 2023 (seventy-five).

Advise (2): Patients waiting 63 days or more on the Cancer PTL has increased from 225 (May 2023) to 241 at the end of June 2023. This is above the trajectory of 179 submitted as part of the national planning programme for 2023/24.

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

Assure (2): At the end of June 2023 the Trust had 957 RTT patients waiting over 65 weeks, below the end of month trajectory of 1,085.

2023/24 Operational Guidance Requirement	May	Jun-23	
Eliminate 104 week RTT waits	0	0 ⟷	National target - 0
Reduce 78 week RTT waits to zero	163	75 ▼	Trajectory 75 by end June 2023
Reduce 65 week RTT waits to zero	972	957 ▼	National ask 0 by end Mar 2024
Return the number of people waiting for longer than 62 days to the level in February 2020	225	241 ▲	National ask - maximum of 143 at end of April 2023

4.2.1 RTT position

The Trust continued to see improvements in the long wait position in June, with the number of 78-week RTT patients reduced to seventy-five (May: 163). The Trust has therefore delivered the trajectory submitted to NHSE that there would be seventy-five 78-week RTT patients at the end of June 2023.

There were zero 104-week RTT waits at the end of June 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 June 2023 the Trust had 957 patients waiting over 65 weeks. A trajectory to deliver zero was 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 June, the Trust was 128 below the end of month trajectory of 1,085 at 957.

The Trust has seen an increase in the total RTT waiting list position, rising to 51,638 at the end of June (May 2023, 51,150). Prior to the COVID-19 pandemic a sustainable RTT waiting list for the Trust was around 26,000 open clocks. Further capacity would be required to deliver significant improvement in waiting times beyond the national ambition for a RTT65 weeks maximum waiting time by the end of March 2024.

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

4.2.2 Cancer Position

The Trust remains off trajectory to meet the target 143 for the end of March 2024, with 241 patients waiting over 63 days at the end of June 2023 against the improvement trajectory of 179.

The Cancer performance figures for May 2023 saw an improvement in the 28-day Faster Diagnosis standard to (63.1% compared to 61.6% in April 2023) however the 62-day wait for first treatment (from urgent GP referral) position deteriorated, 49.9% compared to 56.1% in April 2023.

The weekly Cancer PTL meeting is increasing 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 the end of July 2023.

4.2.3 Diagnostic Position

Diagnostic performance data for June 2023 showed an improvement to 62.7% from 59.1% at the end of May 2023 for patients waiting less than 6 weeks.

Performance in Computed Tomography has improved from 83% at the end of April to 96% (June 2023).

The focus for quarter one and two 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 national diagnostic monitoring 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 Diagnostic Transformation Board has been formed and will meet for the first time on the 1st of August 2023 (further detail can be found at section 4.2.4.2 below).

4.2.4 Elective Programme

The Trust continues to work with the NHSE IST on the key support objectives. Good progress has been made against the demand and capacity work with Gynaecology and Head and Neck, diagnostics, review of Access Policy, development of Cancer Action Plan, review of administrative processes in Ophthalmology and 6-4-2 theatres work. A planning event was held on the 5th of July 2023 with Head and Neck, Gynaecology and Ophthalmology.

The Trust has received an NHSE prioritising diagnostic recovery letter which outlines several priorities including delivery of the cancer Faster Diagnosis Standard, establishment of a prostate mpMRI diagnostic pathway, delivery of 10-day receipt to report to turnaround time for histology. Oversight of the development of these are through the elective programme and cancer delivery group.

The Trust received an NHSE elective priorities letter which outlines a board assurance template. This is being reviewed alongside the programme for presentation at the July 2023 meeting and Executive Committee approval.

A productivity workstream focusing on reduction in outpatient follow ups in the first instance is currently being scoped.

4.2.4.1 Outpatient Transformation programme

The draft Outpatient transformation programme was presented at the last Elective Programme Board with a focus on referral optimisation and new models of care, personalised care and digital. The key ambitions include reduction in DNA rates, reduction in OP follow ups and clinical utilisation. The next steps for the programme are to; continue with data validation exercise, commence speciality specific action plans for PIFU for Respiratory, ENT, Gynaecology, Urology and Gastroenterology, agree the top four specialities for GIRFT review, further roll out of advice and guidance for Orthopaedics and Gynaecology, set and agree speciality specific trajectories for FU:NP ratios and review clinical templates to ensure correct treatment function codes are applied. Project plan being developed with leads and key delivery milestones.

4.2.4.2 Diagnostic Transformation programme

A paper was presented regarding the scope of a proposed diagnostics transformation board. The recommendation to establish board was approved. The scope of the Board will focus on DM01 (nationally monitored) modalities so does not include pathology, discussion about the development of a pathology improvement plan through the SHYPS and Care Group governance to be presented back to Elective Programme Board.

4.2.4.3 Community Diagnostic Centre

There are risks and challenges to the delivery of the CDC programme. The spokes and hub BC have received national approval, but MOU has not yet been received. The revenue business case for the spokes case has been approved by executive committee. Looking at opportunity to pre-mobilise some phlebotomy and cardiorespiratory activity at Selby and Askham Bar. The mobile pads project is off plan which is resulting in a significant risk to the Trust and ICB regarding the mobile CT/MRI activity.

4.2.4.4 Theatre Transformation programme

Theatre transformation programme is making good progress. Theatre templates are currently not accurate and are being updated which once completed will improve the performance data in August 2023 in terms of utilisation. Good progress at Scarborough with four out of seven specialities achieving 85% utilisation. Next focus is ‘on time’ starts with a target of 95% which currently there are no specialities are meeting.

4.2.4.5 Cancer

Priority workstream regarding the development of mpMRI services. Options paper to be discussed at next cancer delivery group. Ongoing development of the personalised care workstream and review of RDC model to develop recommendations for long term service model.

4.2.4.6 Productivity

The elective programme continues scoping a productivity workstream focusing, in the first instance, on reduction in outpatient follow ups.

4.2.5 NHSE Intensive Support Team

The Intensive Support Team (IST) continue to provide support to the Trust. The IST 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	Action plan template approved at ERB. H&N, Gynaecology and Outpatient Services ongoing.On site session held with the three teams on 5th July 2023 to progress and embed this work.
Training	Launch of mandatory RTT training	Completed
	Back to basics workshop	Back to Basics workshop completed. Additional support objective agreed for drop-in sessions for operational manager and clinicians ongoing. Targeted day with H&N, Gynaecology and Outpatient Services held on 5th of July 2023.
KPI's and Reporting	Review of operational reports	Completed
	Development of elective KPI's	Completed
	Implement clock stop audit	Completed
Diagnostics	Develop operational reports and PTL	Commenced and ongoing. Capacity & Demand work in progress.
OP pathway booking process	Process mapping of booking process	Original support objective stood down. New objective agreed to critically review Ophtalmology and H&N OP booking process, this work has commenced and is ongoing. Session to work through recovery plan principles held with service on 5th July 2023.
Maximising capacity	Demand and capacity	Work with H&N and Gynaecology at an advanced stage, 'gaps' in capacity to meet demand have been quantified, mitigating these will form basis of recovery plans.

Recommendation

That the Board notes the report and associated actions.

Date: 11th July 2023

Minutes

Digital, Performance & Finance Assurance Committee
16 May 2023

01-23/24 / Attendance: Lynne Mellor (LM – Chair), Denise McConnell (DM), Andrew Bertram (AB), Melanie Liley (ML), Mike Taylor (MT), James Hawkins (JH), Paul Johnson – Governor observing, Jim Dillon (JD) Nik Coventry (NC), Sarah Barrow

LM welcomed Nik Coventry and Sarah Barrow to the Committee.

02-23/24 / Declarations of Interests

There were no changes to the declarations of interests.

03-23/24 / Minutes of the meeting held on 18 April

The minutes of the last meeting held on 18 April were approved as a correct record.

04-23/24 / Matters arising from the minutes

Action 143 – BAF for submission to Board and action closed.

Action 159 – flagged to the Quality and Safety Committee and action closed

Action 162 –for submission to June Committee extend deadline.

05-23/24 / Escalated Items

There were no escalated items to discuss early in the meeting – a summary is included in the Chair's Briefing.

06-23/24 / Trust Priorities Report – Digital, Finance and Performance, to include:

EPR Outline Business Case

JH provided a presentation (see slides attached) to the Committee overall suggesting that the EPR option 2 was the preferred path.

Due to the proposed costs AB asked how aggressively had other system costs been removed when looking at the financial impact of the proposed EPR option. SB advised that there is still scope to explore the removal of further system costs, although some uncertainty around which modules are included in the solution so this also requires further understanding.

This led to further discussion around inter-operability, sharing patient data, infrastructure and defining benefits of the solution with LM suggesting that this transformative change needed to be reviewed by the Board, linking in to existing strategy and how the system can be an enabler to the Trust as a whole. Further key benefits such as social value, environmental and sustainability should also be explored. LM also suggested reviewing the benefit profile in terms of opex cost for staff in put for example clinical profiles looked low for contributions. SB advised that in the detailed spreadsheets not included in the main report, short-term delivery and clinical backfill teams have been included in 3rd party costs for the longer term.

LM suggested that this would be a good opportunity to review how the Trust is migrating which services to the cloud in alignment with hybrid EPR plans.

ML suggested that a clear outline of a phased integration was required with defined critical tasks.

LM thanked JH and the team for the work that has gone into preparing the case.

Action – LM recommend a Board Strategic Transformation session one of the outcomes being the discussion and ratification of EPR requirements

Action – identify further benefits / costs for example societal, sustainability Cloud and data sharing

Digital and Information Scorecard

JH presented the report and advised on the significant number of P1s listed in the report. DM asked if this was a cause for concern. Jim said the Trust was halfway through NHS365 migration, with increased migration volumes to 400 per night resulting in high volume of service calls. This is the main impact on number of outstanding calls received by the helpdesk.

The Trust had received a cyber phishing attack which was accessed by 27 colleagues, and subsequently communicated to staff for awareness, however this illustrates how easily these attacks can happen.

LM highlighted the policy for remote IT equipment which is being introduced as a positive step forward. JH advised an overhaul of asset management is required. AB advised that the APR may help with processes, such as leavers processes for returning equipment.

The Trust is also not meeting its requirements of the regulator on ICO4 and a paper to Executive Committee regarding this policy is to be drafted.

Action – JH update on paper regarding ICO4.

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

AB stated the financial report is still in a development phase. DM asked for a more executive summary. AB agreed to introduce a high-level dashboard including Key Performance Indicators.

On the plan position reconciliation will be included in the next report. The plan has been submitted and we await approval from NHSE. Plan has a £15.4m deficit – initial £33.7m

with a further £10.3 improvement ask to £23.4m. Varied submission following conversation with ICB, of £6.7m income.

AB highlighted the following key points:

- Month 1 I&E variance £1m put to plan.
- Core CIP delivery – £1.6m planning gap is closing
- ICB reduction – £ 17.5m - £7.7m identified 44% of ask.

LM acknowledged big challenges currently faced and asked re support Committee could provide – AB suggested that conversation with the Care Groups around actions being taken in reducing Covid, reducing follow-ups and increasing productivity. NHSE advised productivity is lower than pre-Covid.

Three main concerns regarding elective recovery - waiting lists, losing income - not delivering required level of elective activity, not making productivity gains. LM suggested that Board strategy session needed to include discussion around improving productivity. ML advised that in supporting the financial position quality should be the primary driver for productivity conversations.

Action – include discussion around improving productivity in Board Strategy session

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

ML advised that we continue to see a downward trend in our Covid position, with previous position of 143 Covid-positive patients reducing to 78 patients at the time of writing.

Activity has been largely impacted by recent industrial action events.

ML highlighted the following key points:

- Acute flow – ar3???? improvement position around acute metrics, ambulance handover, waiting times and decision to admit. Assurance month on month trajectory 76% on target for ECS.

- Next month more comprehensive overview on Urgent Care programme. Important to recognise achievements looking back over the past year.

- Integrated Urgent Care specification – formal notification from ICB to be a prime provider from October – will take paper to private board in July looking at timeline. Looking at what the opportunity brings.

- Community response team – working consistently over and above. There are steps to move to an auxiliary care provider and further investment in CRT. On integrated intermediate care the Trust continues to work collaboratively with other providers.

- With regards to elective recovery, we remain in Tier 1 status although there is an improving position. Challenges recently faced in Head and Neck due to unexpected workforce challenges.

ML requested inclusion in strategy conversation – some services other DGHs don't provide that we do and should we provide. How do we engage more in conversations with

Primary care and strengthen our clinical relationships and network with our local PCP also across the ICS through a clinical pathway. Where do we benchmark against other Trusts.

07-23/24 Risk Management Update

MT advised updated that additional risks have been added to the Corporate Risk Register such as the Trust estate backlog maintenance and steam mains at SGH. New report format is being produced for future Board meetings.

08-23/24 Information Governance Executive Group (IGEG) Minutes

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

09-23/24 Executive Performance Assurance Meeting (EPAM) Minutes – April & May

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

10-23/24 Issues to escalate to Board and/or other Committees

- EPR business case
- Strategy Finance and productivity

11-23/24 / Summary of actions agreed

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

12-23/24 / Any other business

None raised.

13-23/24 / Time and Date of next meeting

The next meeting will be held on 20 June at 9am-11:30am.

Minutes

Digital, Performance & Finance Assurance Committee
20 June 2023

01-23/24 / Attendance: Lynne Mellor (LM – Chair), Denise McConnell (DM), Andrew Bertram (AB), Melanie Liley (ML), Mike Taylor (MT), James Hawkins (JH), Jim Dillon (JD)

The Committee welcomed the Governor Paul Johnson to the Committee as the current DPF Governor observer. The Committee also welcomed Steven Bannister (YTHFM), Rachael Metcalfe (Governance), Claire Hansen (pending COO), Luke Stockdale (DIS), Adrian Shakeshaft (DIS), Karen Priestman and Mark Quinn (Outpatients deep dive).

02-23/24 / Declarations of Interests

There were no changes to the declarations of interests.

03-23/24 / Minutes of the meeting held on 16 May

The minutes of the last meeting held on 16 May were approved as a correct record.

04-23/24 / Matters arising from the minutes

Action 165 – amendment required in action log and minutes

Action 158 – to be addressed to SB as part of YTHFM review

05-23/24 / Escalated Items

There were no escalated items to discuss early in the meeting – a summary is included in the Chair's Briefing.

06-23/24 / YTHFM Update to include:

6.1 Q4 Business Assurance Report

SB presented the YTHFM Quarter 4 (January – March 2023) performance update and the current status of the YTHFM New Start Programme Action Plan, highlighting the following:

- Financial Performance delivered within budget and CIP overachieved target, acknowledged it will be a challenge to meet CIP this year. LM asked that benefits realised from this achievement are highlighted in the next report.

- Review of 'soft FM' – portering, catering, domestics to align to required clinical support and provide a targeted service offer

- Hard FM focus on contract improvements – bundling contracts to extract better value.
- Performance Indicators to be reset to align nationally e.g PLACE
- KPI areas of focus are Sickness Absence, Very High and High Risk Cleaning, work is underway to improve and that current rates are in line with other similar organisations.
- Overdue maintenance reporting will now include schedule works to capture risk carried as a result of works not being carried out.
- New Start Programme, Year 1 People Projects complete, ACAS Tracker presented – Vacancy panels introduced for Band 4 and above with Staffside observer included for Estates. Internal audit review overtime levels and consistency at SGH and York. Director surgeries set-up individually to allow colleagues to raise concerns. Feed into culture work being undertaken by the Trust
- Capital Projects - Scarborough UECC, on programme, York ED, revised completion date of 30th June 2023, PSDS some slippage beyond March 2023. Current state of the construction and manufacturing sectors and the inflationary pressures in the market combine to present a significant risk to the Capital Plan. This is being closely monitored through the Capital Programme Executive Group and the Executive Committee.

07-23/24 Trust Priorities Report – Digital, Finance and Performance, to include:

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

ML advised that we continue to see a downward trend in our Covid position, with previous position of 67 Covid-positive patients reducing to 48 patients at the time of writing. Patients had been admitted for other reasons and had been admitted with Covid symptoms or became symptomatic whilst in hospital.

The following key points were highlighted:

- the Trust is reporting an improved end of May position for 78-week RTT waiters of 163 down from 187 at the end of May. This progress is monitored on a fortnightly basis by the Chief Executive and NHSE.
- the Trust is above trajectory for the number of patients waiting over 62 days on a Cancer pathway, at 225 against a target of 185 for May however the latest validated position on the 11th of June 2023 shows improvement to 188. Impact of industrial action and recent bank holidays which affected MDTs held on a Monday
- The May Emergency Care Standard position was 71.7%, achieving the trajectory of 70.1%
- UEC programme update – modest improvements in data and point of focus on internal standards for dischsrge framework. LM requested assurance on plans from ICB to understand which specialities are part of the rollout, the impact that this will have on UEC and elective backlog.

The Committee welcomed MQ and KP to provide a presentation (attached) on Outpatients improvements A number of improvements were discussed such as Do Not Attend rates improving as bi-directional emails have been introduced for patients recently moving from DNA 7.7% in March to 4.9% in May. The Committee discussed the Rapid Expert Input pre-hospital triage system, its plans for wider rollout. Risks such as PMO support and wider system, primary care support were noted.

Digital and Information Scorecard

EPR Business case approved at Board. JH addressed risk to timescales on EPR if national sign off is required for the business case due to joint procurement with Harrogate.

Essential Services programme and the new programme replacement - LM raised the issue of significant slippage in some of the deliverables which were not highlighted in the report such as the Virtual Desktop deployment (significant delay from original baseline), noting perhaps lessons learnt in deployment for forthcoming programmes.

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

AB highlighted the following:

- the Trust is reporting an adjusted deficit of £6.4M against a planned deficit of £5.1M for the period to May. The Trust is £1.3.M adrift of plan.
- Core CIP delivery improvement from £1.6m to £1.2m behind plan.
- ICB cost £17.5m no movement. Intervention work starting involving Care Groups and ask in reducing costs.
- Capital programme deteriorating – need to spend to deliver by end of year.

DM welcomed the new presentation format of dashboards, ERF and CIP outline.

AB discussed the Robotics Programme report. RPA is a complex area and has a number of associated risks around successful delivery. In addition, the entry costs for establishing a resilient and cost-effective RPA infrastructure are significant and do not necessarily deliver cash releasing savings. This needs to be factored into any future business case.

LM requested once in delivery a further update is given to the Committee.

Action: RPA pilot update

08-23/24 Risk Management Update

The current Corporate Risk Register was noted to the Committee updated for June reporting via the Risk Committee.

09-23/24 Shadow IT Policy

AS was welcomed to the Committee to discuss the Shadow IT policy. LM requested that the potential impact on patients be considered as a risk of this policy not being followed.

Action: Update in Q4 on implementation of Shadow IT policy as an assurance to mitigating risks.

10-23/24 Issues to escalate to Board and/or other Committees

None

11-23/24 Issues to escalate for BAF and CRR consideration

None

12-23/24 / Summary of actions agreed

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

13-23/24 / Any other business

None raised.

14-23/24 / Time and Date of next meeting

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

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Lynne Mellor	Date: 20 June 2023

2023 – 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 Steven Bannister (YTHFM) Rachael Metcalfe (Governance) Claire Hansen (pending COO), Luke Stockdale (DIS), Adrian Shakeshaft (DIS), Karen Priestman and Mark Quinn (Outpatients deep dive). The Committee thanked Melanie Liley for her tenure as Interim COO for the Trust.			
Digital			
i)	- The Committee discussed the KPIs and in particular Cyber with phishing attacks increasing it requested assurance that the desktop exercise, discussed in previous committees, to include YTHFM, was planned with an update in the next few months to mitigate the risk. - The Committee noted the risk to timescales on EPR if national sign off is required for the business case given it will be done jointly with Harrogate.	BOARD	INFORMATION
ii)	- The Committee discussed the Essential Services programme and the new programme replacement. The Committee raised the issue of significant slippage in some of the deliverables which were not highlighted in the report such as the Virtual Desktop deployment (significant delay from original baseline), noting perhaps lessons learnt in deployment for forthcoming programmes. It sought that enough funding was in place for the network infrastructure, platform and service layer improvements to support the Trust as it moves to Cloud and the forthcoming EPR programme. It wondered if a further review was needed. The Committee also wondered if there was sufficient resource to support the EPR programme. - The Committee discussed the Shadow IT policy and requested also that the potential impact on patients be considered as a risk of this policy not being followed. It welcomed the swift production of the report and asked once implemented that an update be given in e.g., Q4 on its implementation adoption in the future as an assurance to mitigating the risks.	BOARD	INFORMATION
Performance			
i)	- The Committee noted the continued downward trajectory of Covid patients presenting at the Trust from 67 last Committee Day to the current day of 48 patients. The Committee discussed the Trust's current Covid patients and it was confirmed that these patients were admitted for other reasons and either had arrived in hospital with Covid symptoms or became symptomatic whilst in hospital	BOARD	INFORMATION

	- The Committee noted that the Trust is still not meeting targets for ambulance handover, however it is positive that there is a downward trajectory from 17% last month to 14% (target is 10%). The total number of patients waiting in ED over 12 hours remains static (16% against a target of 8%). - The Committee did note the achievement of the Emergency Care Standard improvement trajectory with a performance of 71.7% (Trust May trajectory is 70.1%). - The Committee noted the UEC programme update and asked for assurance on plans e.g., national ambition is 40 virtual beds per 100,000 population by December 2023; the ICB has agreed that the Trust has a plan of 10 beds by December and we want to understand which specialities will be part of the rollout		
ii)	For Elective Backlogs: The Committee noted 78 week waits position continues to improve from 187 to 163, however is concerned about delivering 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 repeatedly over 51k – a sustainable waiting list for open clocks is 26k. T*he Committee requested last month that the Board include this as part of the strategy discussions given* in year plans are forecast only to deliver a 3% improvement. - Cancer position – the Committee noted the Trust remains off trajectory for the 62-day Cancer backlog (225 patients versus 185 planned trajectory). The Committee discussed the issues and noted the Industrial Action has contributed to some of the delays. - The Committee had a deep dive on Outpatients given the Committee has sought assurance on outpatient improvements e.g., follow ups not meeting trajectories. (HNY has a target of 25% reduction in follow ups). A number of improvements were discussed such as Do Not Attend rates improving as bi-directional emails have been introduced for patients recently moving from DNA 7.7% in March to 4.9% in May. The Committee discussed the Rapid Expert Input pre-hospital triage system, its plans for wider rollout. Risks such as PMO support and wider system, primary care support were noted.	BOARD	INFORMATION
Finance			
i)	- The Committee noted the Trust is reporting an adjusted deficit of £6.4M against a planned deficit of £5.1M for the period to May. The Trust is £1.3.M adrift of plan. - Core CIP delivery is £1.2m behind plan. - The Committee discussed the Capital position and the need for the business to spend its allocation to reap the associated benefits earlier for the Trust and to avoid any year-end pressure. - The Committee welcomed the new presentation format of dashboards, ERF and CIP outline. - The Committee noted the Robotics Programme report and its potential, and requested once in delivery a further update is given to the Committee.	BOARD	INFORMATION
YTHFT			
i)	The Committee discussed the CIP position and noted the good outturn of 80% of CIP benefits being recurrent. It wondered if the benefits realised from this achievement could be highlighted in the next report and communicated more widely.	BOARD	INFORMATION

	The Committee welcomed the plans on 'soft FM' with a review of e.g., portering, catering and domestics. The committee discussed concerns re cleaning standards but were assured that plans were in place to address gaps. For 'hard FM' the committee noted the focus for example on contract improvements such as the planned reduction of STAs and bundling contracts. The Committee also welcomed a review of KPIs to align more readily to quality indicators e.g., PLACE. The Committee discussed sickness absence and were assured that work is underway to improve and that current rates are in line with other similar organisations. Maintenance plans were discussed including assurance given on the need for more information on status of maintenance and tracking (e.g., introduction of RFID technology). It was also assured that there will be a focus on key areas such as compliance to water and fire standards. The Committee were assured that the plans to review CAFM and the older asset base system were in place including data migration. The Committee was assured some steps are being taken to improve culture including addressing ACAS concerns e.g.: - Vacancy panels for any role over band 4, with a more transparent recruitment and selection process. - Managers encouraged to be visible now to listen to staff and raise a concern.		
Governance			
BAF/Corporate	- The Committee discussed the risk paper and noted no material changes to the risks 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		LLP cyber desktop discussed in conjunction with the Trust. The Committee sought assurance that the Trust can mitigate any risks should an attack happen. The Committee suggested that external specialised support could be brought in to assist with the review.	Committee sought assurance as to when the exercise would take place and who is conducting it.
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.

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Denise McConnell	Date: 18 July 2023

2023 – 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 new Chief Operating Officer Claire Hanson who joined the Trust 17 July. The Committee was also attended by Melanie Liley as part of her handover from her tenure as Interim COO for the Trust. The Committee extended its thanks to Melanie for her contribution as interim COO. Governor Paul Johnson attended the Committee as the current DPF Governor observer.		

Finance			
i)	- The Committee extended the time allocation given in the agenda to allow for an in depth discussion on the Trust's financial performance. - The Trust is reporting an adjusted deficit of £11.3M against a planned deficit of £7.6M for the quarter to June. The Trust is £3.7M adrift of plan. - There are four main areas of expenditure giving rise to the deficit 1) Pay expenses £1.1m, Drugs £700k, Core CIP £1.4m and Other £900k. - The Committee noted the underlying reason for the current deficit was the additional cost reduction of £17.5m allocated by the ICB in the setting of the financial plan. - The Trust has already started to implement strong measures to bring about cost control. Agency costs are being tightly controlled with the Agency cap now being implemented, subject to any quality and safety considerations. - The Committee was informed calculations had indicated the current pay award was not being fully funded through increases in rates, with a projected annual shortfall of £1.2m. - A detailed analysis of drugs expenditure was being carried out because 50% of the £700k deficit was for in tariff drugs. - Meetings with Care Groups are to take place w/c 17 July to look at recovery plans which may have to be implemented if a gap in funding remains. - Opportunities for undertaking additional work may be reviewed if a funding gap remains. - The Committee was advised that cash balances could be an issue if the current level of deficit continued.	BOARD	INFORMATION

Digital			
i)	- The Committee discussed the KPIs and noted the number of P1 had risen slightly from 3 in May to 4 in June. P2 incidents had reduced from to 37 in May to 21 June. The number of service desk calls fell from 6605 in May to 5650 June although remained above the 3500 target. Similarly calls abandoned fell from 2318 to 1209 against a target of 500. Cyber with phishing attacks also decreased to from 516 to 239 .The Committee discussed the risk raised in June to timescales on EPR if national sign off is required for the business case given it will be done jointly with Harrogate.	BOARD	INFORMATION
ii)	- The Committee discussed the annual SIRO report . The assessment from the Auditors has reduced the overall Risk Rating to a limited risk rating compared to moderate last year. This is due to the Trust having a better understanding of its gaps in security and being able to provide a more accurate assessment. - The report highlighted that Data Security training was at 77% compared to a target of 95%. - The Committee noted the Information Security Policy and Protocols had been updated. - The Committee discussed the challenges of having 90 different staff members having been identified to be IAOs, of which 83 were trained to understand what being an IAO involves. There has been difficulty with engagement in this project. Failure of IAO's to identify medical devices could result in an increased cyber risk if they are operated with current security patches. - The Committee discussed the CPD penetrating testing which is planned to take place early September, and the importance of communicating the timing and implications of the test to medical staff.	BOARD	INFORMATION
Performance			
i)	- The Committee noted that the Trust is still not meeting targets for ambulance handover, however it is positive that there is a downward trajectory from 14% last month to 13% (target is 10%). The total number of patients waiting in ED over 12 hours also improved to 13.7% (16% May) against a target of 8%. - The Committee did note the achievement of the Emergency Care Standard improvement trajectory with a performance of 69.2% (Trust June trajectory is 70.1%). - The Committee noted the UEC programme update and asked for assurance on plans e.g., national ambition is 40 virtual beds per 100,000 population by December 2023. The Committee asked for the monthly Operational Report to include an update on the rollout on the virtual ward including projected numbers and specialties.	BOARD	INFORMATION
ii)	For Elective Backlogs: The Committee noted 78 week waits position continues to improve from 163 to 75.	BOARD	INFORMATION

	The Committee has consistently raised concern over the overall total RTT waiting list position which is unsustainably high and continues to rise (June 51638 May 51150) A sustainable waiting list for open clocks is 26k. *As reported in June the Committee requested that the Board include this as part of the strategy discussions given* in year plans are forecast only to deliver a 3% improvement. - Cancer position – the Committee noted the Trust remains off trajectory for the 62-day Cancer backlog (241 patients versus 179 planned trajectory). The Committee discussed the issues and noted the Industrial Action has contributed to some of the delays. - The Committee discussed the opening of the new Emergency Department requested a report on the functioning of the acute care model for the February 2024 meeting.		
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YTHFT			
i)	- The Committee discussed the EPAM minutes and noted the improvement in sickness absence, however due to the many complexities of sickness absence in the YTHFT the Committee was advised not to see this yet as a medium term trend.	BOARD	INFORMATION
Governance			
BAF/Corporate	- The Committee discussed the risk paper and noted the changes highlighted . The Committee asked for PR5 to be reviewed considering the reported quarterly deficit to determine if the risk level had increased.	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		CPR penetration testing to take place in September.	Committee sought assurance as to when the exercise would take place and who is conducting it.
PR3 – Performance Targets	Performance Targets		Significant operational pressures noted.	Focused plans on acute flow and elective backlog to address significant operational pressures . Request to board as May for RTT levels to be discussed within a strategy discussion.
PR5 – Inadequate Funding	Deficit		Deficit issue for Trust targets 23/4. Deficit forecast is very concerning with risk of significant deficit.	Agency cap in being rigorously implemented. Meetings are set up with care groups to look at recovery plans. CIP targets are being managed. Cash flow reporting to include forecast that reflects the scenario of the current level of deficit remaining throughout 23/4.