York and Scarborough Teaching Hospitals
NHS Foundation Trust

Board of Directors – Public

Wednesday 27th September 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 27th September 2023

TIME	MEETING	ATTENDEES
9:00 – 12:00	**Board of Directors meeting held in public**	**Board of Directors Members of the Public**
1:00 – 3:00	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 26 July 2023** To be agreed as an accurate record.	Mark Chamberlain	Report	08	
5.	**Matters Arising / Action Log** To discuss any matters or actions arising from the minutes or action log.	Mark Chamberlain	Report	15	
6. 6.1 6.2	**Chief Executive's Report** To receive the: • Chief Executive's Update • The September 2023-24 Trust Priorities Report	Simon Morritt	 Report Report	 18 23	9:10

Item	Subject	Lead	Report/ Verbal	Page No	Time
7.	**Risk Management Update – Board Assurance Framework** To receive the latest Board Assurance Framework.	Mike Taylor	Report	62	9:25
Trust Priority: Our People					
8.	**Trust Priorities Report: Our People** To receive an update on the Our People priority of the Trust Priorities Report (TPR) (Item 7.2).	Polly McMeekin	Item 6.2	-	9:30
9.	**Workforce Race and Disability Equality Standard (WRES) and (WDES) Action Plans 2023-2024** To receive and approve the action plans.	Virginia Golding	Report	81	9:35
10.	**Gender Pay Gap Report** To receive the report.	Virginia Golding	Report	130	9.40
11.	**Nurse Staffing Report** To receive the report.	Dawn Parkes	Report	142	9.50
12.	**Freedom To Speak Up Annual Report** To receive the annual report.	Stefanie Greenwood	Report	151	10.00
13. 13.1 13.2	**People and Culture Assurance Committee** To receive the: • July meeting minutes • September meeting exception report	Jim Dillon	 Report Verbal	 160 -	10:15
Trust Priority: Quality and Safety					

Item	Subject	Lead	Report/ Verbal	Page No	Time
14.	**Trust Priorities Report: Quality & Safety** To receive an update on the Quality and Safety priority of the Trust Priorities Report (TPR) (Item 6.2).	Karen Stone & Dawn Parkes	Item 6.2	-	10:20
15.	**CQC Compliance Update Report** To receive an update on the CQC actions.	Dawn Parkes	Report	164	10:25
16. 16.1 16.2	**Maternity Reports** To receive the report including: • Bi-Annual maternity midwifery and neonatal workforce report • CQC Section 31 Update	Dawn Parkes	 Report Report	 174 189	10:35
17.	**Responsible Officers and revalidation Update** To receive the update.	Karen Stone	Report	204	10:50
10.55 - Break					
18.	**Safeguarding Annual Report**	Dawn Parkes	Report	209	11:05
19. 19.1 19.2	**Quality and Safety Assurance Committee** To receive the: • July meeting minutes • September exception report	Steve Holmberg	 Report Report	 218 226	11:10

Trust Priority: Elective Recovery & Acute Flow

Item	Subject	Lead	Report/ Verbal	Page No	Time
20.	**Trust Priorities Report: Elective Recovery and Acute Flow** To receive an update on the Elective Recovery and Acute Flow priorities of the Trust Priorities Report (TPR) (Item 6.2).	Claire Hansen	Item 6.2	-	11:15
21.	**Winter Plan** To receive the Winter plan.	Claire Hansen	Report	228	11:20
22.	**Emergency Preparedness Resilience and Response (EPRR) Core Standards** To approve the assessment.	Richard Chadwick	Report	242	11:30
23. 23.1 23.2	**Digital, Performance and Finance Assurance Committee** To receive the: • July meeting minutes • September meeting exception report	Denise McConnell	 Report Report	 259 263	11:35
Governance					
24.	**Group Audit Committee** To receive 5 September Group Audit Committee escalation report.	Jenny McAleese	Report	267	11:40
25.	**Finance Update** To receive the Trust's financial position from the Trust Priorities Report (TPR) (Item 6.2).	Andrew Bertram	Item 6.2	-	11:45

Item	Subject	Lead	Report/ Verbal	Page No	Time
26. 25.1 25.2 25.3	**Items for Information** • Executive Committee Action notes (Blue Box) • Star Award nominations (Blue Box) • TPR Mandatory Reporting (Blue Box)	All		-	-
27.	**Any other business**	Chair	Verbal	-	11:55
28.	**Time and Date of next meeting** The next meeting held in public will be on 29 November 2023 9:00am.				
29.	**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.				
30.	**Close**				12.00

Minutes
Board of Directors Meeting (Public)
26 July 2023

Minutes of the Public Board of Directors meeting held on Wednesday 26 July 2023 in the Boardroom, Trust Headquarters, 2nd Floor Admin Block, York Hospital. The meeting commenced at 9:00am and concluded at 12:12pm.

Members present:

Non-executive Directors
- Mark Chamberlain (Interim Chair)
- Lynne Mellor
- 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
- Dawn Parkes, Interim Chief Nurse
- Polly McMeekin, Director of Workforce and Organisational Development
- James Hawkins, Chief Digital and Information Officer
- Karen Stone, Medical Director
- Claire Hansen, Chief Operating Officer

Corporate Directors
- Lucy Brown, Director of Communications
- Melanie Liley, Chief Allied Health Professional

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

The Chair welcomed everyone to the meeting and confirmed the meeting was quorate.

41 23/24 Apologies for absence
Apologies for absence received from:

- Jim Dillon, Non-executive Director

42 23/24 Declaration of Interests
There were no declarations of interest to note.

43 23/24 Minutes of the meeting held on 24 May 2023

The Board approved the minutes of the meeting held on 24 May 2023 as an accurate record of the meeting.

44 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 11 – Statutory and mandatory training month planned for August. Action closed.

BOD Pub 14 – Task completed and included through agenda. Action closed.

BOD Pub 17 - A matter arising as the policy remained under review and Tara Filby has a meeting arranged 03.08.23 with Emma Hardy to gain views.

45 23/24 Organ Donation Presentation

The Board welcomed Matthew Marks, Specialist Nurse Organ Donation for the Yorkshire Organ Donation Service Team and Rob Ferguson, Consultant in Intensive Care and Emergency Medicine and the Trust's Clinical Lead in Organ Donation.

Rob and Matthew prepared and presented a well-received detailed presentation and short animation video (https://www.youtube.com/watch?v=-MLhC-C9b4Q) to the Board, raising awareness of organ donation and reporting on some of the performance in the area to date.

46 23/24 Chief Executive's Update

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

Industrial Action – clear impact of this is the cancellation of activity which is minimised where possible.

York's new emergency department opening celebration - step in the right direction both for staff and for patients in the emergency department in York.

Care group structure review – moving from 6 care groups to 4. Recognising the need to change in particular in terms of governance.

Board changes – welcome to Claire Hansen Chief Operating Officer and Dawn Parkes, Interim Chief Nurse.

Trust Priority Report

Northing further added outside of the relevant sections in the agenda.

47 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.

Denise McConnel described that the Digital, Performance and Finance Assurance Committee had discussed the importance of changing the finance risk and to pick this up in further discussions. Lynne Mellor suggested that the Board should monitor trends once a quarter or six months to understand potential risks and mitigate them. Steve added that the Board should understand the concept of risk appetite and how to manage it effectively. Mark Chamberlain recommended a Board workshop session on this topic to determine current status and the effectiveness of mitigation plans. The risk register is comprehensive and required a focused and structured discussion.

48 23/24 Trust Priorities Report: Our People

Polly McMeekin discussed vacancy rates and the high turnover rate for healthcare support workers. The Trust had put reviewed establishments in throughout May, and were seeing a high turnover of 9.6%. The Trust was working on a strong recruitment pipeline and mapping movement which currently anticipated around 7 leavers each month. One aspect that needed to be addressed was the flexibility of work in clinical areas, as many leave their positions and join the bank which offers more flexibility of shifts. Dawn Parkes expressed the importance of supporting workers and ambitions for a healthcare academy. Matt Morgan suggested monitoring the turnover rate and its impact, with a goal of seeing a difference in December as described. Denise McConnell asked about the use of the establishment figure and it was noted whether it should be shown as WTE instead of percentage. Andrew Bertram reported he had agreed with the Chief Nurse team to illustrate what was an acceptable investment, different elements of the nursing investment required different implementation and timing. Mark Chamberlain suggested aligning the percentage of turnover between workforce and finance to ensure the Trust was where it should be as it would support the Board to understand the figures more meaningfully. Jenny McAleese questioned the headline pay and benefits for nursing employees, and Polly mentioned that face-to-face recruitment was successful and an ongoing dialogue. Overall, the Trust was working to improve the workforce and support workers, while also addressing the cultural change that is affecting its workforce.

The report described an increasing number of formal grievances related to bullying and harassment, which was described as symptomatic of the Trust's current culture. It was noted as crucial to address this issue and ensure that a significant amount of work is done before a grievance is filed. The Board acknowledged that it would take time to reduce the number of complaints. Matt Morgan was concerned about the staff willingness to make complaints and the need to address these issues. Jenny McAleese highlighted the Trust behavioural framework and it was emphasised the need to communicate the consequence that bullying and harassment is not tolerated.

49 23/24 People & Culture Assurance Committee

The Board noted the discussion of the Committee in relation to nursing workforce and the vacancy rate for Healthcare Support Workers remaining high and a concern. Aspirations for eRostering were discussed and the need for support from the Board. Polly McMeekin described an outline business case for the Executive Committee, which was expected to be brought back in December. Dawn Parkes reported that NHS England Improvement support was working at pace and recognised the benefits of working around eRostering.

50 23/24 Trust Priorities Report: Quality & Safety

The Board received and noted the quality and safety update.

Dawn Parkes reported good progress around reducing Clostridium difficile (C. diff) infection and going back to basics in the ward areas. Steve Holmberg questioned a suite of data to provide assurance. Dawn explained that she would like to provide data at different levels which would be a good contribution to a revised Trust Priorities Report.

51 23/24 CQC Compliance Update Report

Dawn Parkes advised that an action plan had been developed for the Trust, which was submitted as a draft and will receive feedback on assurance and any improvements. 73 actions in total had been merged. The Board also noted the submission requirement of section 31 and on track.

A report on policies and procedures was being developed, some good work shared with CQC in particular on staff training but do need to strengthen governance on assurance. Matt asked if the CQC had any suggestions on policies and procedures impacting patient safety. Dawn responded that although there were not currently any suggestions, she acknowledged that they were outdated or not of good quality. The Board approved of the amalgamation of actions and found the report clear, acknowledging that many of the actions had been in place since the inspection. Simon Morritt asked if the report was in the public domain and if much feedback had been received. Lucy Brown confirmed that the media level of interest was normal, and many issues raised by the CQC had already been discussed at the Board. Jenny McAleese suggested working through the governance around the plan and sharing assurance with the governors.

52 23/24 Ockenden Report Update

The Board received and noted the Maternity and Neonatal Quality and Safety Report and CQC Section 31 update.

Dawn Parkes advised that the report provided for the Board was under review and new reporting aimed to better appeal to the Board, focusing on regulatory requirements. The Board agreed a more concise report would be welcomed.

Jenny McAleese shared her concern for a clear view of maternity. Dawn shared observations of maternity and her concerns around the governance structures and advised working on structuring events at ward level up to Board and into an assurance platform. Clinical front-line staff have a good structure and a can-do team. An area of focus in operational terms was how to grow those pockets of good and focus on how to support them and draw out on what is needed. Data reporting and understanding trajectories, outcomes, and measures were areas of focus. Quality & Safety had taken steps to condense action plans into one, which was ongoing. Melanie Liley highlighted the introduction of a dedicated program approach (noted page 82 & 83 of the agenda), which will help with reporting.

Simon Morritt emphasised the need for governance around the improvement report, which consisted of six workstreams. Karen Stone outlined the focus of assurance groups on those workstreams. The Board thanked Sue Glendenning for her contributions.

53 23/24 Q1 Guardian of Safe Working Hours

The Board noted the Q1 update from the Guardian of Safe Working Hours.

Karen Stone discussed the successful recruitment and the positive impact on workload for the junior doctors. New doctors were starting imminently. The focus was on improving

experience and improving emergency rest facilities. Mark Chamberlain highlighted the importance of junior doctors having the right experience.

Matt Morgan discussed the actions around supporting the portfolio requirements. Karen highlighted sleep as an area where the challenge was accommodation as well as requesting for current contracts to be reviewed to see if they are fit for purpose. She emphasised about having good rest, training supervisors and ensuring that the right support was in place and that didn't always have to fall on doctors but traditionally it had.

Karen shared with the Board that she was considering a different report over the medical workforce through the assurance committees to provide a better overview for the Board, in particular the Non-executive Directors.

54 23/24 Quality and Safety Assurance Committee

The Board received and noted the May and June minutes and the June/July meeting exception report including Action BoD Pub 14, report of significant concerns from the committee.

Steve Holmberg and Dawn Parkes discussed and highlighted mixed sex accommodation concerns and patient movement issues. They acknowledged the need for policy focus and Patient flow work would help to focus on that as there are a number of breaches and do acknowledge that the Trust needed to address this.

Karen Stone highlighted the medicine safety prescribing and governance around non-registered prescribing being identified as a concern and clarified that she was seeking to provide a view that ensures safety around the right medicines being prescribed.

The Board noted the process for identifying paediatric patients. It had previously been identified that only notes from paediatric ED attendances flagged for concern at that time were being reviewed subsequently as possible safeguarding concerns. Karen assured the Board that this potential weakness continued to be reviewed and initial audits had not identified missed opportunities or harm. Mark Chamberlain suggested that the Committee continues to monitor progress on this.

Steve highlighted the diagnostics discussion at the committee and Claire Hansen confirmed that the Trust was reviewing diagnostics. The Board requested that a report or presentation of the review is submitted to a future Board meeting following the deep dive exercise already planned.

Action: December Board to receive a diagnostic review outcome report.

55 23/24 Trust Priorities Report: Elective Recovery and Acute Flow

The Board noted the report and associated actions.

Claire Hansen reported an improved position for 78 weeks, with measures in place to create more capacity. Job planning and demand and capacity modelling were key to understanding where resources need to be targeted. The waiting list was increasing, and work continued to address long waiters. There had been an agreement to reinstate the primary/secondary care interface meeting which would be key in supporting any decision making. There were 6000 less outpatients in Q1 than planned, with many outpatients and electives cancelled. The goal was to reduce waiting times as much as possible. A 4-hour wait was 69.2 against the 70.1 target, but pathways and flow needed to be embedded

before any improvement was likely to be seen (the operational standard for A&E waiting times is that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department). Steve Holmberg discussed the patients waiting longer than planned for treatment, questioning whether these patients were at real risk of harm. Steve also questioned if there was a mechanism that differentiated diseases and the impact of waiting, and if there was a way to monitor data around expecting and trajectory. Mark Chamberlain suggested looking into this with the Executive Team and considering ways to illustrate or demonstrate the impact of waiting. Lorraine Boyd suggested including population data.

Lynne Mellor appreciated the integration of mental health into the UEC program and the evolution of these programs and suggested for future improvements, it would be beneficial to understand where the program is making a difference to mental health patients.

56 23/24 Digital, Performance and Finance Assurance Committee

The Board received and noted the Committees May and June Minutes with June and July exception reports.

Lynne Mellor raised the cyber discussion in the June meeting and the request for assurance that the desktop exercise, discussed in previous committees, was planned with an update in the next few months to mitigate the risk and would include YTHFM.

Denise McConnell highlighted that the meeting of the Committee in July was not quorate but went ahead primarily due to finance and reporting around the current deficit. The Committee members present wanted to understand the actions and what the implications would be if continued. The SIRO report was discussed and was to be presented to the Board in September.

Lynne noted that there had been an error in the recording of the risk around digital and the YTHFM desktop exercise (Page 259). James Hawkins confirmed that there was to be a Cyber attack - practice desktop in September to understand what the implications will be.

57 23/24 Finance Update

Andrew Bertram reported a £3.7m deficit in the core delivery of the CIP programme, with an adverse impact of £1.4m. The Trust was currently facing financial distress, with £17.6m of plans and £4m worth of plans to identify. The ICB had asked for further reduction, with £10.1m remaining. Staff were challenged in terms of identifying plans. The Trust was working on a recovery plan, meeting with care group leadership teams to discuss finance and recovery action options. The recovery plan was to be prepared executive teams and in place to engage with the ICB.

Mark Chamberlain questioned the understanding of care group leadership and staff's business and quality thinking, as these could have a significant impact. Andrew shared that the pandemic had changed NHS resource consumption understanding and are now nationally trying to reset that and conscious that this needed to be done in a way where finance was not dominating. Efficiency was key, but it was not be a barrier to patient care delivery.

Simon Morritt emphasised the importance of efficiency in patient care, stating that it should not hinder delivery. He noted that pre-COVID-19 procedures were more restricted, and he

suggested considering the convenience of certain procedures whether in the circumstances, is it convenient for the Trust to carrying them out.

58 23/24 Any Other Business

Karen Stone reported that she had received an announcement during the meeting that the Junior Doctors trike would proceed on 11 August for a duration of 4 days.

59 23/24 Time and Date of next meeting

The next meeting if the Board of Directors held in public will be on 27 September 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 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	Amber
BoD Pub 05	**155**	21 March 2023			Board to review and discuss the current 'paperlight strategy' and lead the way on e.g. the process, system, culture change needed for adoption of a paperlight strategy across the Trust.	Trust Chair	Escalation from Digital, Performance & Finance Assurance Committee to Board of Directors	Sep-23	Amber
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 & CDIO	MT - Update 06.06.23 chasing up with James Hawkins and Nikki Slater	Sep-23	Amber
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	Nov-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 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	Red
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	Red
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

BoD Pub 17	-	24 May 2023	39 23/24	AOB - Question from the Public	Review of Eliminating Mixed Sex Accommodation (EMSA) Policy	Chief Nurse	Emma Hardy attended the Board meeting. Virginia Golding Reviewing and Emma had been asked to patriciate in that. 26.07.23 - A matter arising as the policy remained under review and Tara Filby has a meeting arranged 03.08.23 with Emma Hardy to gain views.	Sep-23	Amber
BoD Pub 18	-	27 July 2023	54 23/24	Quality and Safety Assurance Committee	The Board requested that a report or presentation of the review is submitted to a future Board meeting following the deep dive exercise already planned.	Claire Hansen	Board to receive a diagnostic review outcome report.	Dec-23	Green

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 September 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, Lucy Letby case, Our voice Our future, care group structure review, vaccination programme, Public Sector Decarbonisation Scheme, Celebration of Achievement and Chair appointment.

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	27 September 2023	

Chief Executive's Report

1. Industrial action

Industrial action for the medical workforce continues across the NHS, with action taking place for consultants on 19 September, junior doctors on 21 and 22 September, and for the first time both juniors and consultants together on 20 September and 2-4 October.

As these strikes continue without resolution, it is putting increasing pressure on our services and has inevitably had an impact on our ability to deliver maximum levels of activity and continue to reduce the backlog of patients who have the longest waits to be seen and treated. This is likely to be further compounded by the consultant and junior doctor strikes taking place simultaneously, as we will need to plan to provide 'Christmas day' levels of service during these periods of action.

We continue to manage and plan for the strikes through our command and control structures, and I must thank everyone for their efforts during all of these strikes, including those responsible for planning our response to the action, and those who are working differently and stepping up to cover colleagues so that they can exercise their right to strike.

2. Lucy Letby case

You will no doubt be aware of the case of Lucy Letby, who was found guilty of the murder of seven babies and the attempted murder of six more while working as a nurse.

This is an incredibly difficult and distressing case, and we are already beginning to see the potential impact on the wider NHS as a result. What is clear is the importance of all staff being able to speak up and freely raise questions or concerns, and that these concerns are listened to and acted on.

Quite rightly, issues of patient safety, how concerns are raised and listened to, culture, governance processes around decision-making and accountability, are all now being scrutinised.

Our Interim Chief Nurse, on behalf of the Trust Board, has commissioned an internal review to investigate our current processes for staff to escalate concerns regarding patient safety, and make any recommendations for improvements.

October is also Speak Up Month in the NHS, and we will be using this as an opportunity to promote all of the ways we have for staff to raise concerns, and relaunching our Fairness Champions role to recruit more champions and promote their role to staff.

3. Our Voice, Our Future

This month saw the launch of our Cultural Leadership Programme, Our Voice, Our Future. To deliver this, we are following an evidence-based programme for continuous improvement to develop compassionate leadership and an inclusive culture.

When I joined this trust we held a largescale conversation with colleagues to help us to understand the priorities for our workforce at the time.

This work, called Our Voice, Our Future, gave us our trust values and our behaviour framework, which are increasingly informing all aspects of how we work. What remains clear is that we didn't go far enough on what is arguably the most important challenge of all: creating a culture where we are all listened to, treated fairly, and feel proud to work.

We now need to build on these foundations in the next stages of our work. That is, listening to and learning from staff across the trust, responding to feedback, and setting clear expectations for how we treat each other, based on our values.

We are recruiting a Change Team, made up of individual Change Makers from all grades and areas of the trust and York Teaching Hospital Facilities Management who will engage with colleagues to discover what it is like to work here, and how we can make things better. This will tell us the actions we need to take and the areas to prioritise to deliver our culture change ambitions. Once recruited, the Change Makers will be trained and supported in gathering insight from across the workforce to help us develop our priorities and actions for change.

This is a long-term programme of work, and we will be revisiting it regularly at our Board meetings.

4. Care group structure review

As Board colleagues are aware, we have been reviewing the current care group structure to deliver a change from six groups to four. These four groups are Medicine; Surgery; Family Health; and Cancer, Specialist and Clinical Support Services care groups.

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.

This structure will formally commence on Monday 2 October 2023, although services have been transferring over in a phased way since the beginning of September.

The recruitment process is also now complete, with people appointed into all of the key roles in the senior leadership teams for each Care Group.

I would like to take this opportunity to pass on my sincere thanks to Care Group Directors Gerry Robins and Srinivas Chintapatla who are stepping down from Care Group Management roles to concentrate on their clinical duties, and Associate Chief Operating Officer David Thomas, who is leaving the trust. I wish David all the best in his future endeavours.

I would also like to welcome Richard Agyekum-Sakyi (Associate Chief Operating Officer) and Sascha Wells-Munro (Director of Midwifery) to our Trust.

As part of the transition to the new structure we are running a leadership development and training programme to support the leadership teams both as individuals in their roles and as collective groups of leaders in each care group. This sits alongside the review of 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.

5. Vaccination programme

Cases of COVID-19 have been increasing since early August, and there are signs of a new variant emerging as we head towards winter.

After a period of time where we have seen low numbers of cases, we have been reminding staff of processes and procedures around testing and PPE, as well as best practice such as hand hygiene and practical measures such as ensuring good ventilation.

We will also be beginning our staff vaccination campaign for flu and COVID-19 on 2 October, which remains one of our most effective tools in managing these viruses.

With the potential for this new COVID variant to increase the risk of infection we are following the latest expert guidance, and once again staff will be able to get their flu vaccine at the same time to maximise protection.

6. Public Sector Decarbonisation Scheme

The Board are aware that we have been successful in two previous bids under this scheme to reduce the Trust's carbon emissions. These schemes have seen improvements on the Bridlington and York sites. Unfortunately, due to overwhelming demand for access to the last scheme, we were unsuccessful in a bid to reduce the carbon emissions from our Scarborough site.

Salix, who administer this scheme on behalf of the Government, have recently announced the next phase of funding and are inviting bids from 12 October. We are working with Vital Energi, our long-term partner in this area, to prepare a bid under this application round. This will be based on improvements to our Scarborough site.

At this stage there is no action for the Board to take other than to note this work is underway and to support the team in making an application. If the Trust's bid is successful, then a full business case will be prepared for the Board to consider before any acceptance of the grant and mobilisation of the work. It is likely if this bid were to be successful then the Board would need to consider a more significant contribution from our own Capital Programme to support the work. Any details of this would be subject to full Board approval as part of approving any business case should the application be successful.

7. Celebration of Achievement

Nominations have now closed for this year's Celebration of Achievement Awards, which will take place in Scarborough on 9 November. Over 200 nominations were received from colleagues and patients, recognising the fantastic work that has been happening across the organisation over the past year.

The judging panels are deliberating as we speak, and I'm looking forward to hearing all of the different stories about how our staff are working hard to make a difference. It's so important that we take the time out to celebrate and recognise all the positive things that are happening in the organisation, more so than ever when we are under pressure and circumstances are particularly challenging. Thank you to everyone who took the time to nominate, and to the judging panels, who have a difficult job on their hands!

8. Chair appointment

I am delighted to be able to confirm that, following the governors' approval of the appointment, Martin Barkley has been appointed as Chair of the Trust.

Martin is a hugely experienced and highly regarded NHS leader with significant knowledge and experience of healthcare organisations and the challenges we face. Martin was Chief Executive of Mid Yorkshire Hospitals NHS Trust from 2016 until his retirement in 2021. This followed eight years as Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust.

Previously, Martin managed the commissioning and opening of the East Surrey Hospital, was Unit General Manager and Chief Executive for East Surrey Learning Disability and Mental Health Services, Chief Executive for Nottingham Healthcare Trust, and Chief Executive for Hampshire Partnership NHS Trust. He is currently a Governor on the Board of Leeds Beckett University and a Volunteer and Trustee at the Charity Zarach.

I'm sure you will join me in welcoming Martin when he joins us on 1 November.

Martin's appointment means that we bid farewell to Mark Chamberlain our Interim Chair. As this will be Mark's final public Board meeting, I must offer my thanks and appreciation to Mark on behalf of the Board for his leadership and support during his time with us. Mark will return to his role as a Non-executive Director on the Integrated Care Board of Humber and North Yorkshire Health and Care Partnership.

Date: 27 September 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

TRUST PRIORITIES REPORT

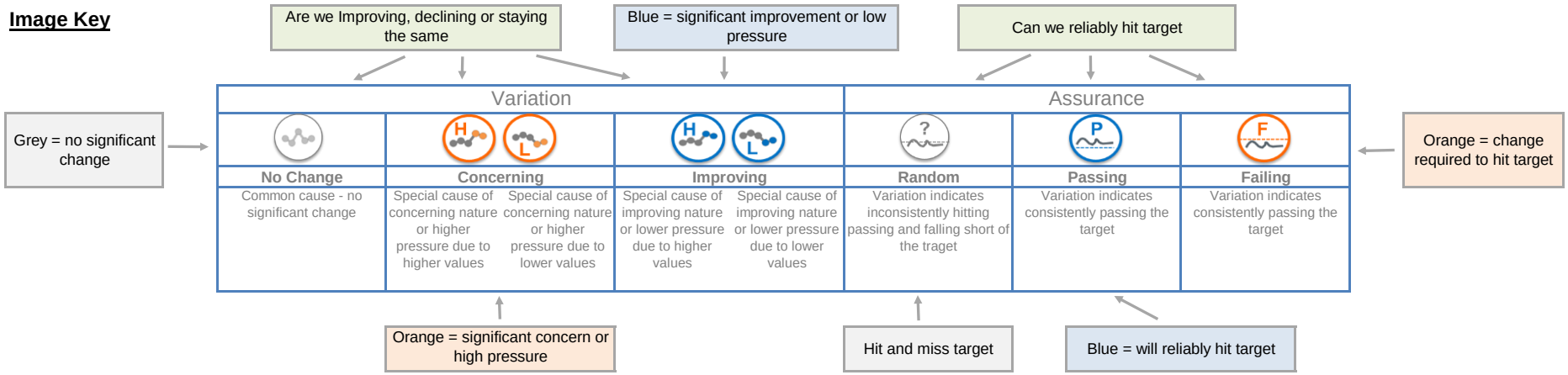
September 2023

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

KEYS

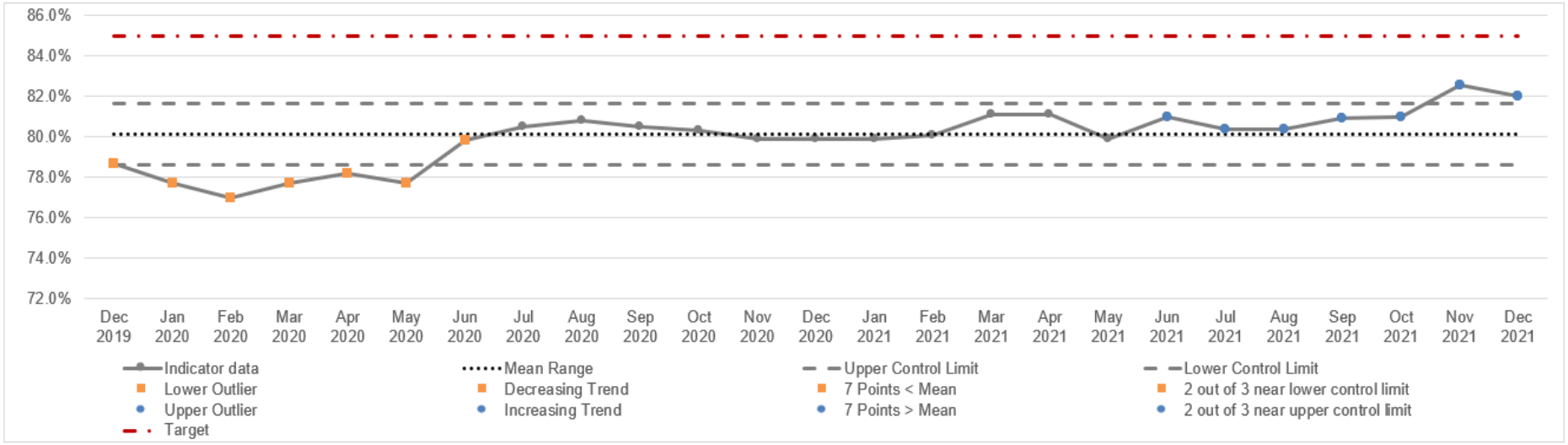
York and Scarborough Teaching Hospitals NHS Foundation Trust

Image Key



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

SPC Key - example SPC chart



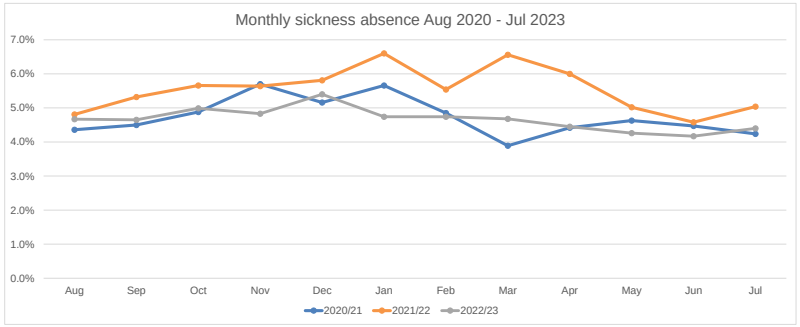
Orange Squares = significant concern or high pressure

Blue Circles = significant improvement or low pressure

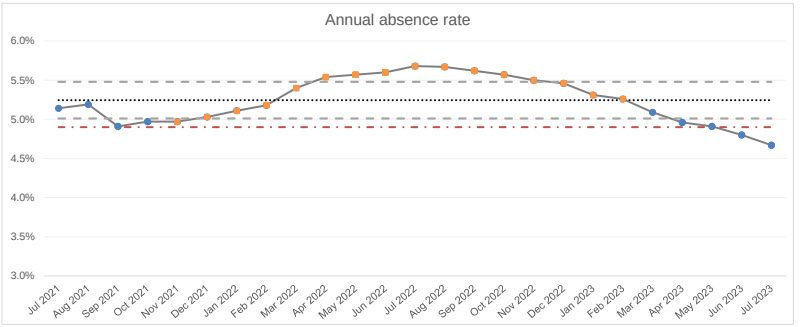
OUR PEOPLE - Sickness Absence and Staff Survey

York and Scarborough Teaching Hospitals NHS Foundation Trust

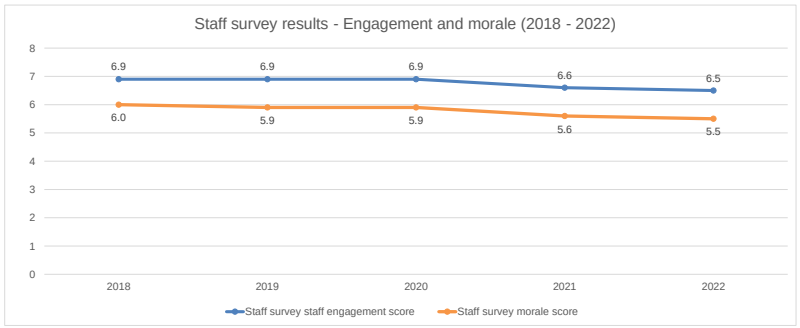
REPORTING MONTH : AUGUST 2023



Jul 2023
4.40%
Target
No Target
Variance
Assurance



Jul 2023
4.67%
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 Jul 2023 (4.40%) is lower than that seen last year (5.04%).
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 November 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

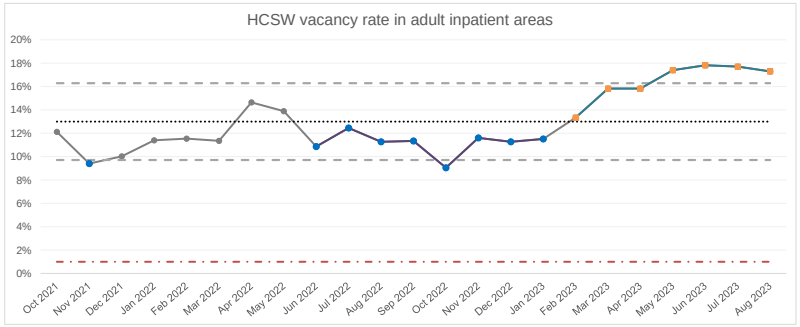
The latest available sickness data is for the month of and year ending July 2023. The most recent data has seen a small increase in the monthly absence rate, however, the annual absence rate continues to move in a positive direction.

Our Voice Our Future is planned for a communications launch on 18th September, this transformational programme should guide the Trust through seeking feedback from staff to understand what it is like to work here so we can make improvements to boost staff engagement and morale. The 2023 staff survey will launch on the 2nd October and run to 24th November, we will use communications through OVOF to try and increase completion rates for the survey.

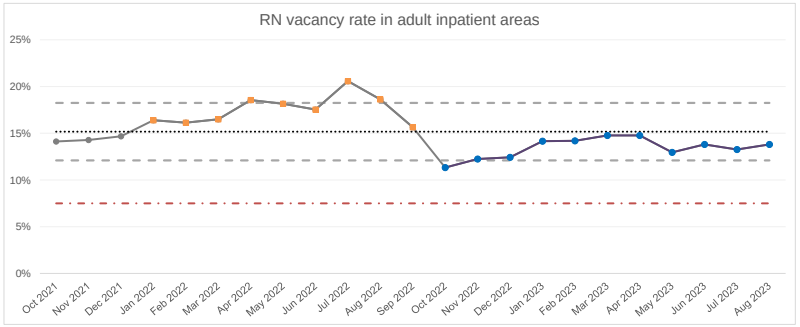
OUR PEOPLE - Vacancy Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

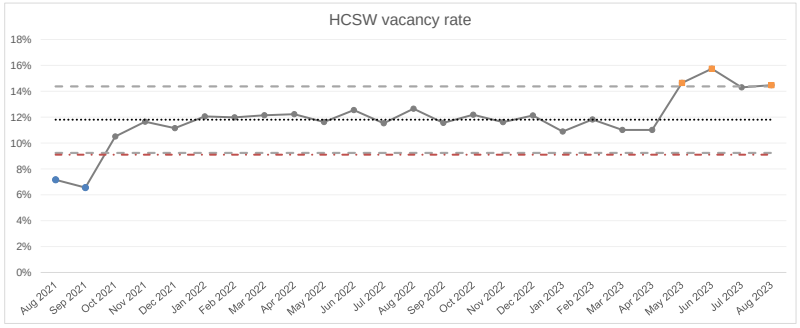
REPORTING MONTH : AUGUST 2023



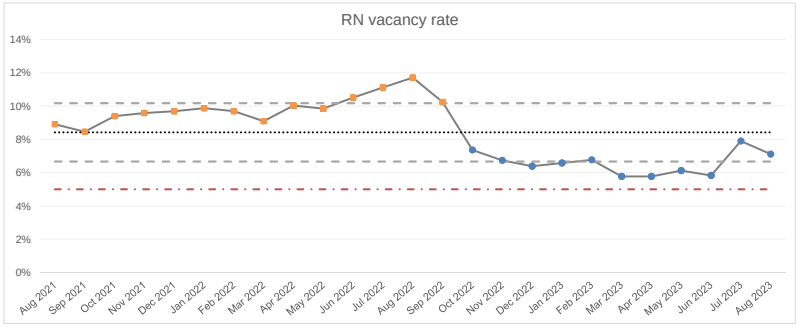
Aug 2023	Target	Variance	Assurance
17.29%	1%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Aug 2023	Target	Variance	Assurance
13.80%	7.5%	Special cause of improving nature or lower pressure due to lower values	Variation indicates consistently falling short of the target



Aug 2023	Target	Variance	Assurance
14.47%	9.10%	Special cause of concerning nature or higher pressure due to higher values	Variation indicates consistently falling short of the target



Aug 2023	Target	Variance	Assurance
7.11%	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 concern above the upper control limit from May 2023, however 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 upper control limit in May, Jun and Aug 2023. The target is slightly below the lower control limit and has not been met since Sep 2021.
RN vacancy rate: The indicator is showing special cause improvement, below the mean from Oct 2022. The months from Jun to Aug 2022 were above the upper control limit. The target is consistently not being met.

Operational Update

There continues to be a lot of recruitment activity in the Trust. The organisation continues to welcome our new international recruits, with 15 nurses commencing in the August cohort. The Trust has welcomed 46 international nurses since April. In September, the Trust will welcome a cohort of 4 paediatric nurses, with two further cohorts of general nurses planned for October and November to reach our recruitment target of 90 nurses by the end of November. The October cohort already has nurses allocated and interviews are currently taking place, with a number of offers already made, to fill our November cohort. NHSE have advised that our bid for additional funding to recruit a further 24 international nurses by the end of February 2024 has been successful, awarding the Trust a further £240k. Interviews are taking place in the first two weeks of September with an expectation that offers will be made for all 24 places.

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 8.44%. The Trust is delighted to be getting ready to welcome 106 Pre-Registered Nurses into the organisation. Preparations continue to support our new recruits to be ready to start their preceptorship programme in October.

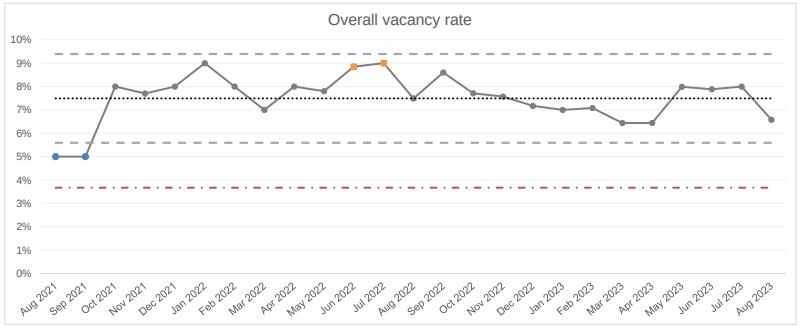
Recruitment of HCSWs continues to be a priority, as we progress pre-employment checks for candidates recently offered posts, so they are ready to move through for the new Healthcare Support Worker Induction Programme and Academy starting at the end of October. The Trust will be trialling a new approach to the HCSW interview process with a smaller number of candidates on 7th September at the Community Stadium. The improvements should give candidates a better interview experience and provide the Trust with more robust assurance around an individual's suitability for the role, with an aim to improve the retention of new starters. Our next Healthcare Support Worker Recruitment Event will be held on the 2nd of October at the Community Stadium, where we plan to fully launch the new and improved interview process. This event will be specifically for Surgery, Family Health and Support Services, with Surgery leading the event. The Trust is also holding an East Coast AHP Recruitment Day on the 9th September with an aim to attract interest from individuals looking to pursue an AHP career. Healthcare Support Worker interviews are also scheduled to take place in Scarborough on the 21st September.

The vacancy rate on HCSW within inpatient areas that was unavailable for July has now been updated retrospectively.

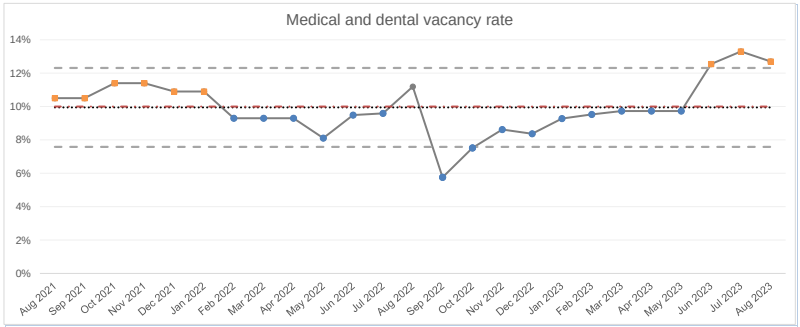
OUR PEOPLE - Vacancy Rate and Turnover Rate

York and Scarborough Teaching Hospitals NHS Foundation Trust

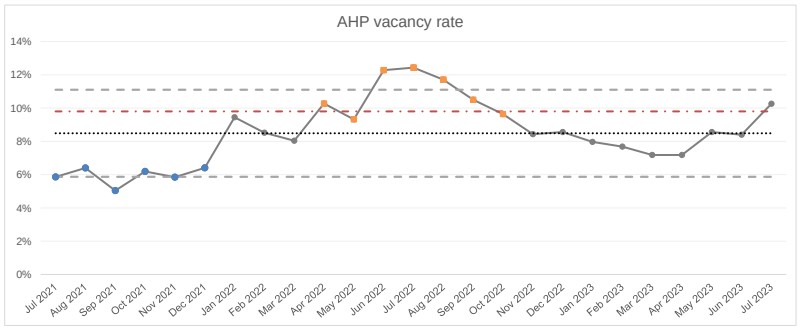
REPORTING MONTH : AUGUST 2023



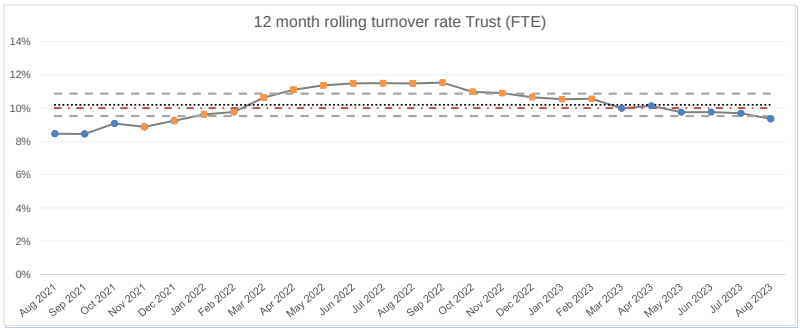
Aug 2023
6.58%
Target
3.67%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Aug 2023
12.7%
Target
10.00%
Special cause of concerning nature or higher pressure due to higher values
Variation indicates inconsistently hitting passing and falling short of the target



Jul 2023
10.3%
Target
9.80%
Variance
Common cause - no significant change
Assurance
Variation indicates inconsistently hitting passing and falling short of the target



Aug 2023
9.35%
Target
10%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
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 is now showing common cause variation. The indicator is consistently failing target.
Medical and dental vacancy rate: The indicator is showing special cause concern in Jun, Jul and Aug 2023 above the upper control limit. The target line is slightly above the mean. Please note that both Apr & May 2023 are showing the same as Mar 2023 due to the reason given above.
AHP vacancy rate: The indicator was 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 Nov 2021 to Feb 2023. 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 just below the mean.

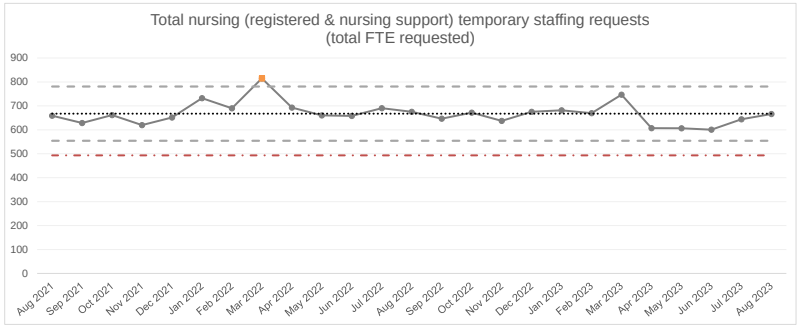
Operational Update

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.

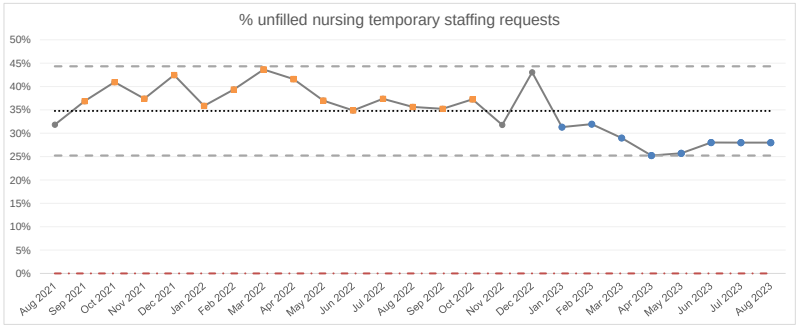
OUR PEOPLE - Temporary Staffing

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

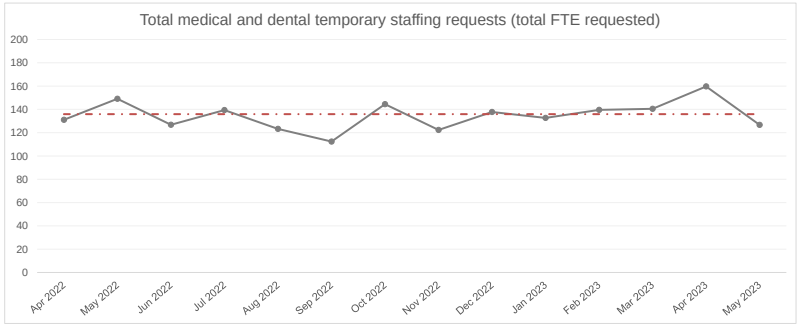
REPORTING MONTH : AUGUST 2023



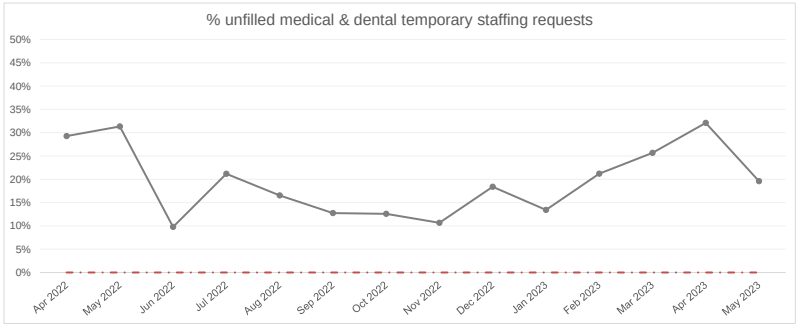
Aug 2023
666.00
Target
493.33
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Aug 2023
28.00%
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
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant



May 2023
19.60%
Target
0%
Variance
There is currently insufficient data, therefore variance and target assurance are not relevant
Assurance
There is currently insufficient data, therefore variance and target assurance are not relevant

Data Analysis:

Total nursing (registered & nursing support) temporary staffing requests (total FTE requested): The indicator was showing special cause concern above the upper control limit in Mar 2022. Since then it has shown common cause variation, and is consistently failing target with the target below the lower control limit.
% unfilled nursing temporary staffing requests: The indicator is showing several points above the mean from Sep 2021 to Sep 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

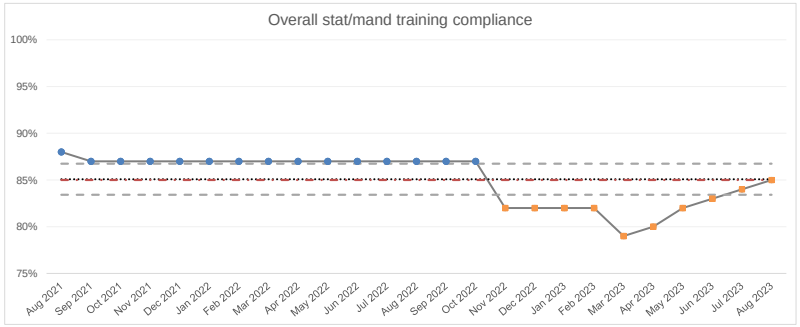
Following Executive Committee agreement to 'turn off' the agency Thornbury from 1st July the Trust has continued not to use any off-framework agency to cover nursing shifts which is a significant milestone for the organisation. Summer incentives were in place for the duration of the school summer holidays, these included the re-introduction of flexibility payments for substantive staff and Allocation on Arrival (AOA) shifts at double time for bank workers. AOA has been well utilised over the summer, with tighter control of shift allocation helping to keep use within the agreed level of incentivised shifts for this period. All ad hoc incentives have ended at this stage, and plans are being prepared for winter incentives.

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. In addition, the Trust has agreed plans to meet the financial controls put in place by NHSE across the ICS relating to the utilisation of agency, this includes the removal of off framework agency (the Trust has just one off framework medical booking at this time), the end of agency use for non-clinical roles and the governance arrangements for approving agency use.

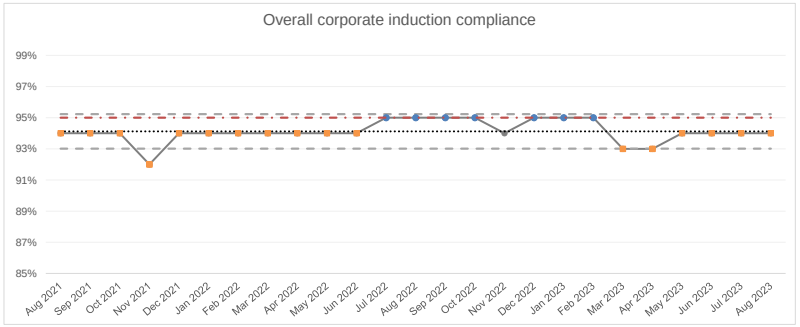
OUR PEOPLE - Training / Induction

York and Scarborough Teaching Hospitals NHS Foundation Trust

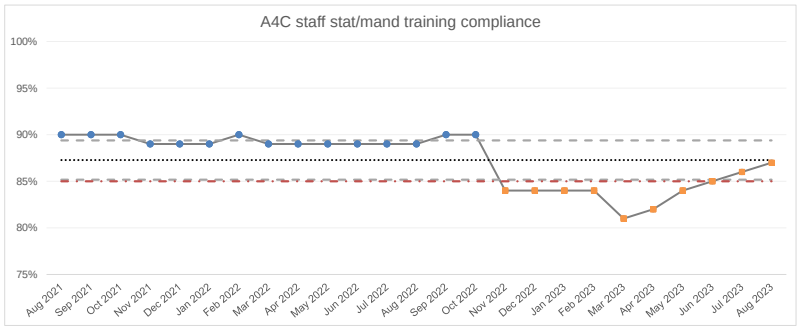
REPORTING MONTH : AUGUST 2023



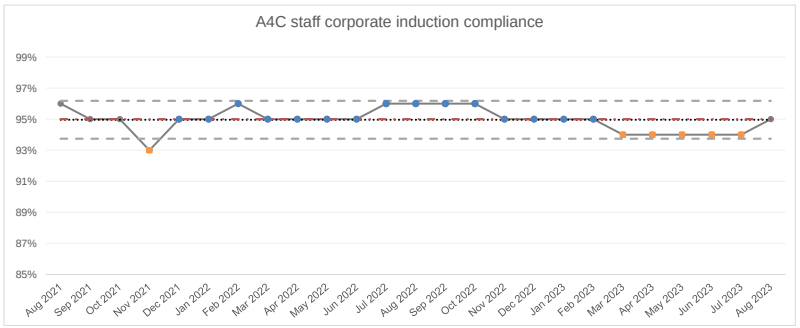
Aug 2023	Target	Variance	Assurance
85%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates inconsistently hitting passing and falling short of the target



Aug 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



Aug 2023	Target	Variance	Assurance
87%	85%	Special cause of concerning nature or higher pressure due to lower values	Variation indicates consistently passing the target



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

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

Overall staff stat/mand training compliance: This indicator was showing special cause improvement up to Oct 2022 with all data points above the mean and slightly above the upper control limit. From Nov 2022 to date the data points are below both the mean, but we now see an upward trend. Jul and Aug 2023 met the target.
Overall staff corporate induction compliance: The indicator was showing special cause concern close to the lower control limit in Mar and Apr 2023. It has now returned closer to the mean but still showing special cause variation. The target is just below the upper control limit.
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 the mean, thus showing special cause concern. Jul and Aug 2023 met the target, however.
A4C staff corporate induction compliance: The indicator was showing special cause concern in Nov 2021, and then again from Mar 2023 to Jul 2023 with the data points below the mean. The months from Mar 2023 to Aug 2023 have also not met the target.

Operational Update

Following Mandatory Training Month in August, the overall mandatory training compliance rate in the Trust has hit 85% in line with the target. This is above the trajectory the Trust set itself following its system failure in February and is a 1% increase from the previous month, whereas August normally sees rates stand still or deteriorate owing to junior doctors' changeover. There is room for improvement however as the rate is -2% compared with 12-months ago. The compliance target will now be stretched to 87%.

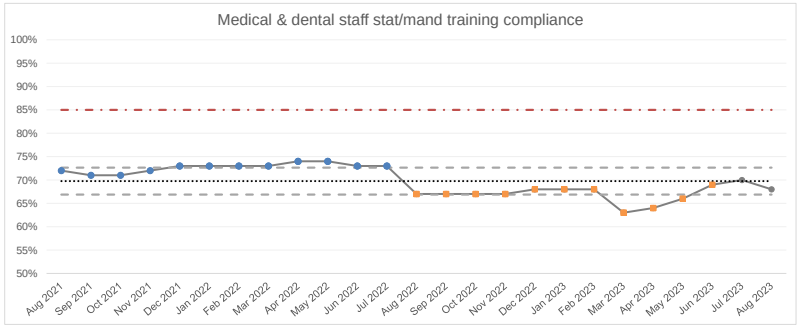
At subject level, training delivered wholly or partly in classrooms continues to see a lower overall completion rate compared with online training. Of note since last month are continuing increases in compliance for Equality, Diversity and Human Rights training (+3% to 78%), Paediatric Advanced Life Support (+3% to 62%) and Deprivation of Liberty Safeguards (+1% to 78% at Level 1 and +2% to 73% at Level 2).

Corporate Induction compliance has maintained at 94% which is 1% below the target of 95%. From next month, the Trust will commence its new programme whereby starters will receive their welcome and orientation as part of a workshop covering values and behaviours created through Our Voice Our Future.

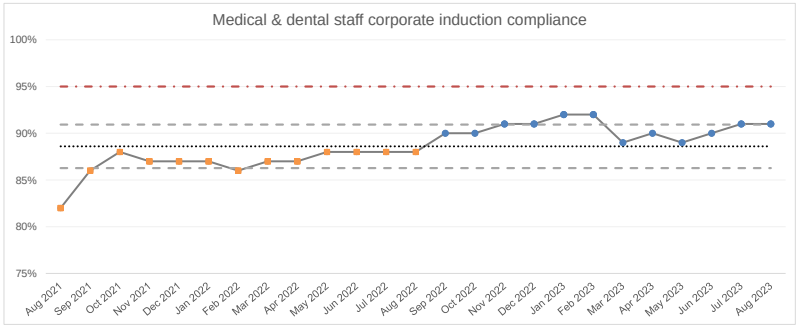
OUR PEOPLE - Training / Induction (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

REPORTING MONTH : AUGUST 2023



Aug 2023
68%
Target
85%
Variance
Common cause - no significant change
Assurance
Variation indicates consistently falling short of the target



Aug 2023
91%
Target
95%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Variation indicates consistently falling short of the target

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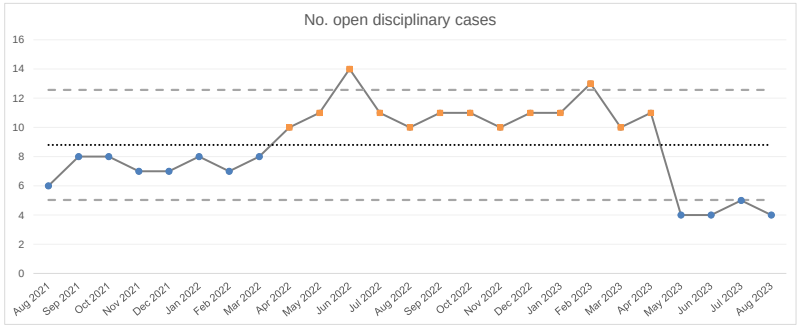
Data Analysis: (Please note Feb 2023 data is unavailable due to the Serious Incident on Learning Hub, the data points on the charts for Feb 2023 are the same as Jan 2023).

Medical & dental staff stat/mand training compliance: The indicator is consistently failing target. Compliance from Aug 2022 to Jun 2023 is below or around the lower control limit, and is therefore is showing special cause concern. Recent months have returned to the mean and is now showing common cause variation.
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. The indicator is consistently failing target.

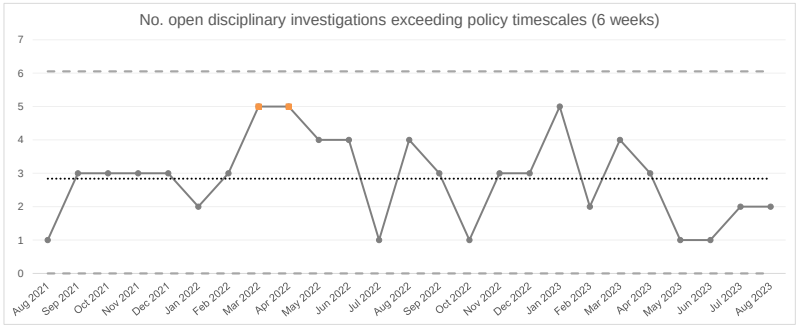
OUR PEOPLE - Employee Relations Activity

York and Scarborough Teaching Hospitals NHS Foundation Trust

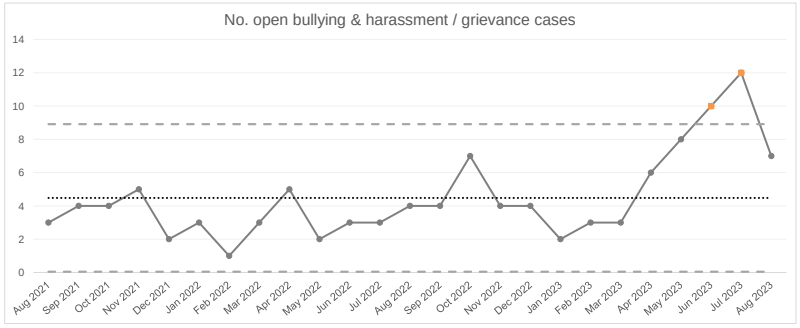
REPORTING MONTH : AUGUST 2023



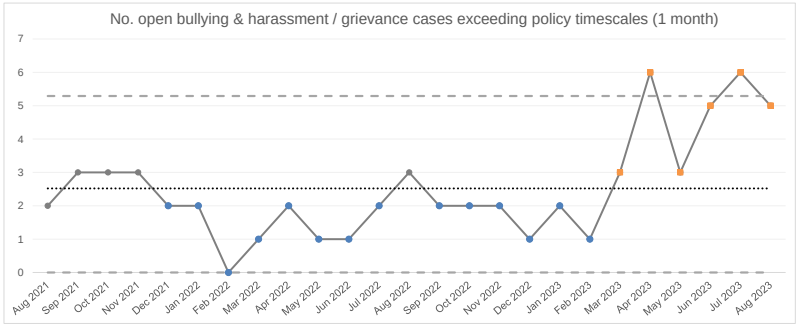
Aug 2023	Target	Variance	Assurance
4	No Target	Special cause of improving nature or lower pressure due to lower values	There is no target, therefore target assurance is not relevant



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



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



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

Data Analysis:

No. open disciplinary cases: The indicator 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 from May 2023, below or around 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 was showing special cause concern above the upper control limit in Jun and Jul 2023, after a prolonged period of common cause variation with some degree of variation around the mean. Aug 2023 returned below the upper control limit.
No. open bullying & harassment / grievance cases exceeding policy timescales (1 month): The indicator has shown special cause concern in Apr and Jul 2023 above the upper control limit, with data points above the mean from Mar 2023.

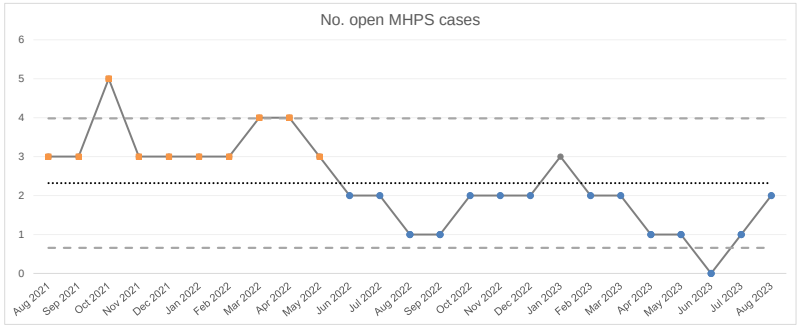
Operational Update

The Operational HR Team are continuing to deal with a high volume of informal cases and investigations which is taking a significant proportion of their time. We are continuing to see a number of concerns being raised regarding the alleged behaviour of colleagues and whilst these may not be dealt with through a formal process, handling these informally takes time and impacts on wider teams.

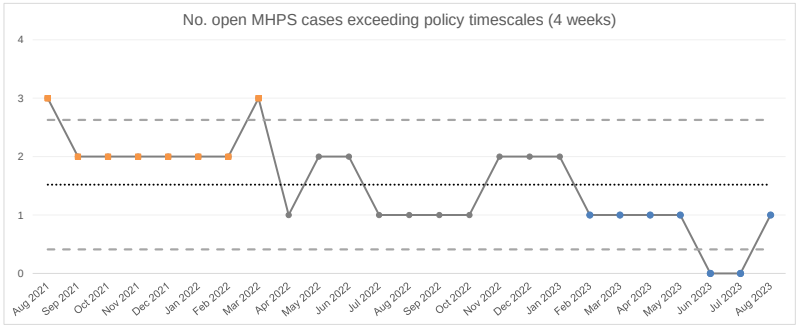
OUR PEOPLE - Employee Relations Activity and Appraisals

York and Scarborough Teaching Hospitals NHS Foundation Trust

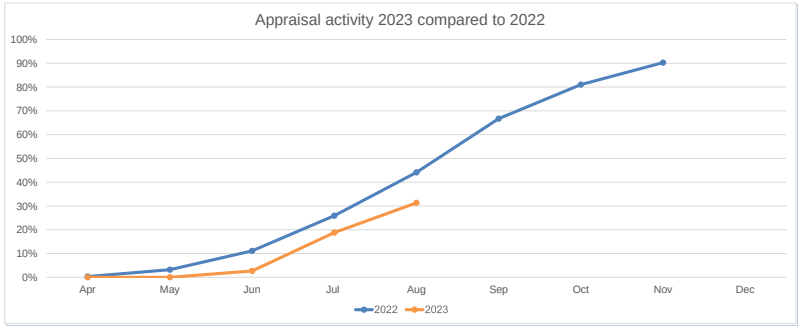
REPORTING MONTH : AUGUST 2023



Aug 2023
2
Target
No Target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant



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



Aug 2023
31.30%
Target
90%

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Data Analysis:

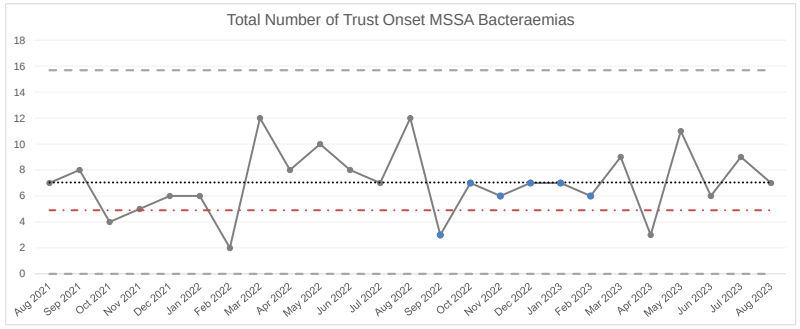
No. open MHPS cases: The indicator is showing special cause improvement from Jun 2022, apart from Jan 2023. Prior to Jun 2022, the data points were all above the mean.
No. open MHPS cases exceeding policy timescales (4 weeks): The indicator is currently showing special cause improvement from Feb 2023, after a period of data points above the mean up 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 2023 (in August this was 31.30% in 2023 compared to 44.09% in 2022, however the start of the appraisal window was delayed in 2023).

Operational Update

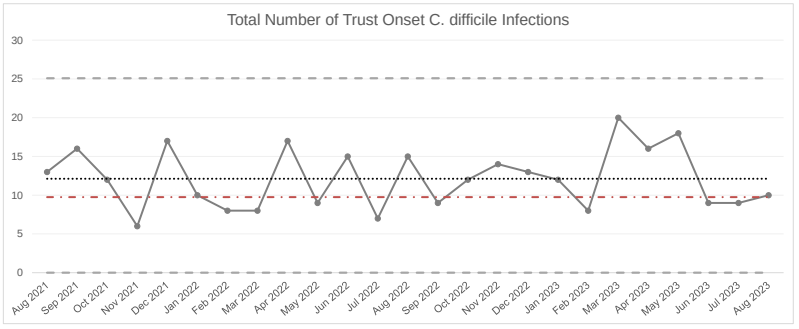
QUALITY AND SAFETY - Priority Metrics

NHS York and Scarborough Teaching Hospitals NHS Foundation Trust

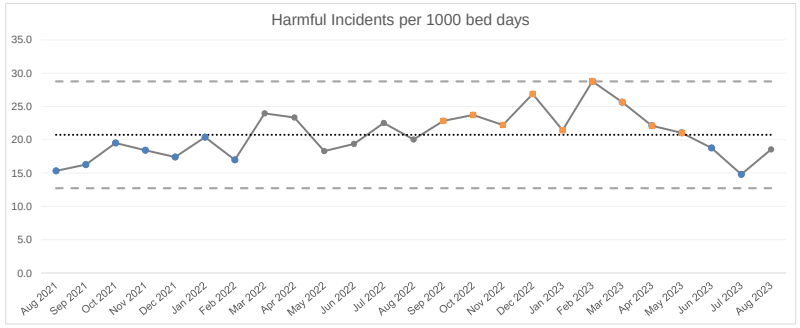
REPORTING MONTH : AUGUST 2023



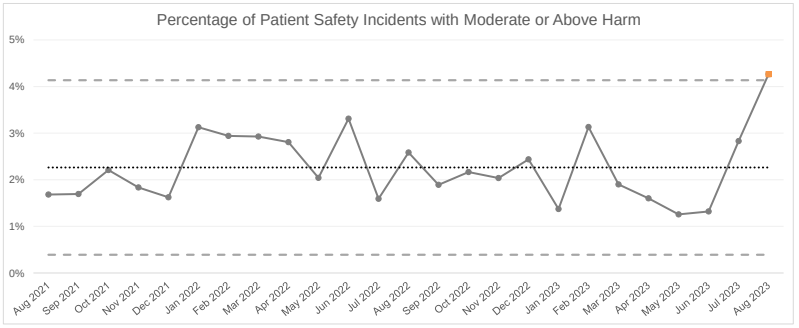
Aug 2023	Cumulative 12-month Target	Variance	Assurance
7	59	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



Aug 2023	Cumulative 12-month Target	Variance	Assurance
10	116	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target



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



Aug 2023	Target	Variance	Assurance
4.3%	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant

Data Analysis:

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 improvement due to the data points below the mean from Jun 2023, but is showing an upward trajectory back towards the mean. Therefore, the indicator is currently showing common 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 special cause concern due to a sharp rise in Aug 2023 above the upper control limit.

Operational Updates:

Total Number of Trust Onset MSSA Bacteraemias
MSSA bacteraemia over trajectory by 10 cases (6 cases in August, target is 5 cases per month, 59 for the year) Of the 35 cases, 22 are attributed to York, 12 to Scarborough and 1 to Easingwold Renal Unit. The Staphylococcus aureus bacteraemia reduction working group continues to drive initiatives to improve cannula management. The recent development of the VIP score functionality on Nucleus will improve cannula checks and prompt removal of cannula when they are no longer required.

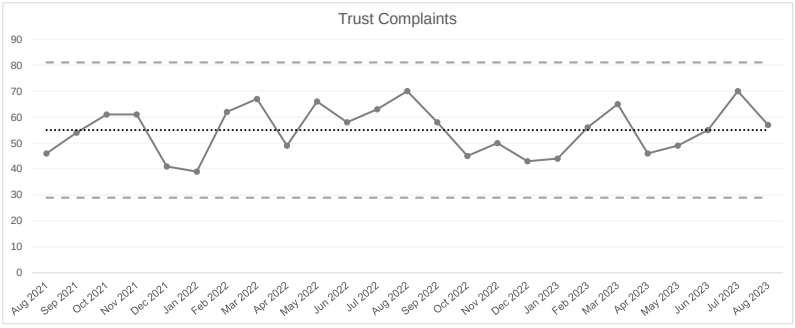
Total Number of Trust Onset C. difficile infections
The C.difficile performance for June to August 2023 has shown slight improvement with three consecutive months of cases on or below our monthly trajectory. The last time the Trust was in this position was March 2022; however, we are over the year-to-date trajectory by 14 cases. Trajectory for the year is 116 cases. Of the 62 hospital attributed cases this year, 42 are attributed to Scarborough and Bridlington, 18 to York and 2 to Community In-patient Units. The CDI Improvement plan will be refreshed in September and reviewed at the C.difficile Improvement Group (CDIG) to progress actions for improvement.

Harmful Incidents per 1000 bed days / Percentage of Patient Safety Incidents with Moderate or Above Harm
In July 2023 there were fewer incidents reported at no harm or low harm, which disproportionately affected the percentage of those incidents showing at moderate or above harm. The Patient Safety Team had reported in June a reduction in the number of incidents being reported, however recent special cause variation has been seen above the upper control limit for incident reporting, likely caused by the DCIQ go live. Issue log has been produced to capture problems arising and regular meetings with the project lead at Datix to rectify these. No recent reports of staff being unable to report incidents, will continue to monitor and encourage reporting. Datix Manager is going to continue to monitor to ensure reporting rates are improving. The launch of DCIQ is being investigated as a Serious incident. The reduction appears predominantly in the number of falls and pressure ulcers reported, although improvement has been seen in the numbers of pressure ulcers reported. The leads have been informed and further communication sent to encourage reporting of these incidents and also in relation to the change in the format for how Falls are reported on the Datix system. August reporting was improving, however The Patient Safety Team has had system calls with DCIQ as they are having national systems failures, which has affected us and ability to report. Business Continuity Plan has been shared with Care groups to ensure incidents are still captured.

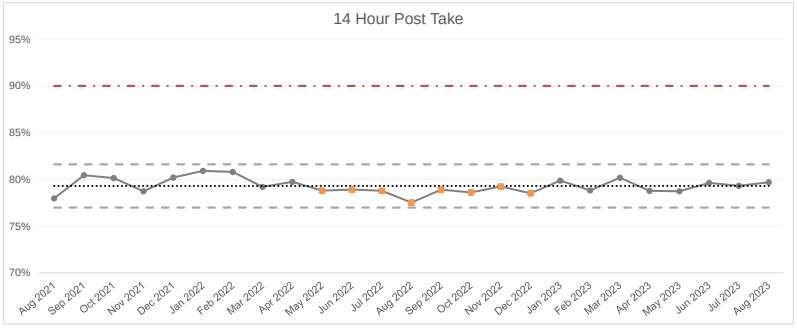
QUALITY AND SAFETY - Priority Metrics (cont.)

York and Scarborough Teaching Hospitals NHS Foundation Trust

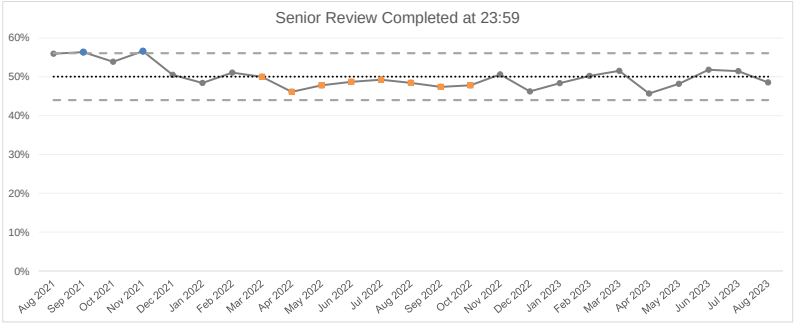
REPORTING MONTH : AUGUST 2023



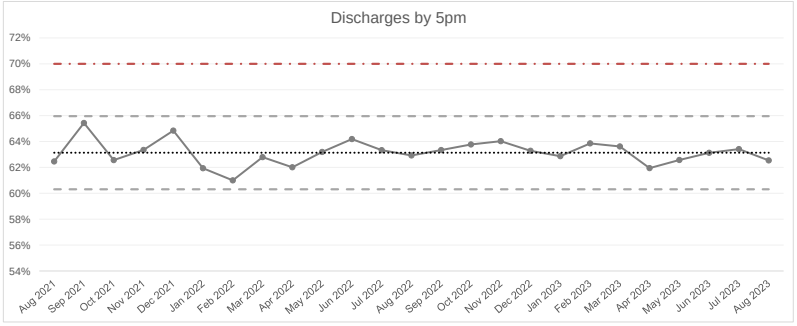
Aug 2023	Target	Variance	Assurance
57	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Aug 2023	Target	Variance	Assurance
79.7%	90%	Common cause - no significant change	Variation indicates consistently falling short of the target



Aug 2023	Target	Variance	Assurance
48.6%	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Aug 2023	Target	Variance	Assurance
62.5%	70%	Common cause - no significant change	Variation indicates consistently falling short of the target

Data Analysis:

Trust Complaints: The number of Trust complaints is currently showing common cause variation.
14 Hour Post Take: This indicator is consistently failing target, with the upper control limit falling beneath the target. This indicator requires process re-design in order to meet target. 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 was previously shown with a run below the mean from Mar 2022 to Oct 2022. 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
Issues with DCIQ and difficulty getting data required but still awaiting training. These issues are ongoing and have been escalated, due to the impact on Patient Experience Team performing their roles.

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 (Priority)

York and Scarborough Teaching Hospitals NHS Foundation Trust

Filters:

METRIC

All

METRIC GROUP

All

VariationIcon	P	?	F		Total
Improvement			2		2
H					
L			2		2
Common Cause		5	3		8
		5	3		8
Concern	1				1
	1				1
Neither					
Empty					
Total	1	5	5		11

MetricName	Date	Variation	Assurance	Target	Latest Value
ED - Proportion of Ambulance handovers waiting > 60 mins	2023-08		F	10.0	18.0
ED - Proportion of all attendances having an initial assessment within 15 ...	2023-08		F	66.0	45.8
ED - Total waiting 12+ hours - Proportion of all Type 1 attendances	2023-08		F	7.5	17.2
ED - Median Time to Initial Assessment (Minutes)	2023-08		?	18.0	16.0
ED - Emergency Care Standard (Trust level)	2023-08		?	71.9	69.4
Cancer - Faster Diagnosis Standard	2023-07		?	70.7	61.6
Cancer - Number of patients waiting 63 or more days after referral from C...	2023-08		?	165.0	315.0
RTT - Total Waiting List	2023-08	H	P	48390.0	53190.0
RTT - Waits over 104 weeks for incomplete pathways	2023-08	L	F	0.0	4.0
RTT - Waits over 78 weeks for incomplete pathways	2023-08	L	F	0.0	83.0
RTT - Waits over 65 weeks for Incomplete Pathways	2023-08		?	880.0	999.0

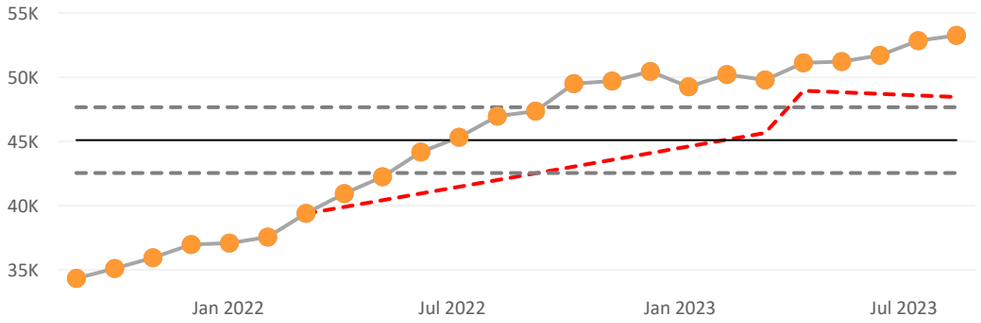
TPR: Elective Recovery Priority Metrics

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



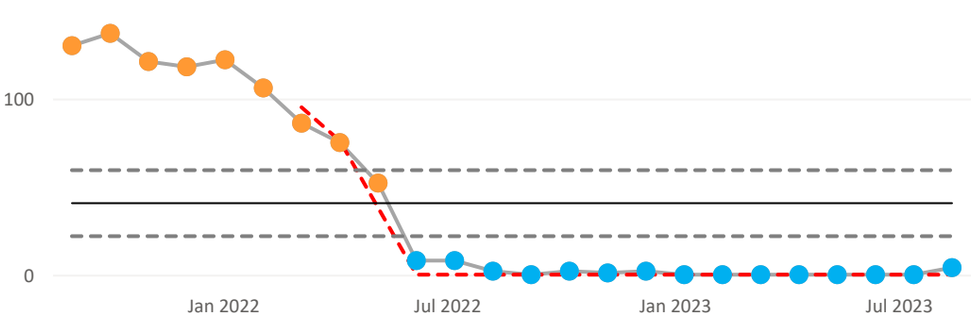
LATEST MONTH
2023-08
Value
53.2K
Target
48.4K

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 **413.0**.

MetricName: RTT - Waits over 104 weeks for incomplete pathways

Variation: L | Assurance: F



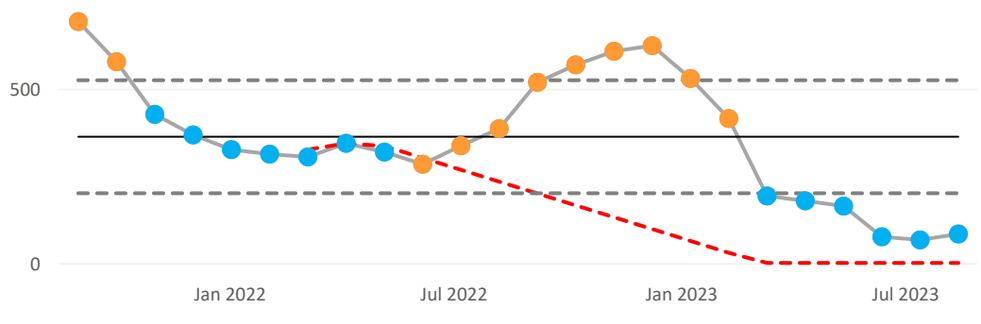
LATEST MONTH
2023-08
Value
4.0
Target
0.0

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 **increased** from the previous reporting month, with a difference of **4.0**.

MetricName: RTT - Waits over 78 weeks for incomplete pathways

Variation: L | Assurance: F



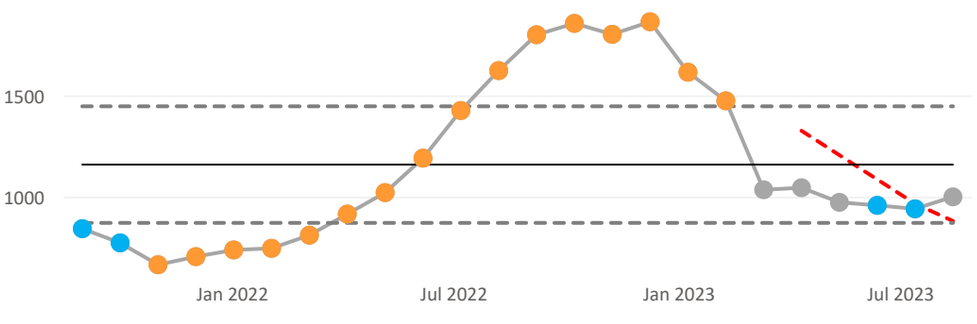
LATEST MONTH
2023-08
Value
83.0
Target
0.0

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 **increased** from the previous reporting month, with a difference of **17.0**.

MetricName: RTT - Waits over 65 weeks for Incomplete Pathways

Variation: | Assurance: ?



LATEST MONTH
2023-08
Value
999.0
Target
880.0

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 **increased** from the previous reporting month, with a difference of **59.0**.

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 315 patients waiting over 63 days at the end of August 2023 against the improvement trajectory of 165. June 2023 saw the highest number of cancer referrals received by the Trust in the last 18 months (an additional 300 above the average for that period) which has fed through into the higher number of patients now waiting over 63 days. 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 Trust has received the Elective Improvement Support Team (IST) closure report. Following the IST undertaking a Tier one review with the Trust on the 6th and 7th of December 2022, a program of support was agreed in line with priorities identified and comprised of sixteen core objectives with a particular focus of targeted support for key areas of the 78/65-week recovery plan, ENT and Max Fax services. An additional two objectives to support Gynaecology were agreed during the assignment. Eleven of the objectives have been achieved and established within the Trust as business as usual, three objectives are ongoing with IST support and four objectives have been paused due to capacity however the IST have agreed to support the Trust to deliver these when the Trust is able to progress. The next stage is for the IST to share the closure report and business as usual recommendations NHS England regional team colleagues with an assurance visit to be arranged in 3 months following closure of the assignment. 2. The Tier 1 regime has moved to a weekly meeting with the Chief Executive, Medical Director, and Chief Operating Officer. The Trust had 83 RTT 78-week waiters remaining at the end of August. 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. Ahead of the start of activity planning for 2024/25 a Planning Masterclass for Care Groups will be held on the 15th of September 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.

TPR:

Narrative for Elective Recovery Priority Metrics

York and Scarborough Teaching Hospitals NHS Foundation Trust

BI&IREF : 10042

Challenges & Risks	Actions & Mitigations
Risks: Ongoing management of high levels of acute activity and delayed discharge impacting ordinary elective work. Theatre staffing vacancy, retention, and high sickness rates. 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 present as well as insourcing options. Conversations continue with partner providers within the ICB around provision of mutual aid. Patient Initiated DMAS (PIDMAS) is coming online at the end of October 2023, the Trust is working with ICB and NHSE colleagues to understand the ask, implications and opportunities this will bring. Weekly Elective Recovery Meetings in place for long wait RTT patients. Use of IS capacity to support delivery of diagnostic activity (currently MRI and CT). Increased endoscopy insourcing was approved at Executive Committee on the 6th of September which when in place will result in an additional ten lists per week and the Trust is exploring mutual aid for endoscopy with NLaG. Radiology: The Trust has also agreed that MRI capacity delivered through the Independent Sector mobile will continue for the rest of this financial year with additional NOUS and DEXA capacity in the CDC spokes at Askham Bar and Selby. Plans in place to mitigate impact of industrial action.

TPR: Health Inequalities (RTT)

RTT PTL by Ethnic Group
At end of August 2023

Ethnic Group	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
White	23	35,457	98.18%	94.34%
Black, Black British, Caribbean or African	24	77	0.21%	0.94%
Mixed or multiple ethnic groups	25	148	0.41%	1.26%
Asian or Asian British	25	298	0.83%	2.97%
Other ethnic group	25	133	0.37%	0.49%
Unknown	22	13,533	-	-
Not Stated	22	3,568	-	-
Grand Total	**23**	**53,214**	**-**	**-**

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 August 2023

IMD Quintile	Average RTT Weeks Waiting	Number of Clocks	Proportion on RTT PTL*	Trust Catchment
1	23	6,276	12.10%	8.88%
2	23	7,256	13.99%	13.59%
3	23	11,010	21.22%	20.94%
4	23	11,236	21.66%	20.68%
5	23	16,103	31.04%	35.90%
Unknown	19	1,333	-	-
Grand Total	**23**	**53,214**	**-**	**-**

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.

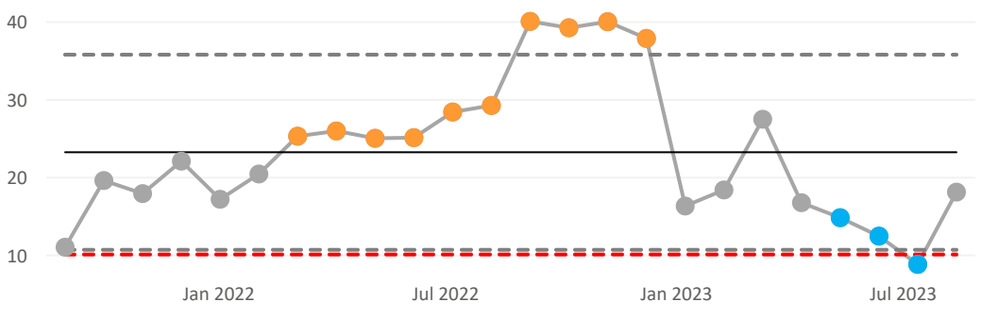
The next steps for this work will be to understand any differentials between the population base and the waiting list. Further analysis will be undertaken in coming months, and this piece of work will also be expanded to include Urgent Care, Cancer, Learning Disabilities and Military Veterans.

TPR: Acute Flow Priority Metrics

MetricName

ED - Proportion of Ambulance handovers waiting > 60 mins

Variation Assurance



LATEST MONTH
2023-08
Value
18.0
Target
10.0

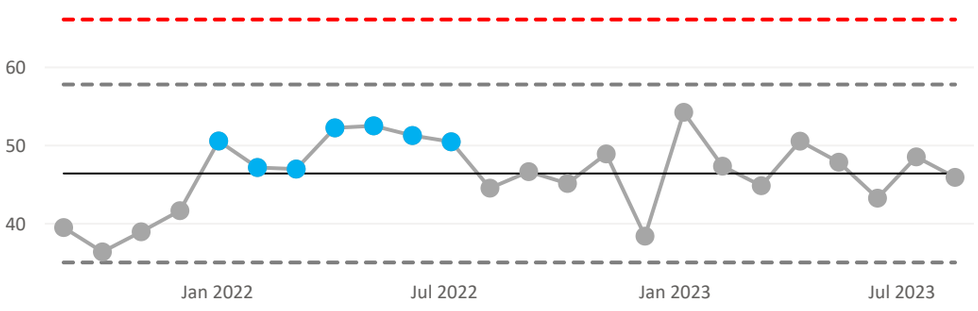
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **increased** from the previous reporting month, with a difference of **9.3**.

MetricName

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

Variation Assurance



LATEST MONTH
2023-08
Value
45.8
Target
66.0

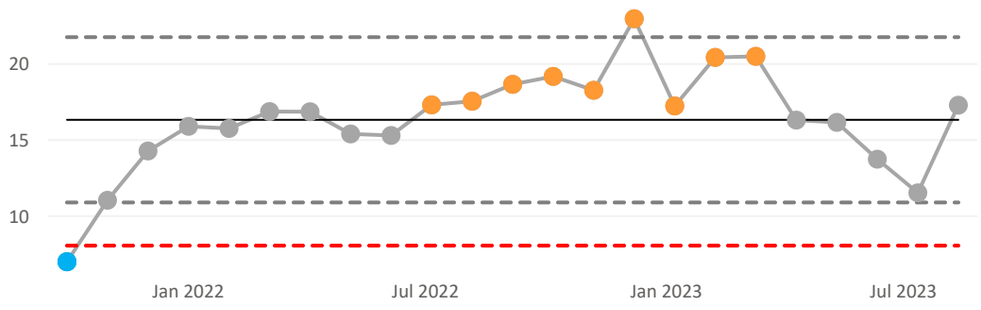
The indicator is **lower than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **decreased** from the previous reporting month, with a difference of **2.6**.

MetricName

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

Variation Assurance



LATEST MONTH
2023-08
Value
17.2
Target
7.5

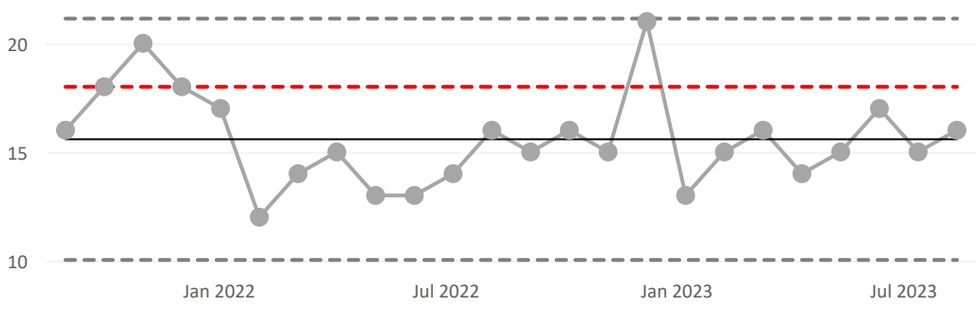
The indicator is **higher than** the target for the latest month and **is** within the upper and lower control limits.

The latest months value has **increased** from the previous reporting month, with a difference of **5.7**.

MetricName

ED - Median Time to Initial Assessment (Minutes)

Variation Assurance



LATEST MONTH
2023-08
Value
16.0
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 **1.0**.

Narrative for Acute Flow Priority Metrics

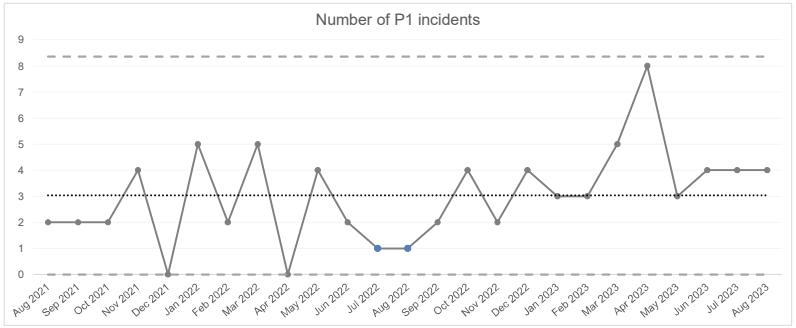
Challenges & Risks	Actions & Mitigations
Challenges: High number of patients without a 'Right to Reside' (227 on 7th of September 2023) in acute inpatient beds affecting flow and ability to admit patients from ED in a timely manner. Additionally, this is impacting Community Hospital inpatients beds (22 patients on 7th September 2023) and community response teams. Increased levels of COVID+ patients; 60-70 in our inpatient bed base throughout August. Staffing constraints (sickness, vacancies, use of agency and bank staff). Acuity of patients in York has increased, with the proportion of immediate and urgent patients increasing to 15.5% from 14.1% in July and 12.8% in June. The conversion rate for admissions also increased in August, 38.21% from 36% in July and 35.32% in June. Reduced workforce levels in the EDs (Christmas Day staffing levels) during industrial action period (24th and 25th August) leading into the Bank Holiday weekend. The percentage of delayed discharges increased in August to 33% from 29.67% in July and 32.4% in June.	Actions: 1. The new Emergency Department in York opened in July, with the full unit planned to be opened in October. The York build is the same size but with improved facilities and an estate that matches the procedural flow. The new clinical model includes rapid assessment at the front door by a senior decision maker. The full department will launch from 9th October 2023. This will co-locate Emergency medical assessment and admission unit/SDEC as well as Frailty same day emergency care. 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. As reported in July, The Humber and North Yorkshire Integrated Care System has been placed in Tier 2 in relation to Urgent and Emergency Care. The tier system has been developed to provide support to those systems who are challenged in terms of Urgent and Emergency Care delivery. For UEC it is grouped as an Integrated Care System, unlike Elective Recovery, to acknowledge the system nature of urgent and emergency care pathways. In relation to the Tier 2 position the system plan is set into stages with stage one ending on 30th September and therefore stage 2 plans are being finalised in the system groups to ensure that joint priorities are agreed for completion by 31st March 2024. Tier 2 systems are identified as requiring some support, whereas level three require more formal structured support, as with Tier 1 in Elective Recovery. The Universal support offer is a key focus of the national support for UEC. In July all providers were required to complete a maturity assessment against the key elements of the National UEC Recovery Programme, as a system. This led to the identification of four priority areas to access a Universal Support Offer. The four system priorities for North Yorkshire and York are: 1. SDEC 2. Virtual Wards 3. Site Management and Flow 4. Single Point of Access The support offer also included the development of UEC Champions, for the North Yorkshire and York system, these have been identified as Gary Young and John Darley from the ICB, Gemma Ellison from YSTH and Victoria Blake from Primary Care. The Champions are offered a network of support and dedicated sessions on the priority areas to provide support to address these. More detail is to be provided from the national team in September.

Challenges & Risks	Actions & Mitigations
	In August the required CQC actions in relation to UEC were developed into a project within the UEC Programme. This project is Operational Delivery Improvement. These actions will be reported on through the Programme from September. The full UEC Programme will also report to the Journey to Excellence Meeting. In September the Site Management Improvement/patient flow plans will be incorporated into the pan Trust UEC Programme to ensure consistent governance and approach. 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. 4. Integrated Intermediate Care A workshop was held on the 10th of July to develop ambition and stages of the project. A joint ambition including the 'one team' approach and objectives to achieve ahead of winter were identified. Subgroup also established in relation to developing the long-term vision and first draft developed for review by all partners. Stage 1: Single decision – one meeting; test frailty hub, specification for reablement, single medication chart. Stage 2: Review of provider of reablement service. Stage 3: Integrated Intermediate Care Offer – home first ethos, exit strategy from IIC to community-based service/independence, streamlined pathways with single point of access, single care record and increased generic workforce. Stage 1 actions (pre winter) for York Place underway with Stage 1 actions for NY Place to be confirmed.
Risks: Inability to achieve Ambulance Handover targets due to patient flow within the hospital although implementation of CIPHER has seen significant improvements. The work to embed new processes following the opening of the ED build in York will seek to impact the ambulance handover performance. Inability to meet patient waiting times in ED due to flow constraints at both sites. Staff fatigue. 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.

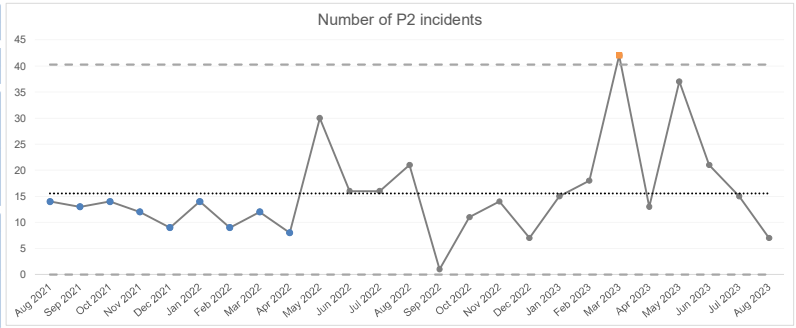
DIGITAL - Digital Indicators

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

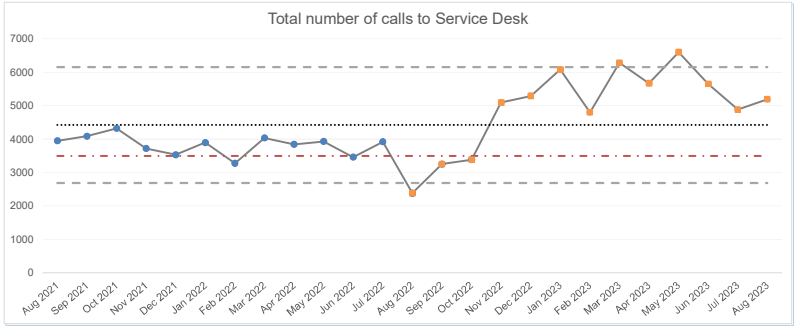
REPORTING MONTH : AUGUST 2023



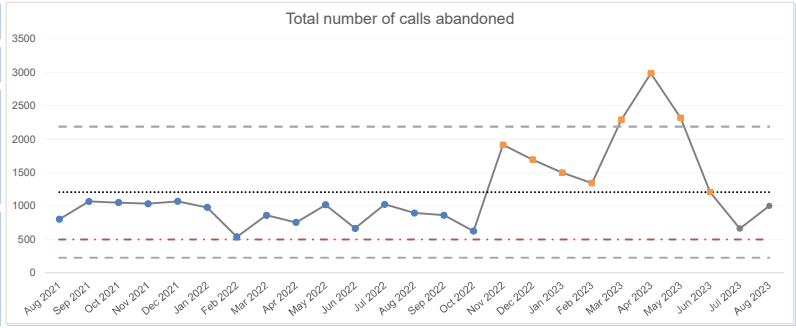
Aug 2023	Target	Variance	Assurance
4	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant



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



Aug 2023	Target	Variance	Assurance
5196	3500	Special cause of concerning nature or higher pressure due to higher values	Variation indicates inconsistently hitting passing and falling short of the target

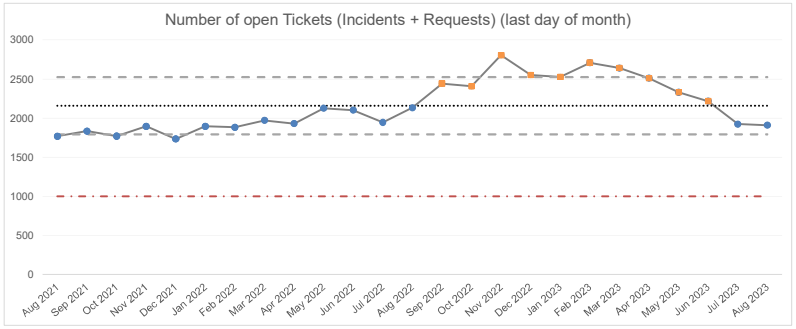


Aug 2023	Target	Variance	Assurance
1002	500	Common cause - no significant change	Variation indicates inconsistently hitting passing and falling short of the target

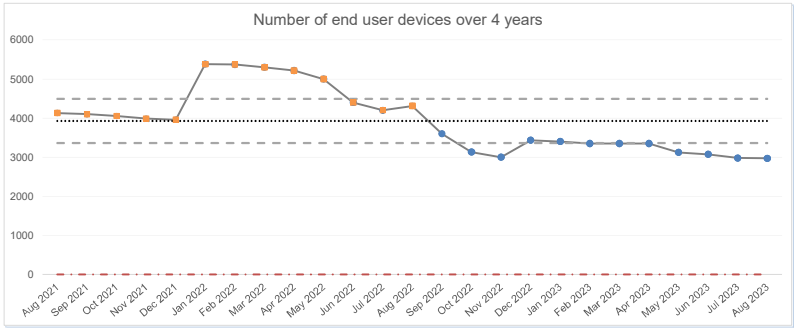
Data Analysis:

Number of P1 incidents: The indicator is currently showing common cause variation, the data points have been above or around 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 above the mean from Nov 2022. Data points for Mar and May 2023 were above the upper control limit. Please note that the Sep 2022 figure is an estimation based on an average of the previous three months. The 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 seen prior to Feb 2023, but from Mar to May 2023 it increased above the upper control limit. The last two months have dropped below 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:
11/8 Monkgate WAN fault (NYNET lost power to circuits)
15/8 Finesse Call queue system problems following planned works overnight
18/8 CCU Telemetry system - planned patching with resilient failover but some devices did not failover to backup
24/8 Power outage affecting Park House data centre - some switches not on backup power were offline for short period. Old Chapel disconnected. CPD report printing affected.
P2 incidents:
2x wifi issues affecting small numbers of users
3x e-mail security incidents
1x REI (Accenda) fault resolved by 3rd party
1x smartsheet e-mail delivery fault resolved by 3rd party
Total number of calls / number of abandoned calls:
August Dr intake results in lots of account changes for staff and results in elevated support demand



Aug 2023	1910
Target	1000
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Variation indicates consistently falling short of the target



Aug 2023	2970
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): From Sep 2022 to Jun 2023, each month has been above the mean and therefore showing special cause concern. From Nov 2022 to Mar 2023 the data points were above the upper control limit. Special cause improvement has been seen in the last two months with both data points below the mean and close to the lower control limit. The indicator is consistently failing the target.
Number of end user devices over 4 years: In Jan 2022 the indicator moved above the upper lower control limit for five months. The number of end user devices (laptops, desktops) over 4 years old rose in Jan 2022 by circa 1500. This was due to a batch of devices triggering their anniversary and moving from 3 year plus to 4. From Sep 2022 onwards, the number of devices has fallen close to or below the lower control limit, with 2970 devices now over 4 years old.

Operational Update:

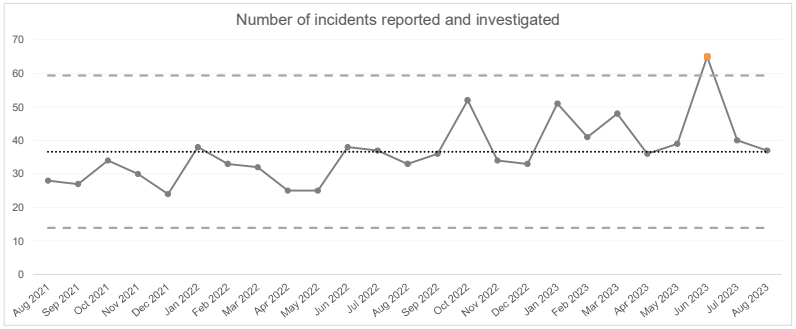
Number of open Tickets (Incidents + Requests) (last day of month)
- 30% open tickets are "Clock Stopped" awaiting user response/confirmation resolved.
- Most teams switched to using 4Me helpdesk software from mid-August. Work continues to reduce tickets on old system, whilst optimising how new system is used by us and end users to improve efficiencies

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 : AUGUST 2023



Aug 2023
37

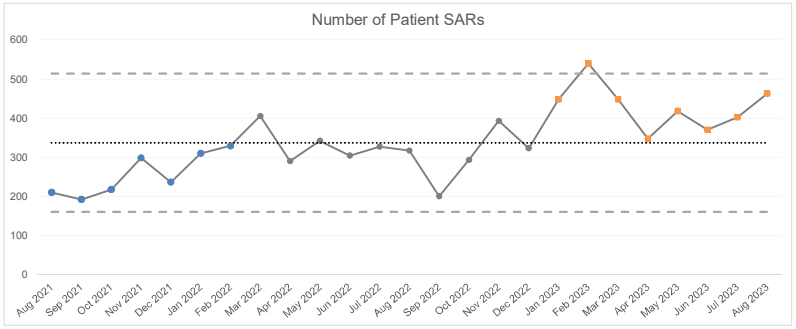
Target
No Target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



Aug 2023
463

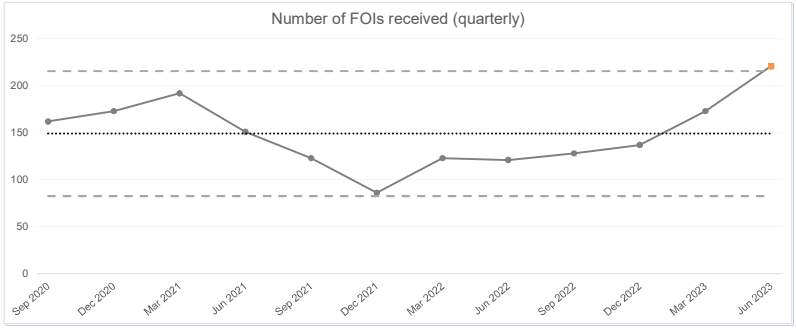
Target
No Target

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

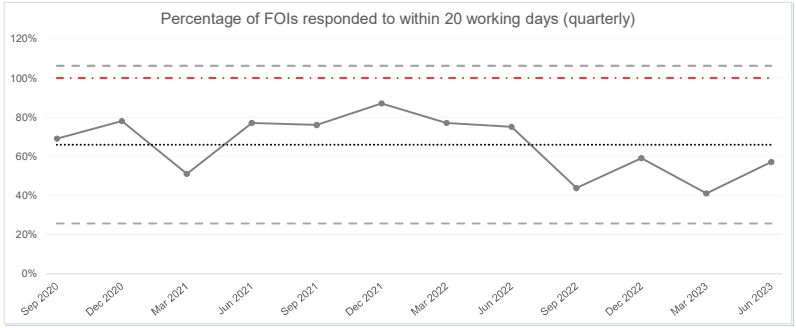
Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Jun 2023
57.0%

Target
100%

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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 from Jan 2023 with data points above the mean. Feb 2023 was above the upper control limit.
Number of FOIs received (quarterly): This indicator is showing special cause variation in Jun 2023, with the data point above the upper control limit.
Percentage of FOIs responded to within 20 days (quarterly): This indicator is showing common cause variation, however the latest four data points have been below the mean.

Operational Update:

Number of incidents reported and investigated:
There was an increase in incidents in May as Care Group 2 completed a service standards audit and identified several records where therapy documentation had not been scanned and is now missing, likely destroyed (8 instances). These were 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:	27 September 2023
Subject:	Financial Position – August 2023 (Month 5)
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 £22.4m against a planned deficit of £10.6m for the period to August 2023 (month 5). The Trust is £11.8m adversely adrift of plan.

Recommendation:

The Board of Directors is asked to discuss and note the August 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	19 September 2023	The report was discussed, and the financial position of the Trust was noted.

Financial Position – August 2023 (Month 5)

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	£8.4m Adverse	£11.8m adverse	↓ Deteriorating
Forecast Outturn I&E Variance to Plan	£0.0m	£0.0m	Static
Core CIP Delivery Variance to Plan	£1.9m Adverse	£1.5m Adverse	↑ Improving
Core CIP Planning (£21.4m Target) Value Identified	£17.7m Identified	£17.9m identified	↑ Improving
ICB Cost Reduction Ask (£17.5m target) Value Identified	£10.1m Identified	£10.1m Identified	Static
Variance to NHSE Agency Cap (3.7% of pay)	£1.9m Above	£2.6m Above	↓ Deteriorating
Month End Cash Position	£18.1m	£15.4m	↓ Deteriorating
Capital Programme Variance to Plan	£2.4m behind plan	£2.7m behind plan	↓ Deteriorating

3. Income and Expenditure Position

Summary Position

The I&E table confirms an actual adjusted deficit of £22.4m against a planned deficit of £10.6m for August. The Trust is £11.8m adversely adrift of plan.

TRUST PRIORITIES REPORT : August-2023

SUMMARY INCOME AND EXPENDITURE POSITION

STRATEGIC OBJECTIVE : TO ENSURE FINANCIAL STABILITY

Income and Expenditure Account

	Annual Plan	YTD Plan	YTD Actual	YTD Variance	FOT
	£000's	£000's	£000's	£000's	£000's
NHS England	81,538	33,974	35,226	1,252	81,538
Integrated Care Boards	550,131	229,721	233,576	3,855	550,131
Local authorities	4,821	2,009	2,010	2	4,821
Non-NHS: private patients	344	143	368	225	344
Other Operating Income from Patient Care	1,466	611	730	119	1,466
Operating Income from Patient Care Activities	**638,299**	**266,458**	**271,910**	**5,452**	**638,299**
Research and development	1,614	672	1,180	508	1,614
Education and training	19,148	8,156	8,827	671	19,148
Other income	44,513	18,582	19,822	1,239	44,513
Other Operating Income	**65,275**	**27,411**	**29,829**	**2,418**	**65,275**
Employee Expenses	-486,712	-203,122	-209,560	-6,439	-486,712
Drugs Costs	-60,750	-25,442	-31,028	-5,586	-60,750
Supplies and Services - Clinical	-71,485	-30,350	-33,561	-3,211	-71,485
Depreciation	-20,281	-8,450	-8,450	0	-20,281
Amortisation	-1,641	-684	-684	0	-1,641
CIP	15,508	1,512	0	-1,512	15,508
Other Costs	-82,680	-33,396	-36,986	-3,589	-82,680
Total Operating Expenditure	**-708,041**	**-299,932**	**-320,269**	**-20,337**	**-708,041**
OPERATING SURPLUS/(DEFICIT)	**-4,467**	**-6,063**	**-18,531**	**-12,467**	**-4,467**
Finance income	830	346	940	594	830
Finance expense	-956	-402	-399	3	-956
PDC dividends payable/refundable	-10,800	-4,500	-4,500	0	-10,800
NET FINANCE COSTS	**-15,393**	**-10,619**	**-22,490**	**-11,870**	**-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**	**-10,619**	**-22,490**	**-11,870**	**-15,393**
Remove Donated Asset Income	-800	-334	-333	1	-800
Remove Donated Asset Depreciation	740	308	351	42	740
Remove Donated Asset Amortisation	28	12	12	0	28
Remove Peppercorn Depreciation	11	5	0	-5	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**	**-10,629**	**-22,461**	**-11,832**	**-15,414**

Corporate Overview of Key Drivers

Variance	Favourable/ (adverse) £000	Commentary
Strike Impact – lost income	-1,655	Assessed reduced elective activity against plan due to cancellation of operations and outpatient appointments due to strike action, but for which the costs are in the system.
Strike Impact – additional net costs	-660	Assessed net increase in costs to ensure adequate and safe staffing levels during strike action, offset by reduced pay for those staff taking part in the on strikes is £1.75m. The decision by NHSE to reduce the national ERF target by 2% to acknowledge the cost of the April strikes has been assessed to increase ERF income to the Trust by £1.05m, thereby leaving a net pressure of £0.7m.
ERF ahead of plan	727	The assessed increased ERF payable to the Trust at M5 is £1.8m of which £1.05m is linked to the 2% reduction in the ERF target and offset against the strike costs incurred above. The balance is linked to elective activity being ahead of plan and is now included in the reported M5 position.
CIP Shortfall	-1,512	Included in the reported position. See section 5 below.
Stretch Target Shortfall	-1,294	Included within the reported position. Current full year shortfall is £7.4m
Short funding of 2023/24 Agenda for Change pay award	-503	Equates to £1.2m annual shortfall for full establishment. Although the pressure for staff in post for the period is £0.2m, the cost of bank and agency to cover vacant posts have also risen thereby contributing to the underlying pressure caused by the pay award shortfall.
Agency and Bank covering vacancies	-2,334	Relates to covering vacancies. Total agency overspending is £2.6m, with minimal levels relating to the cost of covering strike action included above. £0.3m of the pressure is linked to the pay award shortfall referred to above.
Covid test costs more than allocation	-350	Formerly a pass-through cost to NHSE, but now transferred to the ICB with a fixed allocation.
Drugs, devices, unbundled OP Radiology, and Pathology direct access 'in tariff' ahead of plan	-4,528	Includes drugs, devices, unbundled outpatient radiology, and pathology direct access previously contracted with commissioners on a pass-through cost basis, but now within the block contract. Activity on these is significantly exceeding the assessed notional value in the block contract for which no further income is due thereby resulting in a cost pressure. This is further analysed below.

Treatment area	£	Drug or Device
Drugs		
Wet AMD	-1,932,378	Aflibercept, Ranibizumab, Faricimab
Crohn's Disease or Ulcerative Colitis (IBD)	-420,765	Ustekinumab, Vedolizumab, Infliximab, Certolizumab Pegol
Rheumatoid Arthritis	-221,718	Baricitinib, Abatacept, Tofacitinib
Plaque Psoriasis, Psoriatic Arthritis, and Ankylosing Spondylitis	-263,163	Risankizumab
Other	-468,853	
	-3,306,877	
Devices		
Sleep Apnoea	-146,015	CPAP machines
Diabetic Pumps	-381,173	Insulin Pumps and Consumables, Continuious Glucose Monitoring Systems, Insulin I-Ports
Other	42,382	
	-484,806	
Unbundled Radiology	-396,407	
Pathology Direct Access	-340,000	
	-4,528,090	

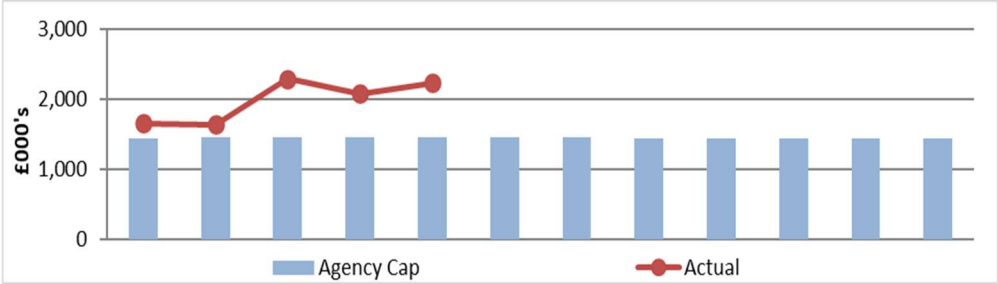
Key Subjective Variances

Variance	Favourable/ (adverse) £000	Main Driver(s)	Mitigations and Actions
NHS England income	1,252	Increased usage of high-cost drugs and devices for which income is earned on a pass-through basis and matched by increased expenditure, ERF behind plan.	Reasons for, and corrective action to address the reduced ERF are being explored.
ICB Income	3,855	Covid outside of the envelope, and depreciation on a reimbursement basis were both previously reported under 'Other' income but are now included under the block contract. ERF ahead of plan.	No mitigation or action required
Other income	1,239	Primarily relates to the sale and leaseback of endoscopes, which is offset by increased costs under clinical supplies and services.	No mitigation or action required
Employee Expenses	-6,439	Agency, bank and WLI spending is ahead of plan to cover vacancies and linked in part 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, 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	-5,586	Relates to high-cost drugs and devices (£1.6m), offset by increased income; with the balance primarily relating to an increase of in-tariff drug and device costs which were previously contracted on a pass-through basis, but now included in the block contract.	To discuss the prospect of additional income with the ICB in recognition of the constraints that the block contract is placing on the Trust.
Clinical Supplies & Services	-3,211	Relates to sale and leaseback of endoscopes and covid testing ahead of plan, both offset by increased income. Also includes overspending on pathology direct access due to increased levels of activity, which was previously covered by a variable tariff, but is now included in the block contract with the ICB.	To discuss the prospect of additional income with the ICB in recognition of the constraints that the block contract is placing on the Trust, plus explore the opportunities to reduce spending.
CIP	-1,512	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	-3,589	Primarily driven by the non-pay related unachieved stretch target, non-pay strike costs, and the Ramsey contracted activity being ahead of plan.	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 August expenditure on agency staffing was £2.6m ahead of the cap.



Workforce

This table presents a breakdown by staff group of the planned and actual workforce establishment in whole time equivalents (WTE) and spend for the year to date. The reserves primarily relate to the 6% medical pay award yet to drawn into budget, but for which the spend is being accrued against Medical and Dental. With the intention to pay the pay award in September the budget and spend will be aligned on the same row going forward.

	Establishment			Year to Date Expenditure		
	Budget WTE	Actual WTE	Variance WTE	Budget £000	Actual £000	Variance £000
Registered Nurses	2,389.94	2,203.49	186.45	54,168	54,151	17
Scientific, Therapeutic and Technical	1,233.43	1,147.76	85.67	26,735	26,130	605
Support To Clinical Staff	1,791.84	1,611.96	179.88	24,497	25,396	-899
Medical and Dental	1,023.28	1,035.81	-12.53	52,518	59,963	-7,445
Non-Medical - Non-Clinical	3,030.23	2,815.11	215.12	42,880	43,240	-361
Reserves				1,608	0	1,608
Other (primarily the Apprenticeship levy)				716	681	35
TOTAL	**9,468.72**	**8,814.13**	**654.59**	**203,122**	**209,560**	**-6,439**

The table illustrates that a key driver for the pay position is spend against Medical and Dental staff, although establishment is broadly on plan. In interpreting the variance, the favourable reserves variance largely links to medical and dental so should be netted off. The key drivers for the residual adverse variance include the cost of strike cover, and agency cover for vacant posts across the Care Groups.

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 indications are that activity is up against plan and potentially presents a £1.8m surplus for the period.

As reported last month, NHSE have now confirmed that the Trust's elective target is to be reduced by 2% as acknowledgement of the impact the strikes have had on elective activity. As a result the assessed surplus ERF for the period has significantly increased over last month with ICB activity running ahead of the revised 102% target value, however NHSE Specialist Commissioned activity continues to remain low. At NHSE's direction the assessed additional ERF is now included in the reported position.

Trust Performance Summary vs ERF Target Performance

Commissioner	23-24 Target % vs 19/20	ERF Target Weighted Value at 23/24 prices (Inc Pay Award CUF) v5.7 baseline inc strike	ERF Month 5 Phase (Av 41.470%)	Activity to Month 5 Actual (Inc Pay Award CUF)	Variance - (Clawback Risk)	% Compliance Vs 19/20
Humber and North Yorks	102.00%	£122,895,169	£50,964,627	£53,131,501	£2,166,875	106.3%
West Yorkshire	101.00%	£1,293,075	£536,238	£468,343	-£67,895	88.2%
Cumbria and North East	113.00%	£162,950	£67,576	£72,012	£4,436	120.4%
South Yorkshire	119.00%	£144,693	£60,004	£50,420	-£9,584	100.0%
Other ICBs - LVA / NCA	-	£574,133	£238,093	£250,863	£12,770	-
All ICBs	***102.00%***	***£125,070,020***	***£51,866,537***	***£53,973,139***	***£2,106,602***	**106.14%**
NHSE Specialist Commissioning	113.00%	£5,129,552	£2,127,225	£1,829,847	-£297,378	97.2%
Other NHSE	101.00%	£282,897	£117,317	£107,751	-£9,566	92.8%
All Commissioners Total	**102.00%**	**£130,482,469**	**£54,111,080**	**£55,910,738**	**£1,799,658**	**105.4%**

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 - August										
2023/24 Cost Improvement Programme - Technical CIP - August										
		August Position			**Planning Position**		**Planning Risk**			
	Full Year CIP Target	**Target**	**Delivery**	**Variance**	**Total Plans**	**Planning Gap**	**Low**	**Medium**	**High**
Technical CIP	**£16,525**	**£6,886**	**£6,886**	**£0**	**£16,525**	**£0**	**£16,525**	**£0**	**£0**
2023/24 Cost Improvement Programme - Core CIP - August										
		August 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	£924	£264	£660	£1,332	£3,259	£1,233	£59	£40
2. Acute, Emergency and Elderly Medicine (Scarborough)	£2,379	£479	£161	£317	£1,666	£713	£977	£689	£0
3. Surgery	£4,913	£989	£284	£704	£2,258	£2,655	£1,938	£320	£0
4. Cancer and Support Services	£3,084	£621	£386	£234	£1,348	£1,736	£1,261	£0	£87
5. Family Health	£2,073	£417	£370	£47	£1,115	£958	£1,115	£0	£0
6. Specialised Medicine	£1,863	£375	£224	£151	£1,205	£657	£1,099	£106	£0
7. Corporate Functions									
Chief Exec	£105	£21	£14	£7	£14	£91	£14	£0	£0
Chief Nurse Team	£270	£54	£51	£3	£223	£47	£223	£0	£0
Finance	£92	£19	£219	-£200	£411	-£318	£411	£0	£0
Medical Governance	£83	£17	£13	£4	£153	-£71	£153	£0	£0
Ops Management	£187	£38	£0	£38	£5	£182	£5	£0	£0
Corporate CIP	£0	£0	£580	-£580	£6,464	-£6,464	£1,651	£1,068	£3,745
DIS	£205	£41	£64	-£23	£205	£0	£205	£0	£0
Workforce & OD	£145	£29	£42	-£13	£552	-£408	£552	£0	£0
Sub total	**£19,988**	**£4,022**	**£2,672**	**£1,350**	**£16,952**	**£3,037**	**£10,837**	**£2,243**	**£3,872**
YTHFM LLP	£1,400	£282	£120	£161	£961	£440	£338	£399	£224
		.							
Core Programme - Group Total	**£21,389**	**£4,304**	**£2,792**	**£1,512**	**£17,912**	**£3,477**	**£11,175**	**£2,641**	**£4,095**
CIP PROGRAMME TOTAL	**£37,914**	**£11,190**	**£9,678**	**£1,512**	**£34,437**	**£3,477**	**£27,701**	**£2,641**	**£4,095**

Delivery in month 5 of the Core Programme is £1.5m behind plan. Full year delivery is £5.9m of which £4.6m is recurrent (21.78% of the Core Target). Non-core CIP relating to technical efficiencies, covid spend reductions and estimated productivity gains of £6.9m

have been met in line with plan. There is currently an in-year planning gap of £3.5m, as well as high risk plans totalling £4.1m. 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 the end of March 2023 to £40.6m at the end of March 2024, with the planned I&E deficit being a key driver in the reduced balance.

August's cash balance showed a £22.1m adverse variance to plan, which is mainly due to the debtors and accrued income position being above plan (£5m), creditors and accrued expenditure being below plan (£5m) and the I&E position behind plan (£11.8m). The table below shows our current planned month end cash balances.

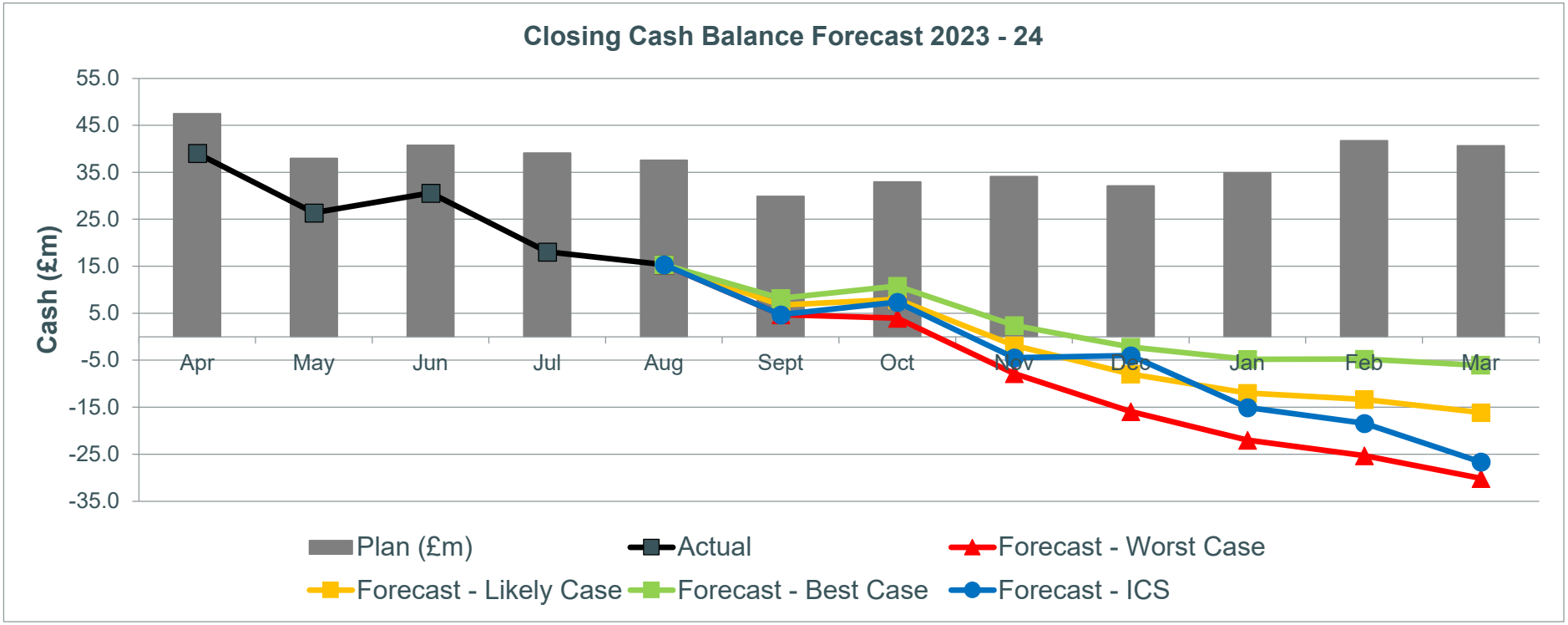
Month	Mth 1 £000s	Mth 2 £000s	Mth 3 £000s	Mth 4 £000s	Mth 5 £000s	Mth 6 £000s	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s	Mth10 £000s	Mth11 £000s	Mth12 £000s
Plan	47,455	37,960	40,729	39,099	37,524	29,841	32,947	34,072	32,068	34,842	41,691	40,625
Actual	39,054	26,392	30,644	18,082	15,382							

The current cash forecast to the end of March 2024 indicates a requirement for cash support. Discussions with the ICB have taken place to identify **opportunities** where the ICB can support the Trust from a cash perspective. Examples of these are bringing forward the block contract payment dates from the 15th to the 1st of the month and consolidating income to allow upfront payments rather than profiled monthly payments. These discussions are ongoing.

Despite the support offered by the ICB, it is anticipated that further cash support will still be required in November and December in line with our cash scenario modelling below. An application to NHSE for cash support will be made during September relating to Q3.

The cash scenario graph below shows the cash position based on the actual cash balance at the end of August with income and expenditure in line with current run rates so in effect the worst-case scenario. This has been adjusted to model scenarios of best and likely cases. An additional forecast has been included to model the ICB actions outlined above. Not one scenario indicates that the Trust can manage without cash support.

The Board should be aware that supplier payments will be restricted during September to prioritise cash availability for the payment of monthly salaries, and this will have a direct impact on the Better Payments Practice Code (BPPC) measures reported in section 8 below.



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 5 Planned Spend £000s	Mth 5 Actual Spend £000s	Variance £000s
45,852	14,032	11,337	-2,694

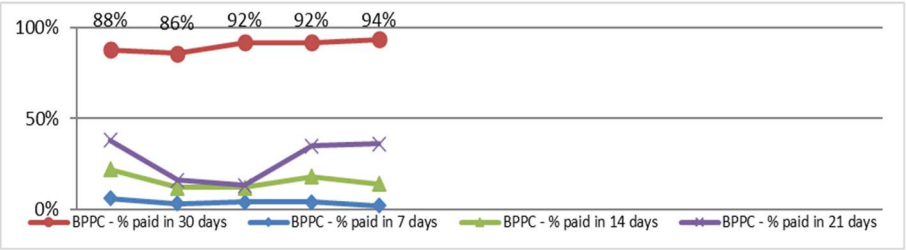
The capital programme at month 5 is £2.7m behind plan. Of this, £1.7m relates to IFRS 16 leases, mainly influenced by delays in completion of equipment leases and supplier lead times.

If we remove the impact of IFRS 16 figures the capital programme is £1m (9%) behind plan. This is due to the Scarborough UEC scheme (£2.1m) running behind the plan expenditure profile offset by other schemes running ahead of plan.

Most of the capital programme allocation has now been approved, this leaves £1.3m discretionary expenditure to be allocated, which 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 August the Trust managed to pay 94% of its suppliers within 30 days.

9. Income and Expenditure Forecast

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

For this report we are reporting that we will still meet our plan at the year-end by agreement with the ICB; however the Board should be aware that there is a growing risk to this, which is currently being assessed and actively being discussed with the ICB's Executive Director of Finance and Investment.

Each of the Trust's Care Groups, along with YTHFM, have been formally asked to prepare a financial recovery plan considering all action that can be taken to reduce our current run rate expenditure trend. Further controls have been implemented along the lines of those prescribed by NHSE. Prospective recovery plans have recently been received from the Care Groups and are in the process of being reviewed. Where there are non-contentious proposals Care Groups have been asked to proceed with these immediately, but for other more contentious proposals Quality Impact Assessments will be required. These plans are necessary to understand the extent to which we can mitigate the current position. The table below summarises the potential impact of the recovery plan to date.

YORK & SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST
FINANCIAL RECOVERY PROGRAMME 2023/24

	Net I&E Forecast Outturn 2023/24		
	Worst Case Scenario	Most Likely Scenario	Best Case Scenario
	£	£	£
Current Forecast			
Forecast outturn at M5 before any recovery actions	-41,851,000	-41,851,000	-41,851,000
2023/24 Plan	-15,414,000	-15,414,000	-15,414,000
Distance from plan	-26,437,000	-26,437,000	-26,437,000
Recovery Actions			
(a) Potential additional income	6,384,441	6,500,510	6,819,317
(b) Internal recovery to stop/reduce spending	1,076,786	7,644,210	19,955,099
(c) Resolution of pressures on the Block contract from previously pass-through cost	0	5,611,196	13,189,438
Revised Forecast	-34,389,773	-22,095,084	-1,887,145
Revised Distance from Plan	-18,975,773	-6,681,084	13,526,855

10. Recommendation

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

Research & Development Performance Report : Aug-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, with only 1206 accruals so far, we are struggling to open news studies due to lack of clinical engagement.

•How the Trust is measured in terms of research outputs has changed. The CRN will only monitor Recruitment to Time and Target for open studies and we must now make sure 80% of our studies (not 60% as it was originally) are on target – we are currently 69% for non-commercial and 100% for commercial trials. This is probably to make the UK look more attractive in reaction to the recent lord O'Shaughnessey review Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report - GOV.UK (www.gov.uk)

•I'm thrilled to say we have two NIHR grants get through to second round for the first time!! They are Sarah Ma's Research For Patient Benefit (150k) looking at Improving specialist nurse facilitated Sexual Health Assessment and care of Men with inflammatory bowel disease and Professor James Turvills £3.24M bid to look at the diagnostic accuracy of colon capsule endoscopy compared to standard colonoscopy. We have our fingers crossed for both as both sets of feedback we have received for each application have been OK!

•We also have around another 6 grant applications currently being worked on by the team, in total we have submitted 19 grants in the past 18 months

•We are still moving to open the Babi study that could see all babies born in York & Scarbough eligible to participate. We have had a lot of interest in the bank shifts we have offered in Midwifery to support the study and we progress with the paperwork. The study will hopefully open later this year but won't bring in big number of accruals for at least 12 months.

•We continue to work with the community and volunteer sector at Scarborough and we are aiming to put in an NIHR bid in October to build a community partnership to develop ways to tackle the health inequalities in the region.

•We continue to support our ICB by attending its Community of Practice events and IRIS launches.

•Upcoming event- Our second Celebration of Research event being held on 15th November at the Principal Hotel, is sold out!

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: Sep-2023

TRUST PRIORITIES REPORT : August 2023

CLINICAL RESEARCH PERFORMANCE REPORT

Recruitment

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2023-24	170	222	377	249	188								1206
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 August 2023

Care Groups	Accruals Running Total 23/24
CG1 Total	291
CG2 Total	55
CG3 Total	90
CG4 Total	61
CG5 Total	0
CG6 Total	40
RP's Total	388
Cross Trust Studies Total	281
ACCRUAL TOTALS	1206

Accruals Still Required	2294
Trials Open to Recruitment	96

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	41%	51%	*Weighted 11*
Observational	47%	14%	*Weighted 3.5*
Large Interventional	3%	2%	*Variable weighting by study*
Large Observational	4%	33%	*Weighted 1*

Breakdown of Trial Category % - All Open Studies

Commercial	3%
Non Commercial	97%

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	69%	80%
Commercial	100%	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 : AUGUST 2023

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

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

Source: https://publicview.health as at 12/09/2023
* 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	Inpatients - Proportion of patients discharged before 5pm (70%)	Aug-23	62.5%	70%	64	44/120	*Jul 23
	UEC	ED - Median Time to Initial Assessment (Minutes)	Aug-23	16	18	27	91/124	*Jun 23
	RTT	RTT - Total Waiting List	Aug-23	53190	48390	35	112/171	*Jun 23
	RTT	RTT - Waits over 104 weeks for incomplete pathways	Aug-23	4	0	100	1/171	*Jun 23
	RTT	RTT - Waits over 78 weeks for incomplete pathways	Aug-23	83	0	16	144/171	*Jun 23
Quality & Safety	Healthcare Associated Infections	Total Number of Trust Onset MSSA Bacteraemias	Aug-23	7	59 (12-month)	8	125/136	*Jun-23
	Healthcare Associated Infections	Total Number of Trust Onset C. difficile Infections	Aug-23	10	116 (12-month)	10	122/136	*Jun-23
	Patient Experience	Trust Complaints	Aug-23	57	No Target	23	162/210	*Q4 21/22

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Risk Management Update – Board Assurance Framework
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 approve the September Board Assurance Framework.

Recommendation:

The Board of Directors is asked to approve the September Board Assurance Framework.

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 – Board Assurance Framework

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. Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) demonstrates the most pertinent strategic risks to achieving the Trust's strategy. The BAF is owned collectively by the Board of Directors.

The BAF should be a live document demonstrating where assurances can be identified and what specific positive assurances the Trust has in managing each of its identified strategic risks on an ongoing basis.

Documenting a BAF robustly demonstrates that the Trust in managing its risks is aware of the controls and future actions that mitigate the likelihood of risks occurring and the impact of these should they occur. The assurances identified and evidence achieved against each of the risks managed, provide confidence to internal and external stakeholders that the Trust can deliver its objectives.

3. Risk updates

The BAF was reported at the September Risk Committee with any further requests for update. Subsequent updates are provided in red text at appendix 1.

The BAF was subsequently reported in September through the assurance Sub-Committees of the Board:

- Quality & Safety Assurance Committee
- Digital, Finance and Performance Assurance Committee
- People and Culture Assurance Committee

4. Next Steps

The risks on the Board Assurance Framework will be requested for update for Board Sub-Committee reporting in October.

Trust Priorities; Quality and Safety

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

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

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Internal effectiveness reviews against national standards	None identified	-Clinical effectiveness team -Internal Audit	- Clinical Effectiveness reports - Internal Audit reports	None identified
Review of data from national surveys e.g. NICE, NSF	- Volume of data makes it difficult to focus on key issues - Data does not always flow through correct governance	-Healthcare Evaulation Data (HED) -Clinical Effectiveness Audits -NICE	- HED reports - National Survey results	None identified
Implementation of Clinical standards	None identified	- Board of Directors - Quality and Safety Assurance Committee	- TPR reported and duiscussed at every Board of Directors and Quality & Safety Assurance Committee - Minutes and actions of papers April- June, July-December Board of Directors , Executive Committee and Quality & Safety Assurance Committee inc Nurse Staffing, Ockenden, CQC, IPC	None identified
Revalidation of professional standards for doctors	None identified	-Trust internal appraisal and revalidation process/system	- Annual Revalidation Report to Sept Board	- Revalidation requirements and links to appraisal

Oversight of performance	None identified	- Oversight & Assurance meetings and other governance forums	- TPR reported to April-July Board of Directors and April-July Quality & Safety Assurance Committee - Minutes and actions of papers TPR April-July Board of Directors , Executive Committee and Quality & Safety Assurance Committee - KPIs in Care Group dashboards - Q1 Minutes of Oversight & Assurance meetings	None identified
Implementation of the Performance Management Framework	None identified	- Oversight & Assurance meetings and other governance forums	- Q1 Minutes of Oversight & Assurance meetings and other governance forums e.g. Quality Committee, Care Group Board meetings.	None identified
Ongoing Implement Workforce & OD Strategy (Being Renewed)	Poor diversity in leadership positions (gender pay, race equality)	- Board, Executive and Digital, Performance and Finance Assurance Committee.	- Board/Committee papers - Oct Board Equality, diversity and inclusion data reporting	None identified
Ongoing monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	-TPR reported to April-July Board of Directors and May and July People & Culture Assurance Committee - Executive Committee Agency Usage Report	None identified
Oversight of Establishments	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	-Limited visibility to investments required but not progressed.
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports Bank only training for non-medical is at 77% (dropped due to LH incident) and Medical is at 41%.	-Training deferred/delayed due to operational pressures.
Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
Monitoring the effectiveness of waiting lists	None identified	Clinical Risk stratification, validation and monitoring of waiting lists	- Risk stratified elective waiting lists.	- Diagnostic waiting lists to be risk stratified in July; outpatient list to follow.
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT. -Business Planning process	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	- April & May Executive Committee and Board of Directors approved plan - Capital planning process underway for 2023/24	None identified

Routine monitoring and reporting against capital programme	None identified	-Financial Services	-Agenda, papers, minutes and action logs for internal governance meetings (CPEG), Digital, Performance and Finance Committee, Executive Committee, Board of Directors) -Reports to external bodies (the ICS and NHSE/I)	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Recruitment	Reintroduce open days (July); Launch recruitment website (Sept); International nurse recruitment (90 by Feb 24)	Polly McMeekin	**Feb-24**

Trust Priorities; Quality and Safety

Risk description	PR2 - Access to patient diagnostic and treatment is delayed	**Causes** *What has to happen for the risk to occur?*	- Increased waiting times - Insufficient bed capacity - Failure to transform patient pathways - Inefficiencies in buildings, premises and medical equipment - Insufficient and appropriately qualified staff - Failure of clinical staff to meet required professional standards - Lack of space for patient treatment and staff handovers
		Consequences *If the risk occurs, what is its impact?*	- Patients suffering avoidable harm - Damage to the trust reputation - Regulatory attention - Increased Financial costs

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Quality & Safety Assurance Committee**	
Likelihood	5	4	3	**Risk Appetite: Exceeding**		
Impact	5	5	4	**Date to achieve target score:**	**Risk Owner:**	**Medical Director**
Overall risk rating	25	20	12		**Links to CRR:**	**3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implementation of Clinical standards	None identified	-Board of Directors -Quality & Safety Assurance Committee -- OAMS	- TPR Committee reporting of learning from Patient Safety Incidents - Minutes and actions of papers (Board, Executive, Quality Committee) - National Audit Clinical Standards - -GIRFT Visit	System pressures including ambulance and across local authorities with surges in activity leads to difficulties in applying consistent high clinical standards
Revalidation of professional standards for doctors	None identified	-Annual Board Report	- Annual Organisational Audit Report to Sept Board	None identified
Conduct Incident Reporting and learning from Safety incidents	None identified	- Datix - Care Group Boards - Oversight & Assurance meetings - CPD	- Action plans following investigation of incidents on a case by case basis - Datix incident reports - Monthly SI/Never Event reports presented to Quality & Safety Committee, Operataional Quality Group, Care Group Boards and Oversight & Assurance meetings April-July 2023/24 - Learning from deaths and 6 monthly Cancer Harm report to QPaS - Patient experience report Q1-Q3 reported to Quality & Safety Assurance Committee - Medical Legal report - Escalations recorded on CPD - -Medical Examiner Report	Overarching analysis and triangulation of all information. Clinical pressures divert Clinical Staff from Audit Assurance work.

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**

Trust Priorities; Elective Recovery - Acute Care Flow

Risk description	PR 3 - Failure to deliver constitutional/regulatory performance and waiting time targets	**Causes** *What has to happen for the risk to occur?*	- Covid 19, increased waiting times - Insufficient bed capacity - Inefficient patient pathways - Nursing and speciality workforce recuitment challenges
		Consequences *If the risk occurs, what is its impact?*	- Patient harm - Reputational damage - Regulatory attention - Financial costs

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Finance and Performance Assurance Committee**	
Likelihood	4	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Q2 2023/24**	**Risk Owner:**	**Chief Operating Officer**
Overall risk rating	20	16	12		**Links to CRR:**	**3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 17**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
1. Oversight of performance	None identified	Board and DPF Committees Oversight & Assurance meetings and other governance forums	TPR reported and discussed at every Board, Digital, Performance and Finance Assurance Committee - Minutes and actions of papers April- June (IBR), July, Sept, Oct (Board, Executive, Digital, Performance and Finance Assurance Committee) - KPIs in Care Group dashboards - Minutes of Q3 & Q4 Oversight & Assurance meetings and Care Groups	None identified
A. Implementation of the Performance Management Framework	None identified	Board and DPF Committees Oversight & Assurance meetings and other governance forums	- Minutes of Q4 & Q1 Oversight & Assurance meetings - Minutes and actions of papers TPR April-July (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) EY review of performance Management Framework as part of Tier 1 actions	None identified
B. Implementation of surge plans	None identified	- Scenario testing of surge plans (Winter resilience) Lessons learned paper to Exec Committee and Board - Silver and Gold Command standard operating procedures	- Results of scenario testing. Minutes of March Board & March Exec Committee were lessons learnt were presented - OPEL 4 daily calls assurance to YAS and NHSEI on Ambulance turnaround when required - Bronze/Silver/Gold Command enacted for	None identified
C. Implementation of Operational Plans (including Covid plans)	None identified	- Operational meetings to monitor and respond to operational requirements	- Minutes from operational meetings	None identified
D. Implementation of winter plans, resilience plans and surge plans	None identified	- Winter and resilience plans discussed at governance meetings (Executive, Board, Quality Committee)	- Minutes of Sept Board and Sept Executive Committee where winter and resilience plans were discussed.	None identified

E. Delivery of Building Better Care programme. Established as Elective Recovery Board UEC Board, Maternity Transformation Board People & Culture Committee	Programme completed	Programme structure established Transitioned to BAU.	- April-Sept Transformation Committee reports and minutes inc KPIs Closing report to Execuive Committee May 2023	- None identified
F. Monitoring the effectiveness of waiting lists	None identified	- Elective recovery planning and monitoring of waiting lists - ERB	- Reporting on progress of meeting waiting lists, via Tier 1 meetings and DPF Committee & Board	- None identified
G. Urgent Care working at place	None identified	- Collaboration of Acute Providers	- Engagement and participation at Collaboration of Acute Providers for elective recovery	- None identified
H. Deployment of health inequality assessment to inform waiting list management	None identified	- Board and Executive Committee	- Oct Executive Committee York City Council reporting of Health Inequalities across Trust area	- Specific system reporting against health inequalities

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Deliver the 2023/24 Plan on activity	Oversight provided through the Executive Committee as a Committee of Board. Assurance provided through the Digital, Performance and Finance Assurance Committee.	Claire Hansen	**Jul-23**
Rapid Quality Review System action plan	Weekly place based monitoring meeting of actions and performance trajectories. Monthly ICB assurance meeting.	Claire Hansen	**Jul-23**

Trust Priorities; Our People

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

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: People and Culture Assurance Committee**	
Likelihood	5	4	4	**Risk Appetite: Exceeding**		
Impact	5	4	3	**Date to review target score: Q2 2023/24**	**Risk Owner:**	**Director of Workforce and OD**
Overall risk rating	25	20	12		**Links to CRR:**	**3, 7, 9, 11, 13, 15, 16, 18**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Implement Workforce Strategy and People Recovery Plan	- Poor diversity in leadership positions (gender pay, race equality) - Lack of resources to fund intiatives	- Board, Executive and People and Culture Committee.	- Board/Committee papers June 2019 approval - Equality, diversity and inclusion data reporting of WRES/WDES Oct Board of Directors report	None identified
Deliver Board development sessions	None identified	-Board meetings	- Board development independent review	None identified
Conduct Talent Management Framework	None identified	-Trust intranet - Board of Directors papers	- Learning Hub - PREP	None identified
Design and Deliver Internal Leadership Programmes	None identified	-Trust intranet - Shadow Board development with NHS Elect	- List of programmes on Learning Hub	None identified
Leadership succession plans	None identified	- Board, REMCOM, Executive Committee - Shadow Board development with NHS Elect	- Board papers (agenda, minutes, action log) - REMCOM papers (Oct agenda, minutes, action log)	None identified
Implement ICS initiatives e.g. Ambassador Scheme	Poor diversity in leadership positions (gender pay, race equality)	- Board (reporting on Equality, diversity and inclusion)	-Board papers (agenda, minutes, action log) -REMCOM papers (agenda, minutes, action log)	None identified

Implement Workforce models and planning on a case by case basis	National contract limitations National training programmes	-Director of Workforce & OD	-Board approved Workforce models and plans	None identified
Target overseas qualified staff	None identified	- Overseas AHP and medical recruitment programme	- QIA for new nurse roles - CHPPD - ICS international recruitment programme (Kerala)	None identified
Incentivise recruitment & reintroduced recruitment open days. Launched careers website.	None identified	-Reduced vacancy rates in TBR	- TPR and workforce reporting at May and July People and Culture Workforce Committee	None identified
Monitor staffing levels (temp/perm)	None identified	- Review of vacancy rates and agency usage through governance forums and departmental meetings	- Minutes and actions of papers TPR April-July (Board, Executive Committee , People & Culture Assurance Committee) - Executive Committee Agency Usage Report	None identified
Oversight of rotas - e-Rostering	Approximately 50% of AHP rotas remain manual	- Internal Audit	- Internal Audit reports on E-Rostering - CHPPD	None identified
Oversight of Establishments and establishment reviews (nursing and AHP)	Estate limitations - lack of staff rest areas	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs.	Limited visibility to investments required but not progressed.
Monitor performance against the People Plan	None identified	-Resource Committee updates against the People Plan	- Sept 22 Minutes People and Culture Committee	None identified
Implement Workforce & OD Strategy	None identified	- Reporting on performance against the Workforce & OD Strategy to Board, Executive and Resources Committee.	- People & Culture Assurance Committee updates July, September, November and January	None identified
Monitor Bank Training Compliance	None identified	-Bank training compliance discussed by the Workforce & OD team	- Bank training compliance results/reports (%) - May and July People and Culture Committee reporting, action plan and minutes	None identified
Workforce resilience model	None identified	Executive Committee	- Executive Committee approval October 2021	None identified
Communicate guidance for Managers for remote working	Space restrictions	- Trust intranet	- Agile Working Policy	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**

Culture change (Retention)	Implement E,D & I gap analysis Our Voice Our Future programme commenced June 23 Visibility Programme launched July 23	Simon Morritt	**Jun-25**
Leadership Framework roll-out and Line Management toolkit		Polly McMeekin	**Mar-24**
Recruitment	International nurse recruitment (90 by Jan 23);	Polly McMeekin	**Feb-24**
Workforce Plan	Clinical Establishment review continues (Nursing complete - AHP to be completed by Mar 24); Develop further alternative roles ; Increase Apprenticeship levy spend	Polly McMeekin	**Mar-24**

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

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

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

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Annual Business Planning process including Trust Strategy	Lack of clarity over funding from NHSE/I due to pandemic emergency financial regime.	-Business Planning process - Internal Audit	-Business planning schedules. - Internal audit reports on effectiveness of controls around the Business Planning process.	None identified
Preparation and sign off of annual Income and Expenditure plan, balance sheet and cash flow	None identified	-Executive Committee and Board of Directors.	Plan approved at March with update at April Board.	None identified
Routine monitoring and reporting against I&E plan	None identified	-Monthly updates to Care Group OAMs, Resources Committee, Financial Review Meetings, Executive Committee, Board of Directors, the ICS and NHSE/I.	- Minutes and actions of papers TPR April - July (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) - Reports provided to external bodies (PFR monthly to NHSE)	None identified
Expenditure control; scheme of delegation and standing financial instructions.	None identified	-Board of Directors	-Approved scheme of delegation and SFIs November Board of Directors -System enforced delegation and approval management. - Written confirmation by prime budget holders or responsibilities	Operational pressures and CQC safe staffing level concerns may cause Care Groups to spend outside of budget resource envelopes.
Expenditure control; business case approval process	Investments approved outside of the business case process. Unplanned and unforeseen expenditure commitments.	-Internal audit -Financial Management team	-Business Case Register -Internal audit reports on effectiveness of controls around the Business Planning process. -Reports produced by the Financial Management team on variance analysis.	None identified

Expenditure control; segregation of duties	None identified	-Finance systems	-System enforced approvals. -No Purchase Order No Payment policy.	None identified
Expenditure control; staff leaver process	Management failing to notify Payroll in a timely way of staff leavers	-Contract change notification process. -Routine reporting of staff in post (i.e. paid) to budget holders.	-Salary overpayment recovery policy. -Reports from Finance to budget holders on their staff in post	Limited visibility to issue
Income control; income contract variation process	Unforeseen and unplanned in-year reduction in income.	-Financial Management Team	Income Adjustment form register.	None identified
Capital planning process including Trust and Estates Strategy	None identified	-Backlog maintenance programme. -Essential Services Programme for IT.	-Schedules detailing capital investment needs. -Business Planning schedules	None identified
Preparation and sign off of annual capital programme	None identified	-Executive Committee and Board of Directors approved plan	-April/May Executive Committee and Board of Directors approved plan	None identified
Routine monitoring and reporting against capital programme	None identified	-Financial Services	- Minutes and actions of papers TPR April-July (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) and CPEG - Ad hoc reports to external bodies (the ICS and NHSE)	None identified
Overspend against approved scheme sums	None identified	-Financial Services	-Scheme sum variation process. -Scheme expenditure monitoring reports to CPEG.	None identified
Routine monitoring against cash flow	None identified	-Board of Directors - Finance team	- Minutes and actions of papers TPR April-July (Board, Executive Committee , Digital, Performance and Finance Assurance Committee) - PFR monthly to NHSE	None identified
Cash flow management through debtors and creditors	None identified	-Financial Management Team -Government	-Monthly debtor and creditor dashboard to Finance Managers and Care Groups. -Trend data reported to Executive Committee, Resources Committee and Board of Directors. -Better Payment Practice Code (BPPC) - monthly report	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Care Groups finance recovery plan meetings to initiate future interventions	Care Group recovery plans in diaries	A Bertram	**Completed**
Opportunities for further interventions being considered	Analysis being considered for future interventions	A Bertram	**Completed**

Trust Priorities; Quality and Safety

Risk description	PR 6 - Failure to deliver safe, secure and reliable digital services required to meet staff and patients needs.	**Causes** *What has to happen for the risk to occur?*	- Succesful cyber attack through a computer virus or malware, malicious user behaviour, unauthorised access, phishing or unsecure data flows. - 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
		Consequences *If the risk occurs, what is its impact?*	- Potential patient harm - Regulatory attention (ICO) - Reputational damage - Financial costs

Risk Rating	Gross	Net	Target	Risk Appetite Assessment	Committee Oversight: Digital, Performance and Finance Assurance Committee	
Likelihood	5	4	3	Risk Appetite: Exceeding		
Impact	4	4	3	Date to achieve target score: November 2023	Risk Owner:	Chief Digital and Information Officer
Overall risk rating	20	16	9		Links to CRR:	4, 5, 6, 7, 8

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Information Governance Policies and Procedures The trust have policies and staff guidance in place communicating the organisations principles and procedures for data protection. The following policies are in place: Data protection Record Management Data Security Registration Authority Subject Access Requests Freedom of Information Network Security	The Data Quality Policy is currently under review. The Network Security Policy requires updating. The draft Registration Auhority Policy requires approval. Limited monitoring of policy implementation and adherance	Yearly internal Data Security Protection Toolkit (DSPT) audit report. Bi-annual Data Security Protection Toolkit submission to NHS England. DSPT improvement plan. Policies are available to all staff through the Information Goverance pages on Staff Room Information Governance Executive Group minutes and actions	DSPT Internal Audit report highlights 'Medium' assurance. IGEG meeting minutes highlight policies being reviewed. Proactively follow IG breach management and report to the ICO as appropriate. Regular trusts wide communications regarding new policies and procedures.	Levels of compliance with the Trust Data Protection/Confidentiality Policies should proactively be undertaken on an annual basis through unannounced IG walks.
Data Security and Protection Training All staff should undertake their mandatory Information Governance Training All Board members should complete their Core Statutory and Mandatory IG and Data Security training on an annual basis. Continuous campain to raise staff awareness of cyber threats.	Further awareness training should be provided.	KPIs highlighting number of staff undertaking IG training	SIRO Completed Manadatory Training. Majority of IAOs completed relvenat training. Majority of staff completing IG training. All staff must have initial IT induction training before they are granted access to the Trust network.	All Board members complete their Data Security Awareness Level 1 training on an annual basis. Provide specialised cyber security training to all members of the Board of Directors.

User Access Controls Processes for dealing with joiners, movers and leavers that identify/change appropriate user access as necessary. Wherever possible, the Trust should use multi factor authentication (MFA) for end user and end point devices.	Lack of access management policy, or similar, that documents how access is removed from user accounts that are no longer required and whether payroll systems or other means, such as manual processes, are involved in triggering the revocation of access. A Multi-Factor Authentication Strategy and/or Action Plan should be developed, with the aim of bringing Trust activity logging in line with best practice guidance required to evidence compliance with the DSP Toolkit.	Regular audits of access to the Active Directory as part of the leavers process.		
Business Continuity and Resiliance Data security incident response and management plan. Penetration Testing of key systems Backup policy and Testing	Draft cyber incident response plan needs to be finalised and approved by IGEG. The Trust Backup Policy requires review in line with best practice.	Business Continuity exercise conducted in September 2022 and results presented to DPF Committee. Desktop excercice undertake within DIS. A full backup review has been undertaken.	Exercise outputs indicated staff perfomed well in exercise. A test restore have been undertaken on minor system as proof of concept, and schedule of quarterly retores planned.	Trust wide participation in business continuity exercise Further businiess continuity exercise to be undertaken. Penetration testing of CPD is outstanding. Recovery Time Objectives (RTOs) and Recovery Point Objectives (RPOs) need to be defined for the Trust's key systems.
Software Patching Patch management procedure that enables security patches to be applied at the operating system, database, application and infrastructure levels. This procedure should be set out in a patch management procedure and/or strategy/policy.	The Patch Management Process needs to be updated to reflect the procedures in place for the management of security patches to mitigate high and critical vulnerabilities, and to include procedures for escalating patching exceptions to the SIRO, in line with best practice guidance contained in the DSP Toolkit.	All IT assets are currently recorded in the IT Health system, which can be monitored in real time.	The Trust has achieved the required percentage of supported devices, but there are a number of devices that have not logged into the network for more than 90 days.	There are a number of servers and endpoint devices that are not currently in support.

Supply Chain Management The Trust should have an up to date list of its suppliers, which enables it to identify suppliers that could potentially pose a data security or data protection risk to the organisation.	The Trust does not currently possess a comprehensive central register of the processors that the Trust engages with, and a Supplier Management Policy/Process is not yet in place. A Supplier Management Policy or Process is required which provides guidance and standards for the procurement of IT services and products, supplier maintenance, network segmentation and whether 3rd party access is allowed or managed.	The Record of Data Processing Activity (ROPA) identifies the IT systems being used to process personal data.		The Trust does not currently possess a comprehensive central register of the processors that the Trust engages with and a Supplier Management Policy/Process is not yet in place.
Software Development Methodology The Trust should have a secure software development lifecycle (SSDLC) or equivalent software and code security approach in place, aligned to industry good practice such as OWASP, to reduce the risk of code vulnerabilities or web application vulnerabilities being exploited.	The Development Team should be provided with training on secure website design principles to ensure that suitably qualified staff are available as necessary in the future.			Assurances that third party website developers have used secure design principles, and that their web applications are protected against common security vulnerabilities. Penetration Test requires completion.

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Action Plans arising from Compliance Inspection visits should be logged and shared with the IGEG, as planned, together with examples of good and bad practice identified.	Inspection Reports will be presented to the next IGEG meeting in August 2023.	Rebecca Bradley	**Aug-23**

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

Risk description	PR 7 - Trust unable to meet ICS expectations as an acute collaborative partner	**Causes** *What has to happen for the risk to occur?*	- Ongoing Trust operational pressures; Urgent, Elective and Community Care
		Consequences *If the risk occurs, what is its impact?*	- Challenges in delivering overall quality of care provision to patients - Reputational harm in meeting system contribution targets required across the Humber and North Yorkshire region

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Executive Committee**	
Likelihood	3	3	3	**Risk Appetite: Inside Tolerance**		
Impact	3	2	2	**Date to achieve target score: Achieved**	**Risk Owner:**	**Chief Executive**
Overall risk rating	9	6	6		**Links to CRR:**	**6, 9, 12, 18**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Integration with ICS on system wide planning	None identifed	- Attendance of members of Trust Executive Team across H&NY ICS governance structure	- Chief Executive update reports on Board of Directors Minutes and actions of papers April-Jul	None identified
Operational and Finance Plans 2022/23	None identified	- Board of Directors approval processes and sub-committee assurances of delivery	- Approval at Board of Directors and submission to NHSE&I for H1 and H2 plans	None identified
Trust involvement in the Collaborative of Acute Providers	None identified	Acute providers governance in decision making across 5 strategic themed transformation programmes; cancer, diagnostics, electives, maternity and paediatrics, urgent and emergency care	- Trust Building Better Care Transformational Programme - Engagement with H&NY ICS - Managing Director of Collaboration of Providers engagement with Executive Team - Workshop of the Humber and North Yorkshire Collaboration of Acute Providers (CAP) - OD Programme of Work - Board agreed CAP terms of reference and joint working agreement (June 2023)	None identified
Trust CEO Provider representative on H&NY Interim Executive Group	None identified	H&NY Interim Executive Group meetings	Engagement with the H&NY Interim Executive Group	None identified
Trust CEO Provider representative on North East and Yorkshire ICS transition oversight group	None identified	North East and Yorkshire ICS transition oversight group	Engagement with the North East and Yorkshire ICS transition oversight group	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
Ongoing collaborative strategy development at neighbourhood, place and system level delivering for Trust patients and wider H&NY during 2023/24	Progress to be reviewed during 2023/24	Exec Team	**Apr-24**
Finance and activity delivery for 2023/24 as part of H&NY system delivery	Progress to be reviewed during 2023/24	Exec Team	**Apr-24**

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

Risk description	PR 8 - Failure to achieve net zero targets, air quality targets and changing climate adaptation requirements from the Health and Care Act 2022 and Humber & North Yorkshire ICS Green Plan
Causes *What has to happen for the risk to occur?*	- Failure to reduce greenhouse gas emissions from the Provider's Premises in line with targets in 'Delivering a 'Net Zero' National Health Service' (targets are 80% carbon reduction by 2032 and Net Zero by 2040) - Not achieving standard contract 18: Requirement to provide detailed plans as to how the Trust will contribute to a Net zero NHS in relation to a) reducing carbon emissions from Trust premises 80% by 2032; b)reducing air pollution through transitioning fleet to Zero and Ultra Low Emission Vehicles, installing EV charging for fleet and establishing policies which exclude high emission vehicle use and promote sustainable travel choices; and c)adapting premises to reduce risks associated with climate change and severe weather;
Consequences *If the risk occurs, what is its impact?*	- Reputational risk in not achieving targets - Potential NHS England action

Risk Rating	**Gross**	**Net**	**Target**	**Risk Appetite Assessment**	**Committee Oversight: Digital, Performance and Finance Assurance Committee**	
Likelihood	4	4	3	**Risk Appetite: Exceeding**		
Impact	5	4	2	**Date to achieve target score: 2040**	**Risk Owner:**	**Director of Finance**
Overall risk rating	20	16	6		**Links to CRR:**	**6**

What controls are in place that are effective now and operating at intended?	*Where are we failing to put controls / systems in place, where we are failing to make them effective?*	*Where can we gain evidence that our controls / systems, on which we are placing reliance, are effective?*	*What evidence shows we are reasonably managing our risks and our objectives are being delivered?*	*Where are we failing to deliver to gain evidence that our controls / systems, on which we place reliance are effective?*
Controls	**Gaps in Control**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**
Sustainable Design Guide	Internal Audit identified need to review the Sustainable Design Guide and its role to strengthen its contribution to the delivery of Net Zero	Design Guide being implemented for Scarborough new emergency department to reduce carbon emissions	UECC designed with reference to Sustainable Design Guide	None identified
York Hospital part of Carbon Reduction Pathway Modern Energy Partners Programme which estimated the cost to get York Hospital on track. Trust signed up to NHS Living Labs Innovation Programme to investigate new and developing technologies for achieving carbon reduction.	None identified	Modern Energy Partners (MEP) Concept design report received for York Hospital 18/01/21 NHSE Living Labs - MoU signed following Executive Committee approval 20/04/22	MEP Concept Design used as a basis for grant applications for PSDS projets NHSE Living Labs - first meeting held to discuss Innovation Projects	None identified
PSDS3 grant applications approved for £5million for Bridlington Hospital to achieve Net Zero and £5million scheme for York Hospital to start the decarbonisation prcess	None identified	Planning applications submitted and community renewal fund Business case objectives	PSDS Grant work commenced in March for delivery in 2022/23.	None identified
Feasibility funding awarded for reviewing carbon reduction potential at Scarborough and Selby Hospitals	None identified	Feasibility work to identify funding needs and practical implementation issues for Scarborough and Selby complete	Grant application submitted for Scarborough York and North Yorkshire Net Zero Fund launched in January for expression of interest by 6th February- options being discussed.	None identified

Green Plan published setting out the overall Trust approach and latest carbon footprint	Internal Audit identified need to review the Trust Green Plan and its role to more closely align its plans , projects and business cases with contributions to the delivery of Net Zero	Trust travel plan Energy Saving Trust (EST) undertaken and a Fleet and Travel review and draft report released in April 2022 by EST.	Energy Saving Trust (EST) undertaken a Fleet and Travel review and draft report released in April 2022 by EST	None identified

What actions will further mitigate the causes and consequences of the risk to its identified target rating?	*What is the current progress to date in achieving the action identified?*	*Owner of action*	*When action takes affect?*
Actions for further control	**Progress to date / Status**	**Lead action owner**	**Due Date**
New procurement exercise to commenced with CEF to take advantage of next round of grant funding and develop a plan for achieving reductions in line with Net Zero 2040 target	Procurement exercise completed and grant application submitted for Scarborough Hospital, but unfortunately the programme was oversubscribed and the bid failed. Further bidding oppurtunities are expected and will be monitored. No dates are available yet.Works on going at York and Bridlington will achieve a carbon reduction of approx 8% at York and 80-85% at Bridlington. Work on-going and currently on time and on budget. Update September 2023: Commissioning of current PSDS 3b project expected to be completed October 2023.Application for PSDS3c fundingis being preparedcurrently for submission early in October 2023	Head of Sustainability	**Oct-23**
Contract negotiations on going for a contract which develops plans for York, Scarborough and Bridlington to 2040	York contract signing planned for November after gaining Board approval . Bridlington contract discussions on-going. Update September 2023: Contract discussions to incorporate the York and Bridlington PSDS3b works are ongoing.	Head of Sustainability	**Oct-23**
Trust Travel Plan to be updated to incorporate plans to achieve carbon emissions reductions in line with NHS requirements	Current focus of work is a business case which explores support for staff commute options and facilities for York and Scarborough Hospital. This has now been approved and goes live on 12 June 2023	Head of Sustainability	**Completed**
Improve internal temperature monitoring and control for vulnerable groups within the hospital estate to develop a plan in response to the changing climate	Funding agreed for a pilot ward project to improve monitoring, to start to develop a business case for hospital sites. Pilot now underway and prices being sought. The prices requested are to supply and install temperature monitoring systems in 2 phases as follows: •Phase 1 York Hospital covering all inpatient Wards •Phase 2 Other sites with inpatient beds	Head of Sustainability	**Jul-23**
Sustainable Design Guide to be reviewed when Net Zero Carbon Guide published	Awaiting Net Zero Carbon Guide from NHSE. Update September 2023:Head of Capital Projects is attending NHSE Net Zero Building Seminar in September 2023 and thereafter will review the current sustainable design guide to incorporate the NHS Guidance.	Head of Capital Projects	**Oct-23**
Green Plan to be reviewed	Delayed due to prioritisation of PSDS grant project and lack of progress to recruit/replace Environmental Awareness Officer. Part time support to collate carbon footprint monitoring data commenced December 2022. Update September 2023: A final proposed version of the Green Plan (Version 2) has been circulated to statkeholders for comment W/C 11/09/23	Head of Sustainability	**Oct-23**

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Workforce Race and Disability Equality Standard (WRES) and (WDES) Action Plans 2023-2024
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion and WRES Expert

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

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

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

Summary of Report and Key Points to highlight:

The WRES and WDES Action Plans are to address the disparities in the data that was submitted in the annual reports in May 2023. The Action Plans require approval prior to the deadline and publication date of 31 October 2023.

Once the Trust's data from ESR and the Staff Survey was analysed, two engagement events were held to co-create the Action Plans. The first was at a joint Staff Networks meeting and the second was via a Survey Monkey that was available for all staff to access.

This year's WRES Action Plan is also designed to address some of the indicators of the Medical and Bank WRES that were submitted to NHSE in July 2023.

The National WRES Team set three high priority actions for the Trust to focus on this year. These are in relation to the Trust's Race Disparity Ratios, career progression at certain levels.

Both plans address the areas that require improvement, some of the action there were incomplete in the 2022-2023 Action Plan have been moved forward to the 2023-2024 plan.

The Action Plans are iterative, therefore can be used as a working document. They will be shared via different communication methods and with the Inclusion Forum, EDI Workstream and Trust Governors.

2022-2023 Action Plan Progress

WDES

The majority of actions have been implemented or are still ongoing, for those actions that have not been implemented, this has been due to constraints such as human resources, capacity and funding. Where possible, the actions have either been transferred over to the 2023-2024 plan, are still being implemented or have been redrafted. The analysis of this year's data implies that we are making steady progress with disability equality.

WRES

This action plan contained a variety of actions, with a large amount of them being implemented. There are still some actions ongoing or have not been implemented due to the reasons above. As with the WDES, where possible the actions have either been transferred over to the 2023-2024 plan, are still being implemented or have been redrafted. The analysis of this year's data implies that we need to make better progress with race equality.

Recommendation:

The Board is asked to discuss and approve the WRES and WDES Action Plans, it is also asked to note that funding is required for training to continue to be implemented to increase staff's knowledge, awareness and competency.

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
PACC	20 September 2023	

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

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

York and Scarborough Teaching Hospitals NHS Foundation Trust
Workforce Race Equality Standard (WRES) Action Plan 2022-2023

Polly McMeekin Director of Workforce and Organisational Development
Virginia Golding, Head of Equality, Diversity and Inclusion

APPENDIX 1

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
To increase self-declaration of ethnicity and dispel myths as to why the Trust collects this data. Increase percentage of staff in post who share their ethnicity status by a minimum of 3% in 2023	Evaluate communication methods used to disseminate information to staff on self-declaration and re-launch Self Service and the ESR app.	Deputy Head of Resourcing, Digital and Insights	Generate quarterly reports from ESR, workforce to evaluate if communications are being effective. Establish ways to aid communication. March 2023	1,116, 12.5% BME staff in post 303, 3.49% unknown 2022 893, 10.8% BME staff in post 270, 3.3% unknown 2023 Excluding M&D	

1

Not Started	On Track	Completed	Overdue

	Trust Managers to analyse local data and encourage colleagues via local meetings.	HR Business Partners and EDI Workstream	Local quarterly reports provided to the EDI workstream. May 2023	Discussion took place on 4/4/23 with HRBPs to commence discussions with CGs & Dir now and commence analysis in new reporting period. Local action plans to be drawn up against data. **Updated 4/4/23** WFL to now lead on this, meeting with them 23/6. WFIS to provide local data. **Update 23/6/23**	
	Identify perceptions and barriers around self-declaration to feed into Myth Busting Guide	Head of EDI, EDI Workstream and the Staff Networks	Information obtained to aid completion of a Myth Busting Guide. March 2023	Meeting arranged for April 2023	
	Launch an Equality Monitoring Myth Busting Guide to dispel myths about sharing ethnicity status	Head of EDI and the Staff Networks	Production and dissemination of a Myth Busting Guide to support self-declaration. April 2023	Meeting arranged for April 2023.	

Not Started	On Track	Completed	Overdue

				Engaged through joint SN meeting. Guide to be produced. Guide completed, needs to be launched with campaign.	

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Increase the relative likelihood of BME staff being appointed from shortlisting for clinical and non-clinical staff in Bands 8-9. This figure has slightly deteriorated	Continue to implement the action plan for 6 key actions on the overhaul of recruitment and promotion	Recruitment Manager	Review and continue to implement the Trust's Action Plan. August 2023	Discussed with Recruitment Manager and looked at areas for implementation. **Update February 2023** **Requested an update 28/6/23**	Moved to 2023 action plan

for Non-clinical bands and slightly increased for clinical bands. In 2022 Non-clinical bands 8-9 = 0.1% Clinical bands 8-9 = 0.13%. Increase by 2% for non-clinical and clinical. Apart from at VSM level, bands 8-9 have the lowest percentage of BME colleagues in post. Focusing on bands 8-9 will support the Trust's talent pipeline into a VSM position. The relative likelihood in 2021 was 2.61 and in 2022 it was 2.60.	Training – unconscious bias and cultural competence	Head of EDI	Bespoke and specific training implemented in Quarter 1/2.	Workshops commence April 2023	
	Continue to implement the 2021 Race Disparity Ratios action plan.	Workforce and Head of EDI	Review progress to determine action required. February 2023	2023/24 action plan to address this as national team gave the three areas to focus on. **Updated 28/6**	Moved to 2023 action plan
	Interview Skills preparation.	Recruitment Manager	Determine what support can be made available for colleagues to support them in applying for jobs. Date TBC.	Discussed with Recruitment Manager. Need to look at resources to support this. **Update February 2023** Team focusing on filling HCA roles, no resources to deliver these sessions. JS and VG to pick up a conversation with management. **Updated 21/7/23**	Moved to 2023 action plan

				Head of EDI to attend the Recruitment and Selection training in June 2023 to review content. **Updated June 2023** HR to implement recommendations to incorporate more EDI into the workshop. Meeting w/c24/7/23. **Updated 21/7/23**	
	Shadowing or participate in senior leader stakeholder events.	Executive Director/Deputy Director of Workforce & OD	Opportunities to be communicated through REN. From 2023	Staff Network members invited to attend stakeholder recruitment events for COO position. Will be invited to attend other events. **Update 18/1/2023** JS to discuss with S Bannister about more diversity on the stakeholder panel for the MD post. Recruitment 9/23, YTHFM. **Updated 21/7/23**	
	ODIL to promote the Coaching and Mentoring opportunities available for all colleagues within the Trust to REN and the International Nurses.	Head of ODIL	ODIL to attend a REN meeting and IN induction to promote the opportunities available. 2023	ODIL are working on options of promoting and encouraging coaching & mentoring and are looking to offer an internal coach development programme targeting REN members. **Updated 3/4/23**	

Not Started	On Track	Completed	Overdue

				DS attending REN meeting on 21/07/23 to promote coaching & mentoring/coach training. **Updated 12/7/23** Outcome – different marketing and different offers, need meet with IN. DS will send the new marketing material when completed, to get feedback and to circulate. Need to disseminate leaflets for those who do not access online information. **Updated 2/8/23**	

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status

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

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

Reduce the percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public. There has been a negative increase in this metric from 25.5% in 2020 to 28% in 2021. The benchmark group average is 28.8%. Decrease this percentage by 3.5%.	Create a statistical comparison of data – reported through the 2020 Staff Survey, Datix and FTSU. Determine what action is required to address the findings.	Head of EDI, FTSU Champion, Datix Manager, Staff Engagement Project Lead	This action will enable the Trust to identify if there are any differences in colleagues reporting their experiences. It will also enable the Trust to determine what action is required. Quarterly reports to be provided from January 2023.	Meeting arranged for March 2023 Need to speak to Datix manager about this. **Updated 28/4/23** Waiting for a response from Datix manager, emailed again in June. **Updated 28/6**	Action not completed, similar action moved to 2023
	Engagement through the Staff Networks to find out what colleagues lived experiences are.	Head of EDI and Staff Network Chairs	Update the EDI Workstream on the findings to enable them to incorporate actions into local plans. April 2023.	Meeting arranged with the networks in April. Will share with workstream when it is up and running. **Update March 2023.** Meeting held in April **Updated 28/4/23**	

Not Started	On Track	Completed	Overdue

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

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

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
Reduce the percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. There has been little statistical movement with this metric but the Trust figure of 31.4% is higher than the benchmark group average of 28.5% Decrease this figure by 3.5%.	The Trust's Behaviour Framework was launched in 2022.	Head of Employee Relations & Engagement	Evidence - communication methods used to launch the BF July 2022		
	Develop a Microaggressions poster with all Staff Networks for communicating throughout the Trust.	Head of EDI and the Staff Networks	Raised awareness of everyday incivilities that cause unwanted behaviour. February 2023	Meeting arranged for April 2023	
	Review how the Trust's Behavioural Framework has been incorporated into Corporate and Local Induction as well as relevant training.	Workforce and Organisational Development	Dissemination of the Trust's BF increases understanding of the behaviours expected to	Emailed Jenny to ask if she knows how it is incorporated into induction. Will Thornton is working with OD on a new f2f induction for all staff which will be centred around values and	

Not Started	On Track	Completed	Overdue

			support our values. June 2023	behaviours and the BF will feature. Hoping to pilot in September. **Updated 7/7/23**	
	A cultural celebration for colleagues in Scarborough to share aspects of our ethnically diverse colleague's culture, UK colleague's culture to aid integration and breakdown barriers. Run by the Internationally recruited nurses.	Internationally recruited nurses, Hospitality and the Stay and Thrive Committee	Scarborough Festival of Culture implemented at the Scarborough Beach Huts September 2022	Programme: • Career Progression & Cultural Ambassador briefing • African Culture day • Philippines Culture day • British & rest of the world • India, Pakistan and Nepal Culture day • Family Day & Beach Party • Canteen – dishes from around the world Planning commenced in December 2022 to hold an event in York in April 2023. **Update 18/1/2023**	

	For all of metric 4 - review the Trust's processes for addressing experiences of bullying and harassment. (As per the Listening to Employee Voice: Our way forward action plan)	Head of Employee Relations & Engagement	Launch of new Harassment and Bullying Policy 31 March 2023	The Policy went to EPG March 2023 and will go to JNCC and LNC in April. **Updated 5/4/23** Discussed at EPG 13/4/23. **Updated 19/4/23** Ratified by JNCC, now with LNC. **Updated 13/9/23**	Civility & Respect policy to be implemented in 2023.

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

Objective	**Actions / Targets**		**Measurement & Completion Date**	**Progress/Comment**	**Status**
Increase colleague's experiences and perceptions about the Trust providing equal opportunities for career progression or promotion. The Trust has seen a deterioration of this metric over a 3-year period. The figure in 2021 was 41.9% which is	Explore colleague's experiences through the REN Staff Network encouraging other colleagues to attend	REN Staff Network Chair and Head of EDI	Colleagues will have been able to share their lived experiences with the Staff Network Chair. This will feed into wider work.	Invite colleagues who are not members of the network. Meeting arranged for April 2023. Captured these and plan to share at July's EDI workstream meeting, so can be worked on locally. Colleagues are also part of the Trust's Reverse Mentoring Programme.	

Not Started	On Track	Completed	Overdue

below the benchmark group average of 44.6%. Increase this figure by 3%.			April 2023	**Updated 7/7/23**	
	Continue to roll out the Trust's Reciprocal Mentoring Programme.	Head of ODIL	Colleagues will have the opportunity to share their lived experiences with senior leaders and obtain career support and advice. Spring 2023	Pilot has been implemented and a refreshed proposal presented to Trust Board. Training commences March 2023. **Update 18/1/2023** Cohort 2 includes 11 Reciprocal Mentoring relationships - conversations have started and will run to October 2023. **Updated 12/7/23**	
	Explore working with our International Nurses to help them align their overseas qualifications with UK qualifications, as per the Trust's Listening Exercise with the CEO.	International Nurse Recruitment	IN Team will have worked with colleagues to align their current qualifications with UK qualifications to enable them to have an increased understanding.	Meeting held on 27/4/23 with IRT to discuss support. Career Clinics implemented, widely attended by IR. SOPs written around recruitment and support, now looking at robust, sustainable pastoral support. A further meeting arranged for June. IRT to implement Recognising Prior Experience **Updated 28/4/23**	

			Date TBC		
	Promote the NHS Leadership Academy's programmes throughout the year through REN.	Head of ODIL and Head of EDI	Courses promoted throughout the Trust 2022/23	Head of EDI started to promote these in October 2022. Information has been sent out by the Head of EDI during November. Information disseminated by Comms Team on request. **Update March 2023**	
	Explore the implementation of targeted development programmes for: BME Non-clinical, bands 1-4 and Clinical, bands 5-7	Head of EDI	Implementation of a programme supporting BME colleagues with their development for advancement. June 2023	Contact North East London Foundation Trust to obtain information about their band 2-8 leadership development programme. Arden and Gem Commissioning Support Unit (CSU) are currently running cohort 1 of a BME Leadership Programme targeted at all BME colleagues. Run by an academic and WRES Expert. It is envisaged that resources and/or finance will be required to support this action.	

				Had a discussion with A&GCSU, putting this action on hold due to the Trust's financial position. Applied for charitable funding 8/23. Action moved to 2023 plan **Updated 13/9/23**	

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

Objective	Actions / Targets		Measurement & Completion Date	Progress/Comment	Status
The data for this metric has seen a significant deterioration from 16% in 2020 to 20.3% in 2021, this is above the benchmark group average of 17.3%.	Implement a Schwartz Round or panel discussion, open to all staff to attend – subject around people's lived experience of race discrimination	Head of EDI and REN Staff Network	Ethnically diverse colleagues from REN and the wider Trust are invited to be part of a panel to share experiences to	Yvonne Doherty, Psychology Team to arrange meeting to look at implementing a SR in June 2023. **Update 18/1/2023** A meeting was held in March 2023 with Psychological Medicine to discuss implementing a Schwartz round. As they	

Decrease this figure by 5%.			raise awareness. June 2023	were put on hold due the pandemic and were affected by the loss of the Schwartz Lead Facilitator, there has been no delivery. It is planned to restart SR in 2023 so this action will be carried over to the 2023/24 action plan. The team are looking at getting SR up and running again and are working with a mentor to look at the process. **14/7/23**	
	Race Conversations, development programme for managers		A date will need to be determined. The action should be implemented once it is felt that its reception would be welcomed.	The recommended external consultant is Dave Ashton Consultancy who has worked with the NHS Leadership Academy, the Head of EDI and many other Trusts for a number of years and is well versed on the topic of race and possesses the skills to navigate conversations and situations with managers at all levels. Funding obtained in Nov 2022 to implement this programme. Delivery of two workshops commencing in March and June 2023. **Update**	

Not Started	On Track	Completed	Overdue

				18/1/2023 Cohort 1, day 1 complete. **Updated 28/6** Extra session put on due to popular demand, also sought extra funding for two sessions for 2024. **Updated 13/9/23**	
	Implement a Buddy System for the international nurses	International Nurse Team	A successful buddying system will be implemented to support the International Nurses. TBC	IN are buddied with a nurse from the same cultural background by their Care Groups. Further pastoral support is going to be arranged. **Updated 28/4/23**	

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

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

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

Objective	Actions / Targets		Measurement & Completion Date	Progress/Comment	Status
Commence a year on year approach to increase BME representation at Board level by 1%.	Review of VSM recruitment processes within the Trust	Head of EDI, Foundation Trust Secretary and the Recruitment Manager	Process reviewed and advice given. February 2023	Search methods may need widening. Discussion held with Recruitment Manager, meetings set up for March to include FT secretary Met with MT to create a plan of action: VG to review Chair's JD & PS MT to arrange for VG to meet interim Chair to talk about EDI sustainability in Board recruitment MT to attend Staff Network meetings in November to ask them to review NED recruitment docs. Trust to continue to use Gatenby Sanderson's Insight Programme for diverse recruitment Check following apply to the above, use of diverse recruitment platforms, EDI training of staff. Staff Networks to be invited to SLT stakeholder interview events. VG to email ODIL about diversity of Shadow Board recruitment **Updated 23/6/23**	

16

Not Started	On Track	Completed	Overdue

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

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

	Learn from Trusts who have been identified as one of the top ten best performing Trusts for this metric	Head of EDI	February 2023		

Notes

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

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

Status - Key			
Action Not Started	**Action Commenced**	**Action completed**	**Action not completed**

Not Started	On Track	Completed	Overdue

Workforce Race Equality Standard Action Plan 2023-2024

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

Note: BME staff were engaged with via a joint staff network meeting and a survey monkey to obtain their suggestions on the actions required. These actions are designed to address the Workforce, Medical and Bank Race Equality Standards.

Objective	Analysis	WRES Action	Lead	Date	RAG Rating
WRES Indicator 1 BME representation in the workforce by pay band **WRES Indicator 2 Relative Likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointment from shortlisting across all posts**					
Indicator 1 has not seen any improvement in the number of BME staff employed in the Trust under Agenda for Change. Therefore, the Trust needs to Increase support and opportunities for career progression	Race Disparity Ratios High priority areas for improvement suggested by NHSE WRES Team: Career progression in clinical roles (lower to middle levels,)	Use positive action in targeting BME staff within the race disparity ratios levels to attend the internal development courses to support them with career progression	Head of Organisational Development	2023-2024	

	Career progression in clinical roles (lower to upper levels) • Bands 1-4 = 0.8% • Bands 5-7 = 7.3% • Bands 8-9 = 0.07% • VSM = 0% Career progression in non-clinical roles middle to upper levels) • Bands 5-7 = 0.5% • Bands 8-9 = 0.1% • VSM = 0.01% Lower: band 5 and under Middle: bands 5 & 7 Upper: bands 8a and above				
Bank WRES Indicator 1 Percentage of active workers by ethnic group and gender across key grades and staff groups					

Increase BME appointments to clinical and non-clinical A4C posts. Increase this by 0.6% for each race disparity ratio level	On examining the Bank data there could be an improvement in the number of BME staff on Bank.	BME staff invited to attend Bank recruitment events. (This should include existing staff)	Bank Recruitment	October 2023-2024	
WRES, BWRES & MWRES	Qualitive engagement data states that more visible diversity in the Trust's communications is required. This would encourage BME staff to see themselves in different job roles and see others as role models	Continue to ensure there is visible diversity in the Trust's Communications Dedicated equality, diversity and inclusion page in Staff Matters	Head of Communications and Head of EDI	October 2023-2024	
WRES Indicator 2 Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts					
Improve the relative likelihood of being appointed from shortlisting from 2.5 to 1 for the organisation	Y&S has seen no statistical improvement. A figure of 1 would mean there is equity	All recruiting managers/panels to attend Inclusive Recruitment Training (whilst this wouldn't be mandatory training, this should be a	Head of EDI, Medical & Bank Recruitment & HR Recruitment Manager	December 2023-2024	Looked into funding for this training, Aug 2023. Recruitment and Selection training updated to include

		recruitment requirement)			EDI recommendations
		BME representation on recruitment panels for band 8 posts (may need to include colleagues from HNY)	Medical Recruitment Manager, Bank Recruitment & HR Recruitment Manager	October 2023 – 2024	HR recruitment manager to re-start this action Head of EDI has spoken to REN about this, would need to recruit wider than the network
		Continue to deliver Conscious Inclusion training	Head of EDI	2023-2024	Training already planned to 3/24. Looked into funding to continue to implement training
		Workforce Leads to work with CG and Directorates on developing local action plans addressing local data	Workforce Leads	October 2023 onwards	Met with the WFL to discuss how to support their areas
		Implement interview skills training to support staff pre-interview	Head of EDI	TBC	Looked into funding to implement this training
		Offer all BME job applicants the opportunity of	EDI Workstream supported by Workforce Leads	October 2023 onwards	

		receiving improvement feedback after interview			
		Advertise jobs using a variety of recruitment platforms	HR Recruitment Manager, Band and Medical Recruitment	2023-2024	HR Recruitment manager has already commenced this action
MWRES Indicator 1b Percentage of staff by ethnicity in pay bands which cover all non-medical staff and Very Senior Managers					
Encourage BME consultants to apply for the Local Clinical Excellence Awards (LCEA)	The number of staff eligible for and were awarded clinical excellence awards funds in 2022 round, disaggregated by ethnicity = White colleagues 252, BME colleagues 88 (*please note*: The Trust did not run an application process through the 2022 LCEA round. These figures are reflective of equal distribution of available awards funds amongst all consultants who	Ensure any future LCEA process is inclusive of BME consultants to encourage an increase in the number of applications	Medical Director & Medical Workforce Manager	Next round of awards	

	would have been eligible to apply had an application process taken place. Moving forward the Trust plans to revert to an application and reward scheme).				
WRES Indicator 5 Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives or the public in the last 12 months					
See a year on year decrease in the number of staff experiencing this behaviour. To reach 30.8% by 2025	There has been a significant deterioration over the last two years with the number of BME staff experiencing unwanted behaviour from those who use our services, this figure is high and is above the Staff Survey benchmark group average of 30.8%.	Review of the Trust's Exclusion (Challenging Behaviours) Policy	Nicola Cowley	2023	Nicola Cowley, Learning Disabilities is leading on this and is setting up a Task and Finish Group
		Implement training for ward staff on how to deal with unwanted behaviour in line with	TBA	After implementation of the policy	

		the Challenging Behaviours Policy			
		Procedure developed on how to support staff including access to psychological support	Nicola Cowley	Q1 2024	
		Communications campaign to inform all services users and visitors to the Trust regarding approach to bullying, harassment and violence to staff	Head of Communications, Patient EDI Lead and EDI Workstream	Q1 2024	
Metric 8 In the last 12 months have your personally experienced discrimination at work from any of the following: Manager/team leaders or colleagues?					
For the Trust to see a reduction in people's experiences and the reporting in the Staff Survey by 2.5% by March 2024	After seeing a steep deterioration in 2022 compared to 2021, there has been little statistical improvement in 2023. The Trust's data is currently above the Staff Survey benchmark group average of 17.3%.	Improve mandatory Equality, diversity and human rights training compliance. Target 85%.	EDI Workstream supported by Workforce Leads	Q1 2024	As CQC action plan
		Implement NHS England's Culture and Leadership	Head of Employee Relations and Engagement	May 2024-Sep 2025	As CQC action plan

		Programme. Included within this will be the Behavioural Framework implementation, launch of the Civility, Respect and Resolution Policy, the importance of raising concerns and the FTSU remit			
		Examine data collected with ER to determine trends in specific departments, roles or pay bandings • monitor exit interview data to identify any particular trends and issues relating to staff leaving for these reasons. Create local action plans to address the findings	EDI Workstream supported by Workforce Leads	November 2023 – 2024	
Metric 9: BME Board members – Percentage difference between the organisation's Board voting membership and its overall workforce					
Increase the number of BME Board members by to be	Metric 9 has seen no statistical improvement in the number of BME	Associate Director of Governance to engage with staff networks to review	Associate Director of Governance	November 2023	Arranged to attend staff network meetings in November. Staff

more reflective of the organisation	staff on the Trust's Board of Directors and as voting board members. The difference in comparison to the rest of the organisation is-4.9%	Chair and NED recruitment documentation for any barriers			Networks contacted for involvement in the Chair selection process. As of March 2023, there are no BME Board members so representation has further declined
		The Trust to continue to engage with Gatenby Sanderson's Inspiring Leaders Programme to aid diverse recruitment	Associate Director of Governance	November 2023	Discussed with Associate Director of Governance
		Head of EDI to review Chair's JD & PS for any potential barriers	Head of EDI	July 2023	
		Career conversation/coaching and mentoring (action also applicable metrics 1, 2 and 4)	OD Facilitator	March 2024	OD Facilitator has commenced discussions
		Positive action in recruitment allowed under the Equality Act 2010 – state in advertisements looking for someone	Council of Governors	September 2024	Advice to be taken from HR Recruitment Manager

		from a visibly diverse background			
		Ensure the Council of Governors is diverse	Governor and Membership Manager	September 2024	Out of Area Governor nominations advertised in governor elections. Staff Network groups to be engaged on staff governor elections.

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

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

York and Scarborough Teaching Hospitals NHS Foundation Trust
Workforce Disability Equality Standard (WDES) Action Plan 2022-2023

Polly McMeekin, Director of Workforce and Organisational Development
Virginia Golding, Head of Equality, Diversity and Inclusion

APPENDIX 1

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status

Not Started	On Track	Completed	Overdue

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

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

To increase self-declaration of disability and long-term health conditions and dispel myths as to why we collect this data. Increase percentage of staff in post who share their disability status by a minimum of 2% in 2023	Evaluate communication methods used to disseminate information to staff on self-declaration and re-launch Self Service and the ESR app.	Deputy Head of Resourcing, Digital and Insights	Generate quarterly reports from ESR, workforce to evaluate if communications are being effective. Establish ways to aid communication. March 2023	Workforce Systems Manager to contact other Trust's to look at good practice. Contacted Comms to ask for support on doing a comms piece. Head of EDI gave information on how to take forward i.e. social model of disability and NHS Employers. **Updated 28/3/23** 4.6% of disabled staff as of 31/3/23. 4.08% of disabled staff at of 31/3/22 (Lest staff in post) Reduction in unknown in 2023 but less staff Updated 5/7/2023	
	Trust Managers to analyse local data and encourage	HR Business Partners and	Local quarterly reports provided to the EDI workstream.	Discussion took place on 4/4/23 with HRBPs to commence discussions	

2

Not Started	On Track	Completed	Overdue

	colleagues via local meetings.	EDI Workstream	March 2023	with CGs & Dir now and commence analysis in new reporting period. Local action plans to be drawn up against data. Jenny Flinton has asked the Workforce Leads to lead on this work. **Updated 4/23** Head of EDI met with WFL 6/23 to explain requirements. WFL to support their areas to investigate local area. WSM to provide WFL with data. **Updated July 2023**	
	Identify perceptions and barriers around self-declaration to feed into Myth Busting Guide	Head of EDI, EDI Workstream and the Staff Networks	Information obtained to aid completion of a Myth Busting Guide April 2023	Meeting arranged for April 2023 Head of EDI to create a booklet in July 2023. **Updated 5/7/23**	
	Work towards Disability Confident Level 3.	Workforce Lead	Level 3 achieved, or requirements established to achieve the next level. March 2023	Action to be incorporated into the Attraction and Retention Workstream,	

Not Started	On Track	Completed	Overdue

				commencing March 2023 No movement on this. SH asked for SV for actions to progress under current leader status. Likely to not achieve Confident status as need to do more work under leader level. **Updated 30/6/23**	
	Launch an Equality Monitoring Myth Busting Guide to dispel myths about sharing disability status	Head of EDI and the Staff Networks	Production and dissemination of a Myth Busting Guide to support self-declaration. May 2023	Meeting arranged for April 2023. Deadline date not met, plan to incorporate at Staff Network Launch event in October. **Updated 5/7/23** Guide completed but not yet launched. Transfer action to 2023-24 plan.	

Not Started	On Track	Completed	Overdue

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

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

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Reduce the percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public. Statistically there has been little change over 2 years and whilst 31.2% is below the benchmark group average of 32.4% this figure is still high. Aim to reduce this figure by 2%.	Create a statistical comparison of data – reported through the 2022 Staff Survey, Datix and FTSU. Determine what action is required to address the findings.	Head of EDI, FTSU Guardian, Datix Manager, Staff Engagement Project Lead	This action will enable the Trust to identify if there are any differences in colleagues reporting their experiences. It will also enable the Trust to determine what action is required. Quarterly reports to be provided from April/May 2023	Meeting arranged for March 2023. Met with FTSU waiting to hear from Datix manager. **Updated 30/6**	

5

Not Started	On Track	Completed	Overdue

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

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

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/ Comments	Status

Not Started	On Track	Completed	Overdue

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

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

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

Not Started	On Track	Completed	Overdue

	For all of metric 4 - review the Trust's processes for addressing experiences of bullying and harassment. (As per the Listening to Employee Voice: Our way forward action plan)	Head of Employee Relations & Engagement	Launch of new Harassment and Bullying Policy 31 March 2023	The Policy went to EPG March 2023 and will go to JNCC and LNC in April. **Updated 5/4/23** Discussed at EPG 13/4/23. **Updated 19/4/23** **P**olicy is still with staff side. **Updated 5/7/23** The policy is now called Civility, Respect and Resolution Policy and has been fully ratified by JNCC, still negotiating with LNC. **Updated 13/9/23**	

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

	Develop a Microaggressions poster with all Staff Networks for communicating throughout the Trust.	Head of EDI and the Staff Networks.	Raise awareness of everyday incivilities that cause unwanted behaviour. April 2023	Meeting arranged for April 2023 Engaged with networks about this, just need to put together the poster. **Updated 5/7/23** Launch at Staff Networks event, sent to EDI Workstream to disseminate, ask Comms to feature it in Staff Matters	

Not Started	On Track	Completed	Overdue

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

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

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comments	Status
Metric 4d - Ensure all staff are aware of the behaviour expected and how to report bullying and harassment / unwanted behaviour should it occur. This metric has seen a deterioration from 48.7% in 2020 to 45% in 2021 and is above the benchmark group average of 47%. Implement an action to see a 2% positive change in 2023.	Workforce and FTSU to provide quarterly figures on complaints to the EDI Workstream.	Workforce / FTSU Guardian	Data to compare with 2023 Staff Survey Results and to pinpoint areas of focus July 2023	Action slightly changed as Workforce and FTSU will be providing an update to the workstream from 9/23	
	General Allyship/Upstander training implemented in the Trust.	Head of EDI	Staff will access to an opportunity to raise awareness on how to become an active ally. Funded by 2 staff networks. Delivery 30/6/23	Training arranged for 30/6/23 Seeking funding to implement more workshops	

11

Not Started	On Track	Completed	Overdue

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

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

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
The percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work has seen a continuous deterioration, and the figure is below the benchmark group average of 32.6%. 34.4% in 2019 33.3% in 2020 30.6% in 2021 Aim to reduce this figure by 2%.	Re-introduce the Celebration of Achievement Awards for 2022.	Director of Communications	Awards will focus on valuing colleagues contribution, hopefully will impact on all colleagues.	Correlation will be difficult to prove.	
	Introduce an Equality, Diversity and Inclusion Category in the Celebration of Achievement Awards for 2023.	Director of Communications	New category introduced in 2023 demonstrating the value of diversity and inclusion.	Discussed with the Director of Communications on 27/9/22. Excellence in Diversity and Inclusion Award. Awards event 9/11/23	
	Enable Staff Network Chair to discuss this metric with members to ascertain	Enable Staff Network Chair	Engage with staff to delve into the data.	This action to be discussed with Network Chair due to demands on substantive role and network	

12

Not Started	On Track	Completed	Overdue

	actions required for improvement. Feedback to the Head of EDI and EDI Workstream.		Improvement actions considered for implementation. March 2023	membership issue. Timescale will need to be re-addressed Plan to approach this subject at joint staff network meeting arranged in April	

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

Objective	Actions / Targets	Responsible Lead	Measurement & Completion Date	Progress/Comment	Status
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This metric has deteriorated, in 2020 it was 77.1% and in 2021 it was 74.4%. This is still above the benchmark	Previous Enable Staff Network discussions identified issues with the IT process. Review the process with a view to identifying the blockages and creating a new streamlined process.	IT, Head of EDI and Enable Staff Network	New process in place and communicated to staff, Staff Networks and managers. A positive increase in 2023 data. July 2023	Head of EDI met with Matthew Chappell on 272022 to identify the issues. Staff story to board 22/2/23. Report to Board 29/3/23 on actions re learning and educating managers.	

group average of 70.9% which is commendable but anecdotal examples regarding the problems experienced means the organisation should review its process.	Implement a Health Passport to ensure that staff's reasonable adjustments are communicated and met.	Workforce Lead	A Health Passport co-produced with staff, piloted and launched. Date TBC	Almost ready to launch, waiting for IT solution. VG discussed at Feb 23 H&WB meeting. VG will pick this up with the reasonable adjustment process review has progress has been limited. 22/2/23 Action still need to be completed.	

Status - Key			
Action Not Started	**Action Commenced**	**Action completed**	**Action not completed**

Workforce Disability Equality Standard Action Plan 2023-2024

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Red	Not yet begun
Amber	Begun but not complete
Green	Complete
Blue	New

Note: Disabled staff were engaged with via a joint staff network meeting and a survey monkey to obtain their suggestions on the actions required. These actions are designed to address the Workforce Disability Equality Standard.

Objective	Analysis	WRES Action	Lead	Date	RAG Rating
WDES Indicator 1 Staff in AfC pay bands or medical and dental subgroups and very senior managers (Including Executive Board members) compared with the % of staff in the overall workforce					
Encourage staff to update their equality monitoring information to help determine who is in the workforce	Indicator 1 has seen various statistical changes in 2023 with five being positive, four statistically static and one deterioration	Last year's action was partly completed and has been updated. The Sharing Personal Diversity Guide will be launched along with a targeted campaign to update information on ESR.	Head of EDI, Workforce Data Analyst and EDI Workstream	January 2024	
		Maintain current Disability Confident level 2 and promote	Deputy Head of resourcing	Q1 2024	

		the benefits of this charter to managers			
WDES Indicator 5 Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.					
Increase awareness of the support available within the Trust to support Disabled staff in their careers	This has seen a slight negative decrease in 2023 but is equal to the Staff Survey benchmark group average, which has remained the same since 2021. Staff Survey results 2022 52.1%, 2023 51.4%.	Career conversation/coaching and mentoring	OD Facilitator	Q1 2024	OD Facilitator has already commenced discussions with the Staff Networks
		Use positive action in targeting Disabled staff to attend the internal development courses to support them with career progression	Head of Organisational Development	2023-2024	
		Promote the changes in Flexible Working and the Trust's Flexible Working Policy	Workforce Leads and EDI Workstream	November 2023	Changes within Employment Law
WDES Indicator 9 The staff engagement score for Disabled staff, compared to non-Disabled staff					

To engage, listen and support Disabled staff so they feel engaged with and that their needs are taken into consideration and acted upon.	The staff engagement score for the Trust's is 6.5 and the score for Disabled colleagues is below this at 6.1. The Staff Survey benchmark group average for Disabled people is 6.4 and the Trust's is also slightly below this.	Improve mandatory equality, diversity and human rights training compliance. Target 85%	EDI Workstream supported by Workforce Leads	Q1 2024	
		NHS England's Culture and Leadership Programme will continue. Included within this will be the Behavioural Framework implementation, launch of the Civility, Respect and Resolution Policy, the importance of raising concerns and the FTSU remit	Head of Employee Relations and Engagement	May 2024-Sep 2025	As CQC action plan

		Extend the remit of the Enable Staff Network to include Neurodiversity	Enable Staff Network Chair		**Completed July 2023, launched 3/10/23**
		Continue to implement the Neurodiversity at Work for Managers workshop	Head of EDI	August 2023-2024	**Seeking further funding to support this**
		As well as continuing to include Disabled staff in Staff Stories to the Trust's Board of Directors, feature Disabled staff in the new EDI section of Staff Matters, raising awareness promoting good practice and role models	Head of EDI and Communications Team	November 2023	
Indicator 10 Disabled Board members – Percentage difference between the organisation's Board voting membership and its overall workforce					
Increase the number of Disabled Board members to be more reflective of the organisation	This has seen a decrease in the number of staff who identify as Disabled, this is due to an increase in the number of Board members and how they identify. One out of 17 Board	Associate Director of Governance to engage with staff networks to review Chair and NED recruitment documentation for any barriers	Associate Director of Governance	November 2023	Arranged to attend staff network meetings in November. Staff Networks contacted for involvement in the Chair selection process.

	Members identify as Disabled				As of March 2023, there are no BME Board members so representation has further declined
		The Trust to continue to engage with Gatenby Sanderson's Inspiring Leaders Programme to aid diverse recruitment	Associate Director of Governance	November 2023	Discussed with Associate Director of Governance
		Head of EDI to review Chair's JD & PS for any potential barriers	Head of EDI	July 2023	
		Cohort 3 of the Reverse Mentoring Programme targeted at Disabled staff	OD Facilitator	TBC	
		Executive Director Sponsor of Enable to Lead the campaign via a blog to update Personal Diversity Information as in Indicator 1	Executive Director Sponsor of Enable and Head of EDI	January 2024	
		Ensure the Council of Governors is diverse	Governor and Membership Manager	September 2024	Out of Area Governor nominations advertised in governor elections. Staff Network groups to

					be engaged on staff governor elections.

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Gender Pay Gap Report 2023
Director Sponsor:	Polly McMeekin, Director of Workforce and Organisational Development
Author:	Virginia Golding, Head of Equality, Divesity and Inclusion (EDI) and WRES Expert and Amara Ashraf, Workforce Systems Manager

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

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

Trust Priorities	Board Assurance Framework
☒ Our People	☐ Quality 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 Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (the Regulations) require public sector organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31 March of each year, and each organisation is duty bound to publish information on their website. The snapshot date for this report is 31 March 2023.

The gender pay gap is a defined term in the Regulations and means the difference between the average hourly earnings of men and those of women. This is not the same as equal pay, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value. It is unlawful to pay people inequitably because of gender. Instead, the gender pay gap highlights any

imbalance of average pay across an organisation. For example, if an organisation's workforce is predominantly female yet the majority of senior positions are held by men, the average female salary would be lower than the average male salary.

Focusing work on our Gender Pay Gap helps the Trust tackle any gender pay disparities which also supports the retention of our workforce, which is part of our Public Sector Equality Duty Objectives. It is also a requirement of the EDI Improvement Plan, 6 High Impact Actions.

In March 2023 the Trust's Board of Directors requested that the Gender Pay Gap data for 2024 was reported to Board this year. The deadline for submitting the data to the Government's Equality Office is 31 March 2024. Another action plan has not been devised as the relevant teams and Staff Network are currently addressing the issues that were identified in the March 2023 report.

The Trust's Gender Pay Gap has reduced in 2023. The mean gender pay gap is 26.96% with the Median reported at 7.4%. These are a reduction but there are areas of focus that are causing the main disparities. These are at:

- AFC bands 7, 8a, 8b, 8c, 8d and VSM
- Bonus pay for consultants
- Core Trainees & Dental Trainees and Specialty Trainees, Trust Doctors and Dentists, Speciality Doctors and Consultants

Note: Bonus Pay relates to local and national Clinical Excellence Awards

Areas of actions to promote gender equality previously identified include:

- Promoting flexible working, working from home, career development and coaching and mentoring
- Implementing a talent management strategy
- Exploring using diverse recruitment platforms
- Focus groups

Work will involve the medical teams, Medical HR, General HR and the Women's Staff Network.

Recommendations:

- Note the overall improvements in the gender pay for 2023
- Note the areas of disparity
- Approve the data, narrative and areas of focus to reduce the gap
- Approve this report so the information can be submitted to the Government' Equalities Office and the Trust's website

Report History People and Culture Committee – 20/9/23		
Meeting	**Date**	**Outcome/Recommendation**
N/A		

York and Scarborough Teaching Hospitals
NHS Foundation Trust

GENDER PAY GAP REPORT 2024

1. Introduction and Background

York & Scarborough Teaching Hospital's NHS Foundation Trust employs circa. 8,690 (**full pay** relevant employees – excludes employees on leave from work or employees who are in receipt of less than their ordinary basic pay) staff in a number of disciplines, including: administrative; nursing; allied health; and medical and dental roles.

The charts below track the Trust's Gender Pay Gap movement from 2019.

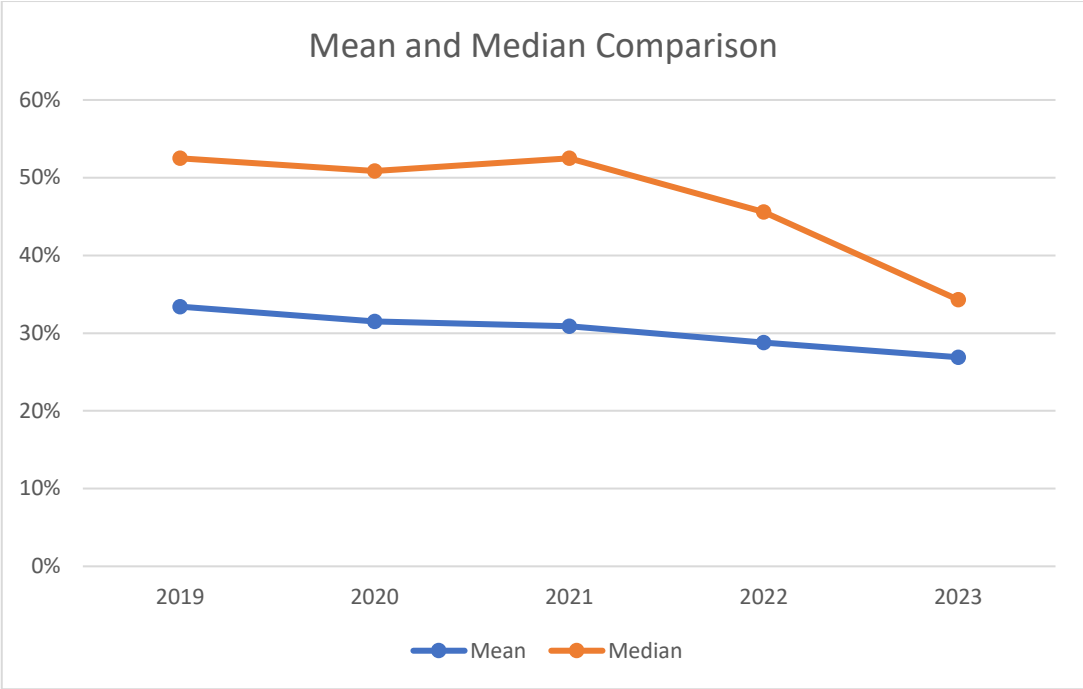
	2019		**2020**		**2021**		**2022**		**2023**	
Total Headcount	7820		7533		7932		8388		8690	
Agenda for Change Staff Headcount	6946		6609		6958		7380		7646	
Very Senior Manager Headcount	14		13		15		16		17	
Medical and Dental Headcount	857		911		959		992		1022	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Gender Profile	19%	81%	20%	80%	20%	80%	21%	79%	22%	78%
Headcount of A4C Staff and VSM	14%	86%	15%	85%	15%	85%	16%	84%	17%	83%
Headcount of M&D	63%	37%	61%	39%	61%	39%	61%	39%	60%	40%
% of Medical and Dental Staff Bonuses	75.61%	24.39%	75.13%	24.87%	75%	25%	73%	27%	67%	33%
	Gender Pay Gap (GPG)		**Gender Pay Gap (GPG)**		**Gender Pay Gap (GPG)**		**Gender Pay Gap (GPG)**		**Gender Pay Gap (GPG)**	

Mean GPG whole workforce	33.41%	31.5%	30.89%	28.8%	26.9%
Median GPG whole workforce	19.08%	19.36%	21.6%	16.8%	7.4%
Mean GPG A4C and VSM	0.07%	4.1%	5%	3.7%	2.3%
Median GPG A4C and VSM	-5.36%	3.8%	0%	- 4.3%	11.4%
Foundation Year 1 Doctors GPG	-0.41%	0%	0%	0%	0%
Foundation Year 2 Doctors GPG	-1.67%	0%	0%	0%	0%
Core Trainees GPG	2.85%	2.45%	2.9%	2.4%	1.3%
Specialty Trainees GPG	8.87%	-1.11%	-1.7%	- 0.2%	-0.8%
LAS Doctors GPG	9.33%	N/A	N/A	N/A	N/A
Trust Doctors GPG	17.25%	10.85%	4.9%	3.8%	6%
SAS Doctors and Dentists GPG	-8.70%	N/A	N/A	N/A	N/A
Specialty Doctors GPG	N/A	2.63%	-11.68%	7%	18%
Associate Specialists GPG	N/A	-33.27%	-28.1%	- 66.3%	-52.3%
Consultants GPG	8.64%	8.07%	6.32%	4.5%	1.4%

Year	Mean Gender Pay Gap	Median Gender Pay Gap
2020	31.5%	19.36%
2021	30.89%	21.6%
2022	28.8%	16.8%
2023	26.96%	7.4%

Year	Bonus Mean Gender Pay Gap	Bonus Median Gender Pay Gap
2020	35%	50%
2021	42.3%	50%
2022	34.9%	50%
2023	32.5%	50%

It is worth noting that the Trust now hosts the Collaboration of Acute Providers (CAP). With this team removed from the data the Trust Mean Gender Pay Gap is 27% with the Median Gender Pay Gap remaining unchanged at 7.4%



2. Scope of this report

The following is a gender pay gap report for York & Scarborough Teaching Hospitals NHS Foundation Trust and does not include the subsidiary company, York Teaching Hospital Facilities Management (or LLP). A separate report has been produced for York Teaching Hospital Facilities Management as an organisation of 250+ employees they are required to report under the Regulations, this will be published on their website.

The report includes all 'full pay relevant employees' who were employed by York & Scarborough Teaching Hospital's (including bank staff on shift) as at the snapshot date of 31 March 2023. Employees who were absent on nil pay and agency workers are not included. For Consultants we include within 'pay' those payments made for Additional Programmed Activities (APAs). All calculations exclude overtime pay and expenses.

The majority of staff are on either Agenda for Change or medical and dental pay scales, which provide a clear process of paying employees equally, irrespective of their gender or ethnicity.

There are 22 individuals who are on personal salaries. 17 of these people are Very Senior Managers. The Very Senior Manager workforce includes executive directors and non-executive directors.

3. What do we have to report on?

The requirements of the Regulations are that each public sector organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females (men and women) in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment

4. Definitions of gender pay gap

The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

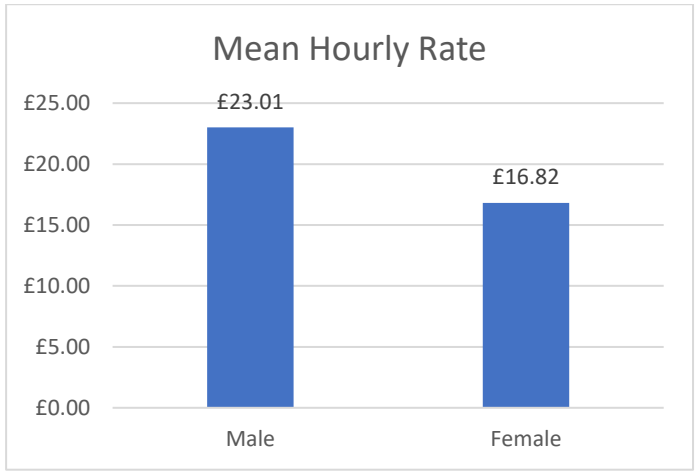
The median pay gap is the difference between the pay of the middle male and the middle female when all male employees and then all female employees are listed from the highest to the lowest paid.

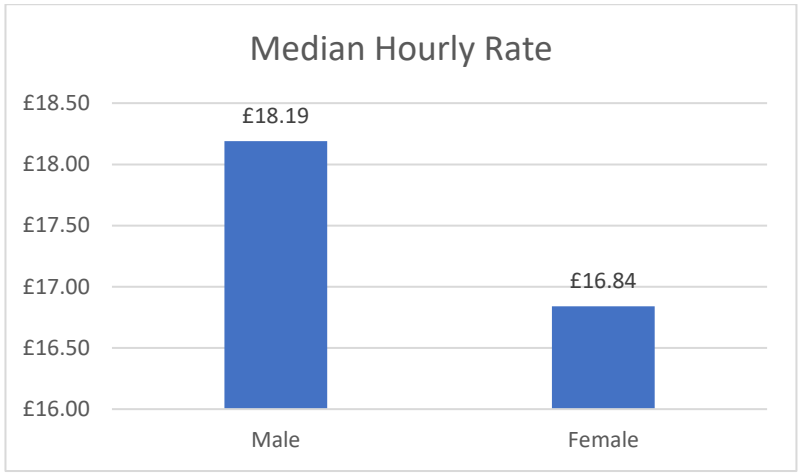
5. Trust Gender Profile

Appendix1 – The Trust's Gender Profile

6. 2024 Gender Pay Gap

The below charts show the mean and median hourly rate for all Trust staff as of 31 March 2023:





Mean gender pay gap 26.9%

Median gender pay gap 7.4%

The above charts show that the mean hourly rate of pay for males is £6.19 higher than that of females, a gender pay gap of 26.9%. They also show that median pay for males is £1.35 higher than females, a gender pay gap of 7.4%.

We are also required to split the workforce into quartiles (blocks of 25%), split by pay and show the proportion of males and females in each quartile. The results of this split are shown below:

Quartile	Female headcount	Female % of whole workforce	Female % of quartile	Male headcount	Male % of whole workforce	Male % of quartile
1	1,764	20%	82%	388	5%	18%
2	1,737	20%	83%	358	4%	17%
3	1,818	21%	80%	443	5%	20%
4	1,466	17%	67%	716	8%	33%
Totals	**6,785**	**78%**		**1,905**	**22%**	
Headcount total (total 'Full Pay Relevant Employees')	**8,690**					

Appendix 2 – Agenda for Change and Very Senior Manager Workforce Information

APPENDIX 2 Agenda for Change and Very S

Appendix 3 – Medical and Dental Workforce Information

APPENDIX 3 Medical and Dental Workforce

7. Bonuses

Only Medical Consultants were in receipt of bonus payments in the snapshot data. These were in the form of Clinical Excellence Awards (Local and National) and Distinction Awards.

There were 144 bonuses paid (under the pre 2018 Clinical Excellence Award process, local and national), 44 were to female consultants and 100 were to male consultants.

	Bonuses in relation to entire workforce	**Bonuses in relation to all Consultants**	**Total percentage of female vs male Consultants**
Female	0.6% of females overall received a bonus	31% of bonuses were paid to female Consultants	33% of all Consultants are female
Male	5.2% or males overall received a bonus	69% of bonuses were paid to male Consultants	67% of all Consultants are male

Mean
Male average bonus pay = £8,446.97
Female average bonus pay = £5,697.25
Difference in mean % bonus pay = 32.5% (in favour of men)

Median
Male median bonus pay = £6,032.04
Female median bonus pay = £3,015.97
Difference in median % bonus pay = 50% (in favour of men)

Note: Bonus Pay relates to local and national Clinical Excellence Awards

8. Summary

Hourly pay mean and median

Difference in mean % hourly pay = 26.9% (in favour of men)

Difference in median % hourly pay = 7.4% (in favour of men

	Female	Male
Lower hourly pay quarter	82%	18%
Lower middle hourly pay quarter	83%	17%
Upper middle hourly pay quarter	80%	20%
Upper hourly pay quarter	67%	33%

Personal Salary Category

While there are women covering the same roles in terms of responsibility and level of seniority within the personal salary grouping, the men in this category earn 12% more than the women.

Bonus pay mean and median

Difference in mean % bonus pay = 32.5% (in favour of men)

Difference in median % bonus pay = 50% (in favour of men)

6. **Bonus pay % split between men and women**
   Female = 0.6% (of entire female workforce)
   Male = 5.2% (of entire male workforce)

Bonuses - local and national Clinical Excellence Awards

The bonuses are paid only to consultants (medical and dental) through the 'Clinical Excellence Awards'. There are far more men in receipt of these bonuses than women, plus the median pay received by those men is 50% more than those received by the women within this category.

The 2023 mean and median gender pay gap for York and Scarborough Teaching Hospitals has reduced in 2023 in comparison to 2022. To continue reducing our gender pay gap we need to ensure that work is targeted at reducing the gap.

There is a gender pay gap in relation to average hourly pay within AfC bands 7, 8a, 8b, 8c, 8d, and VSM. Bonus pay for Consultants, Core Trainees and Dental Trainees, Speciality Trainees, Trust Doctors and Dentists, Specialty Doctors and Consultants.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	20 September 2023
Subject:	Nursing Workforce Report
Director Sponsor:	Dawn Parkes, Interim Chief Nurse
Author:	Emma George, Assistant Chief Nurse

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

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

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

Summary of Report and Key Points to highlight:

To provide information and assurance to the board on how the Trust has responded to provide the safest and effective nurse staffing levels during June and July 2023. This will include the requirement to submit the safer staffing metrics using fill rates. Provide assurance that nursing establishments have been reviewed utilising best practice guidance and the arrangements for daily monitoring of patient safety and quality risks in relation to the workforce are in place.

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

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

No ☐ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

Nursing Workforce Report

1. Introduction and Background

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

2. Considerations

The Trust has complied with the submission of fill rate data for June and July 2023 submission (tables 1 and 2). This shows average fill rates

Table 1 Fill Rates June 2023

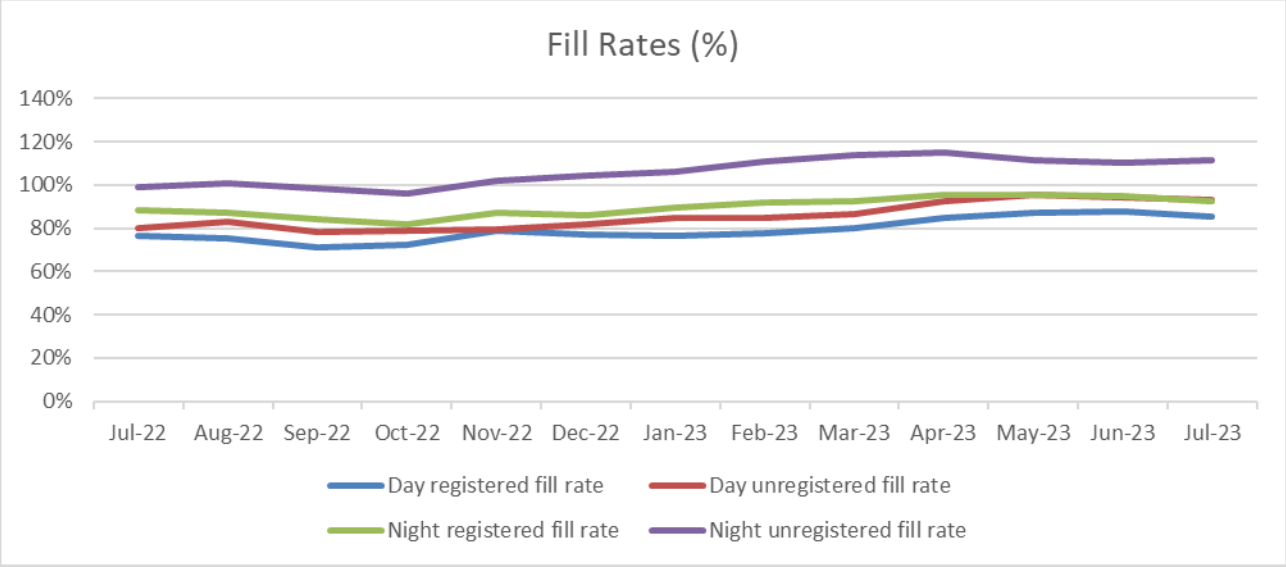
Care Group	Day		Night	
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
CG1	92%	91%	100%	111%
CG2	89%	96%	96%	107%
CG3	84%	102%	91%	119%
CG4	79%	95%	100%	105%
CG5	81%	76%	89%	93%
CG6	-	-	-	-
Total	87%	93%	95%	110%

Table 2 Fill Rates for July 2023

Care Group	Day		Night	
	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
CG1	92%	95%	102%	112%
CG2	87%	94%	99%	110%
CG3	84%	104%	91%	116%
CG4	82%	95%	100%	99%
CG5	78%	76%	89%	98%
CG6	-	-	-	-
Total	86%	95%	96%	111%

The tables (1 and 2) above and graph 1 below indicates that fill rates for both Registered and Non-Registered have been above 80% for June and July 2023 for adult in patient wards.

Graph 1 Fill rates



Night unregistered has been above 100% for nights for both months and indicates the demand for additional HCSWs on wards where enhanced supervision is required and reflecting the uplift and investment on nights for HCSWs from the 2022/23 establishment review recommendations.

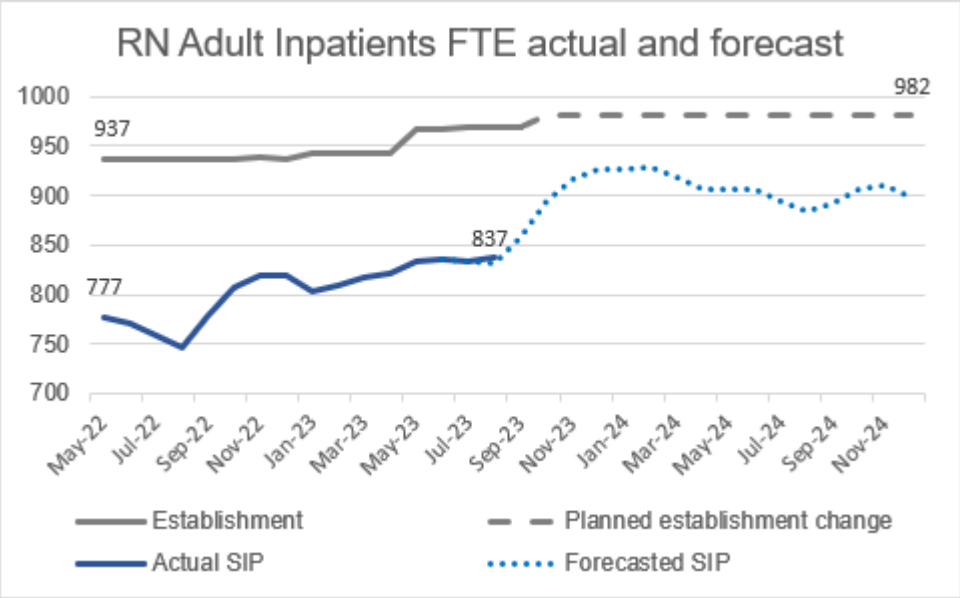
3. Current Position

Nurse Vacancies

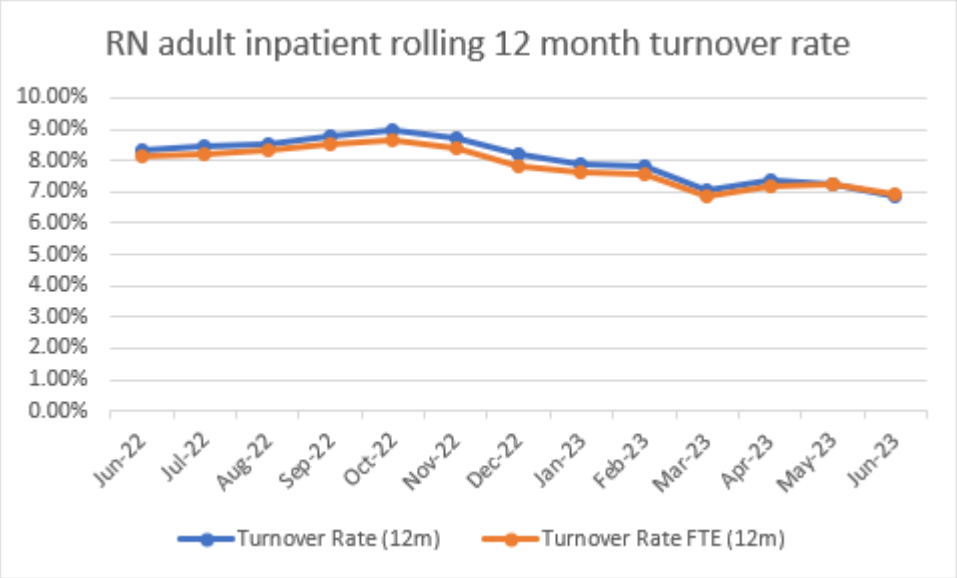
Registered Nurses

Graph 2 below indicates the actual and forecast for Registered Nurses in adult inpatient areas. There was a net increase of 4.18 FTE and this does not include the 107 PRNs who are joining the organisation through September and October 2023. Following the establishment review in 2022/23, there has now been investment and an increase in establishment of 22.8 FTE shown in May 2023 which includes 15.06 FTE investment in Care Group One for night shift cover linked to CQC recommendations plus 6.77 FTE increase for Emergency Assessment Unit (EAU) at York linked to an approved business case. Other uplifts to establishments totaling 15.06 FTE relating to other units for night shift cover have not yet been reflected in the budget which are mainly in Care Group Three.

Graph 2 RN Adult Inpatients actual and forecast.



Graph 3 Turnover rate for RN June 23



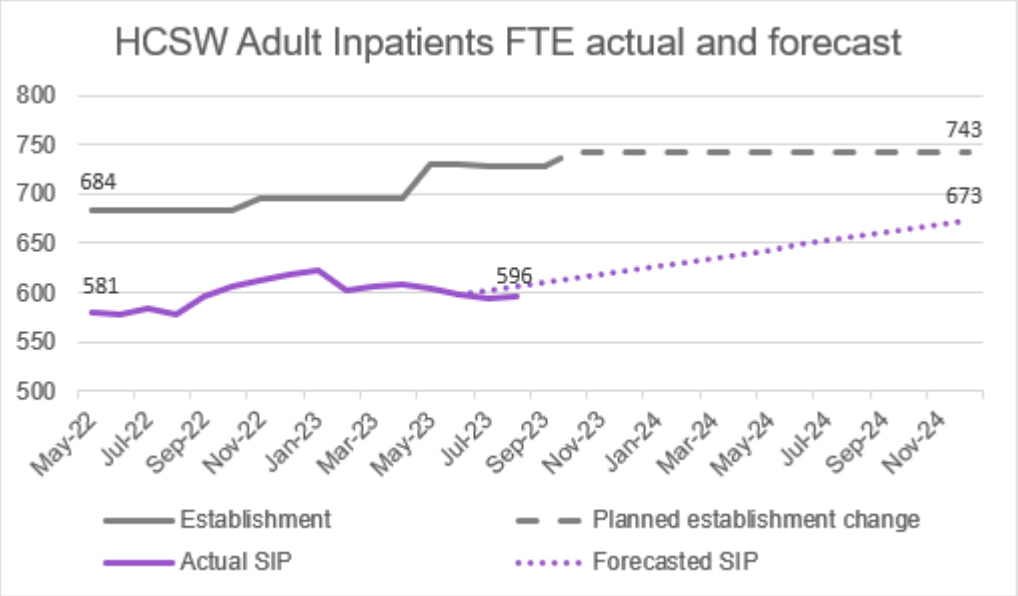
The graph above indicates a continued improvement in leaver rates with the attrition rate now below 7% from a peak at 9% in October 2022.
Following the establishment review in 2022/23, there has now been investment and an increase in establishment of 22.8 FTE shown in May which includes 15.06 FTE investment in CG1 for night shift cover linked to CQC recommendations plus 6.77 FTE increase for Emergency Assessment Unit (EAU) at York linked to an approved business case. Other uplifts to establishments totaling 15.06 FTE relating to other units for night shift cover have not yet been reflected in the budget which are mainly in CG3.

International Recruitment

As an ICB there is collaboration considering the options for International Recruitment beyond 2024, with the relationship built with Kerala and the Schools of Nursing to develop a pipeline for newly qualified nurses, recruiting ethically, supporting the nurses to come to the organisation and offering support before they come to adapt to UK nursing ensuring they stay and thrive. As an organisation we are involved in this project. There is a return trip to Kerala in November to finalise the MoU with two specific colleges to support newly qualifies nurses to join this organisation with a bridging course to support their transition whilst they are in college in Kerala. There is a commitment to recruit 124 International Nurses in 2023/24 and this is monitored through the Nursing Workforce Assurance Group which meets monthly.

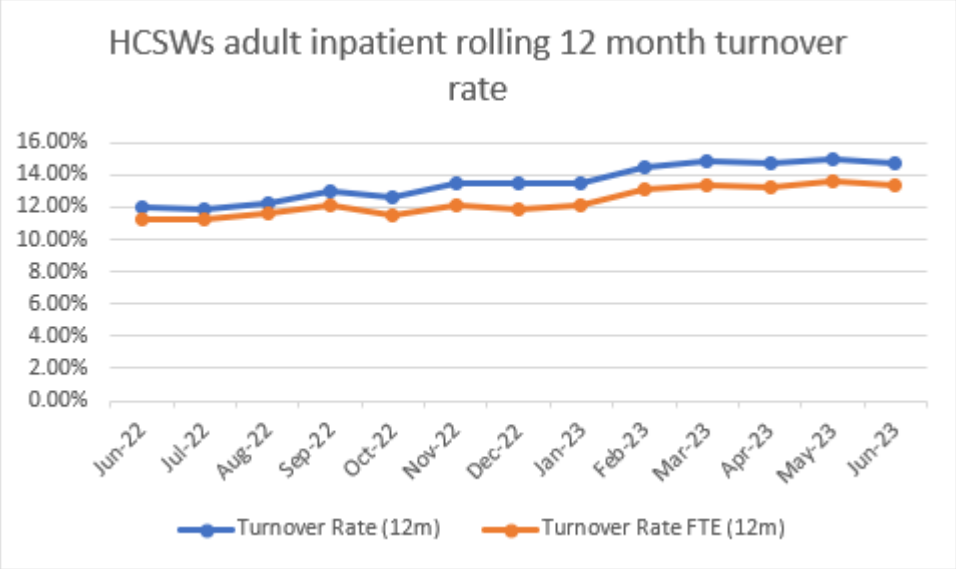
Health Care Support Workers (HCSW)

Graph 4: HCSW Adult Inpatients actual and forecast.



There was a net increase in month of 4.03 FTE for HCSW posts. Graph 4 above includes projections for Health Care Support Workers for the next 6 months which indicates how establishment changes and expected leaver numbers will impact staff in post numbers and the resulting vacancy position.
There has been an increase in establishment of 34.79 FTE shown in May 2023 includes 27.61 FTE investment in CG1 for night shift cover linked to CQC recommendation plus 12.68 FTE for the Emergency Assessment Units at both sites. The Emergency Department at Scarborough there has been a reduction in establishment of 5.5 FTE this month. Other uplifts to establishments totalling 15.06 FTE relating to other units for night shift cover have not yet been reflected in the budget.

Graph 5 HCSW inpatient rolling 12-month turnover Jun 22 – May 23



Graph 4 indicates the current turnover rate for HCSWs in adult inpatient wards with a slight downturn for June 2023.

HCSW recruitment plans for the coming year are likely to result in a break-even position, rather than an overall reduction in vacancies. The issues around why these workforce changes are happening are being explored further, for example the significant shift to bank only work and reducing hours indicates that many staff are looking for a level of flexibility that is not being offered at the point that they are being recruited to join the organisation. This needs to happen alongside the work to reduce attrition of those who are leaving the organisation. There is still a fluctuating picture with the number of leavers for HCSW and the turnover rate, the graph below indicates this.

NHSE continue to offer direct support to the organisation and there have now been two meetings with them, an improvement plan has been developed with engagement from the Associate Chief Nurses in Care Groups. A further meeting is planned for the 17 October 2023 to continue the discussions in how we can retain Health Care Support Workers.

Initiatives include the development of a Healthcare Academy opening in October 2023 which will ensure an in-depth programme with practical application to the role. A HCSW apprenticeship is now underway to commence Dec 2024 to ensure our new to care applicants get an opportunity to undertake a qualification in healthcare as well as working as a Health Care Support Worker.

NHSE have an ambition for a vacancy rate of 3.7% by December 2023, this indicates an increase in 176 WTE HCSW in this time, there is a planned recruitment programme for the next 3 months and the opening of the Healthcare Academy where we expect the leaver rate to improve as a result. There is an overarching improvement plan which is monitored through the leading the journey to excellence process and risk and mitigation presented through a highlight report.

Temporary Staffing

The Trust is being supported by NHSE to reduce high off framework agency spend in nursing. In June 2023, NHS England wrote to the ICB to stipulate a number of financial controls that need to be applied within the system. Several controls relate to the utilisation and monitoring of agency use. The ICB has asked the Trust to complete a 2023/2024 Operational Plan Assurance Statement by 1 September, to confirm that the organisation has in place policies and procedures to ensure the delivery of these measures.

There is a requirement for an established governance process to oversee agency staffing with clear terms of reference (either at overall level or by key staffing group e.g. nursing, medical, corporate) to be chaired by an executive director.

Recommendations:

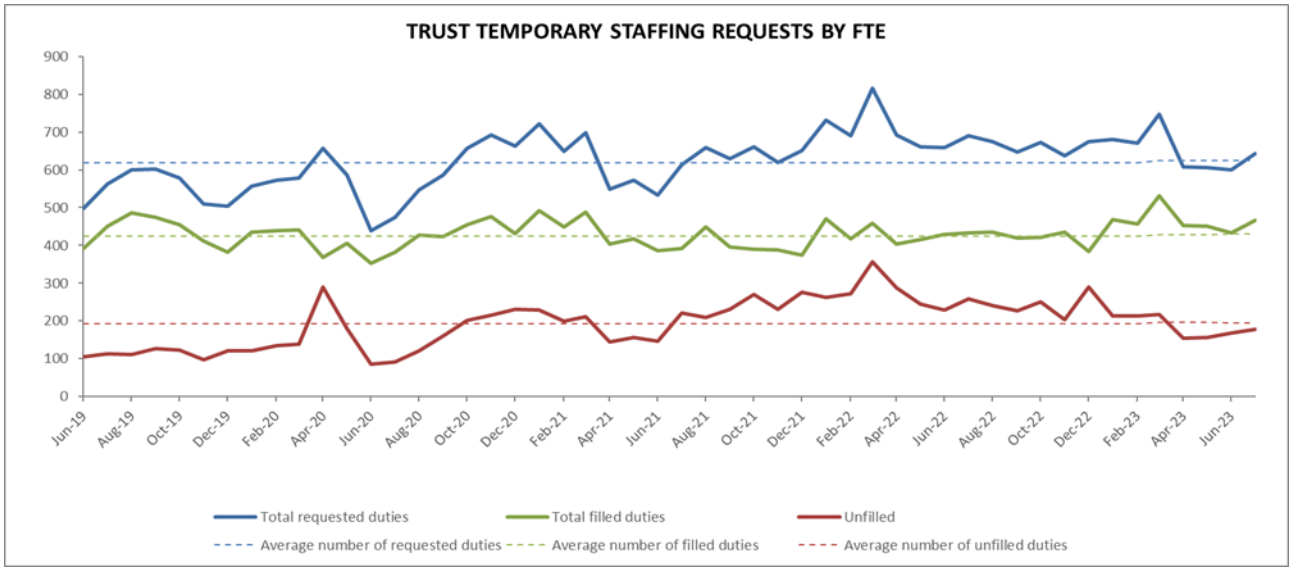
- Existing agency reporting to Executive Committee will be increased to provide key metrics where improvement is required, highlighting specific off framework agency use, non-clinical agency use, HCSW agency use, along with high-cost, long-term agency bookings. Spend data will be incorporated in the reports too, to provide a full overview for scrutiny and assurance.
- Existing Temporary Staffing reporting to monthly Care Group Performance Meetings will be increased to include the same detail as above, along with key metrics around the utilisation of the bank workforce. The report will be a

specific agenda item, to ensure discussion takes place around levels of use and opportunities for improvement.

- As part of the eRostering improvement plan, reporting of eRostering KPIs will be shared too, as there is a direct correlation between effective rostering and utilisation of temporary staffing. Longer term, eJob Planning metrics will be reported too.

The Trust has recently removed off framework agency use for nursing.

Graph 6 Temporary staffing demand



The demand for agency nursing has shown an increase in June 2023, there is a drive to reduce this with the measures in place and is monitored through the monthly nursing workforce assurance group (NWAG).

Table 3

Month	01/07/2023

SUMMARY OF TRUST TEMPORARY STAFFING REQUESTS

	Requested			Agency Filled			% of requested duties	Bank Filled			% of requested duties	Total % of duties filled	Unfilled			% Unfilled
	HCA	RN	Total	HCA	RN	Total		HCA	RN	Total			HCA	RN	Total	
Trust	6152	5638	11790	472	1477	1949	17%	3733	2542	6275	53%	70%	1947	1619	3566	30%
York	3932	3800	7732	471	1097	1568	20%	2196	1716	3912	51%	71%	1265	987	2252	29%
Scarborough	2220	1838	4058	1	380	381	9%	1537	826	2363	58%	68%	682	632	1314	32%

The table above indicates that there has been an increase in June for HCSW agency requests due to the increase in vacancy and sickness rates. There is ongoing direct support within the York site Care Groups to reduce the agency demand for non-registered nurses. Six wards and ED in York have been given permission to book HCSW agency due to the vacancy rates and this is being monitored weekly by the Heads of Nursing to ensure a reduction in this spend.

4. Summary

This report highlights the current workforce analysis of fill rates for June and July 2023, vacancies for Registered Nurses (RN) and Health Care Support Workers (HCSW), net increase for registered and non-registered and actual and forecasted FTE for adult in patient areas.

Date: September 2023

Report to:	Board of Directors
Date of Meeting:	27 09 2023
Subject:	Freedom to Speak Up Report
Director Sponsor:	Simon Morritt, Chief Executive
Author:	Stefanie Greenwood, Freedom to Speak Up Guardian

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

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

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

Summary of Report and Key Points to highlight:

This report provides an annual update regarding Freedom to Speak Up processes and activity from September 2022 to August 2023.

Recommendation:

The Board of Directors are asked to consider the following recommendations:

- Prioritise HEE Speak Up, Listen Up, Follow Up elearning being made mandatory.
- The Trust to conduct a survey to find out from staff whether they know how to speak up, would they speak up, and what stops them from speaking up and their ideas to resolve this.
- A formal monthly meeting to triangulate data, discuss themes, evaluate and share learning.
- Board to receive 2 FTSU update reports a year (page 33 of **B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)**.

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

No ☒ Yes ☐
(If yes, please detail the specific grounds for exemption)

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

1. Purpose

The purpose of this report is to update the Board of Directors on Freedom to Speak Up (FTSU) processes and activities from September 2022- August 2023.

2. Introduction and Background

The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment of staff and to promote learning and improvement.

It is widely acknowledged that what happened in Mid Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Sir Robert Francis highlighted the dangers of losing sight of human concerns in healthcare, the importance of engaging with patients and staff, and the risks to patients when the delivery of care becomes depersonalised. He insisted on the urgent importance of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen.

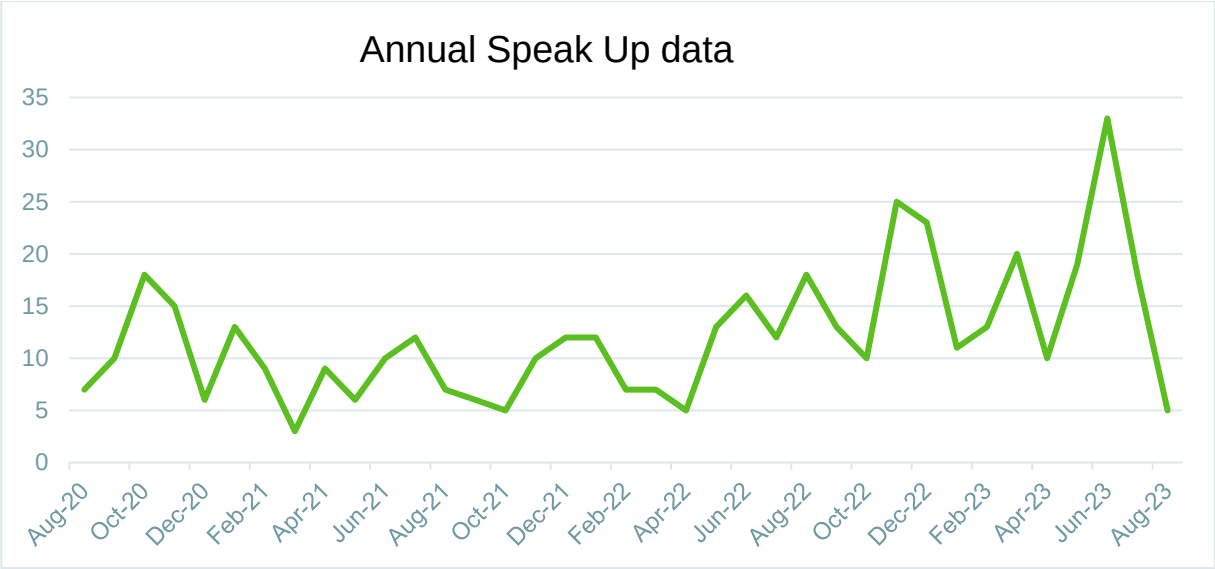
This is the third annual FTSU report produced by the Trust's Freedom to Speak Up Guardian, providing an update on the FTSU agenda.

3. Speak up cases

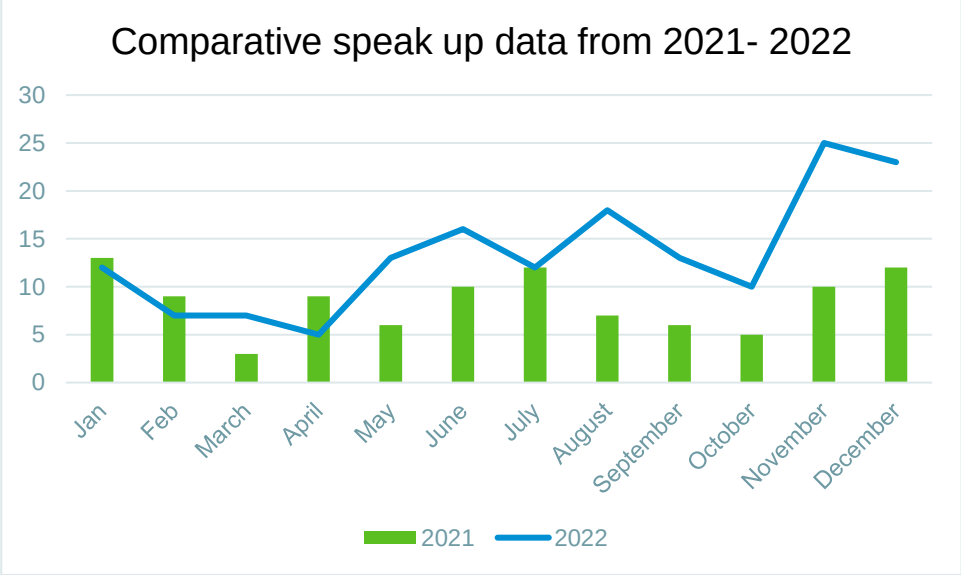
The following chart shows the annual speaking up data since the guardian started in August 2020 to present (August 2023).

The number of cases being brought to the FTSUG is increasing and has been increasing year on year since the FTSUG commenced in post in August 2020.

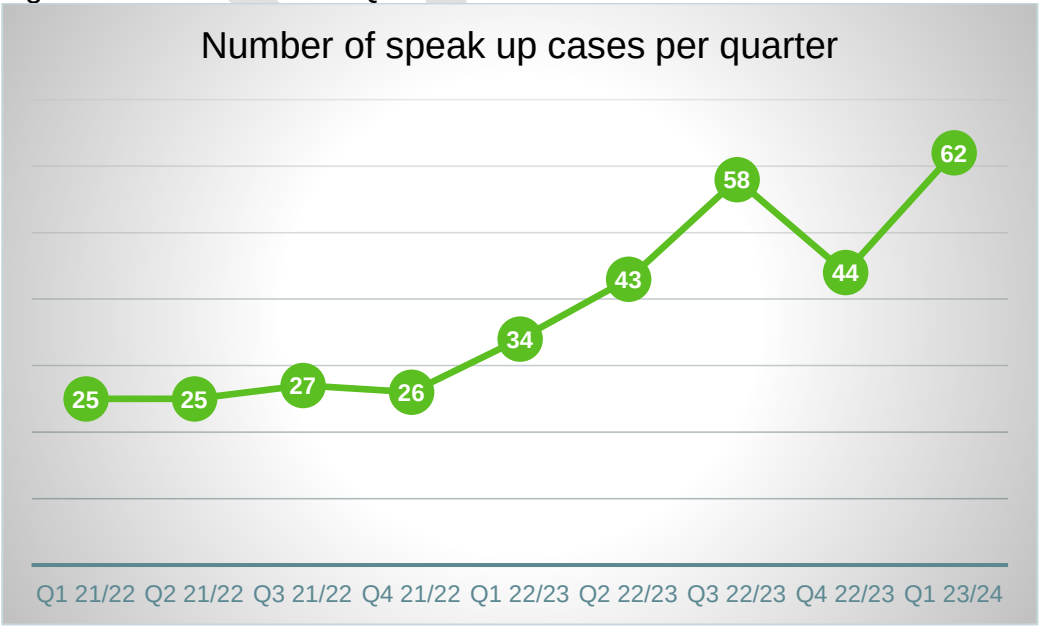
September 2020- August 2021	118
September 2021- August 2022	123
September 2022- August 2023	200



The following graph shows comparative data from Jan- Dec for 2021 and 2022.



The following chart shows the number of speak up cases per quarter, which shows a significant increase from Q2 22/23.

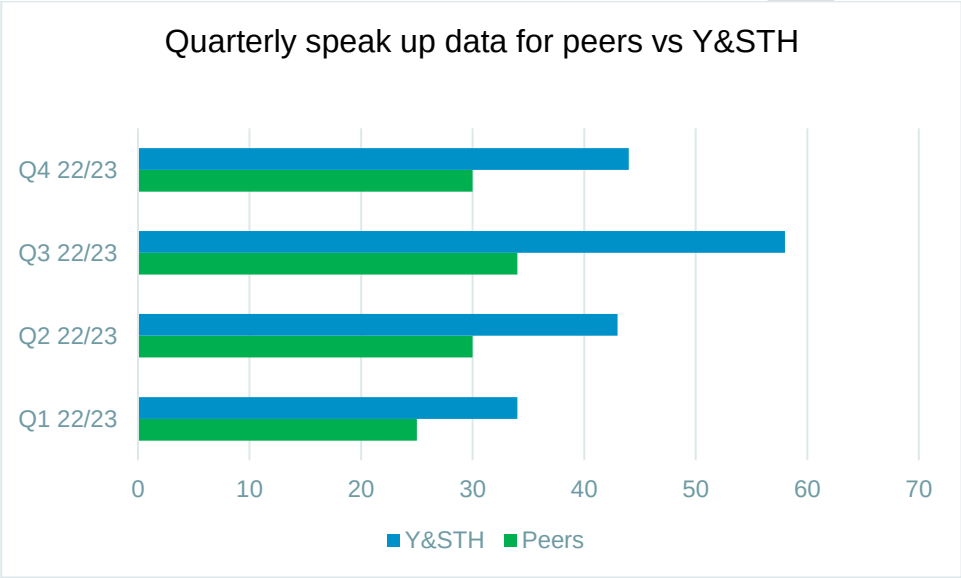


The increase in speak up cases to the guardian is positive in that workers know about the role of the guardian and feel able to speak up. However it could suggest that more local routes are either not being used, or are not working effectively, resulting in workers seeking support from the guardian.

The chart below shows the average quarterly speak up data for our peer organisations compared to the quarterly speak up data for York and Scarborough Teaching Hospitals.

The FTSUG at York and Scarborough is receiving more speak up cases compared to that of its peers.

**Peer organisations are categorised by size or organisation and NHS Trust/ Foundation Trust status.*

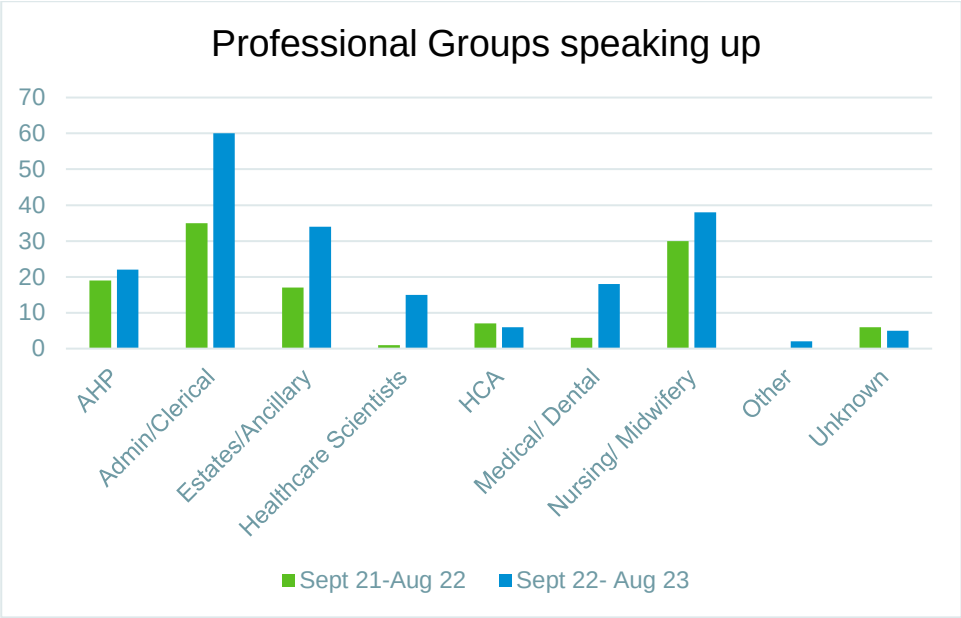


It is difficult to compare speak up culture and the success for FTSU across organisations due to the following:

- Number of hospital sites
- Geographical spread
- Number of FTSUG
- Contracted hours of FTSUG
- Maturity of champion network
- Number of champions

4. Who is speaking up?

Please see below a chart which shows the professional groups speaking up between September 2021- August 2022 and September 2022- August 2023.



There has been a significant increase in concerns from the Medical/ Dental staff group from 3 in 2021- 2022 to 18 in 2022- 2023. This is a notoriously hard group to reach so it is encouraging that awareness of Freedom to Speak Up and the guardian is increasing within this group.

There has also been a noticeable increase in concerns being raised from:

- Healthcare Scientists (Scarborough Hull York Pathology Services (SHYPS))
- Estates and facilities
- Admin/ Clerical

The number of concerns being raised by nurses and midwives has also increased from 30 to 38.

The guardian has been supporting and working with the management team of SHYPs due to the increased number of concerns being received. The guardian held a drop in session with the guardian from Hull University Teaching Hospital for the SHYPS staff at Hull Royal Infirmary and Castle Hill Hospital in June 2023. Both guardians plan to hold a follow up drop in session for the staff in November to facilitate speaking up and support culture change.

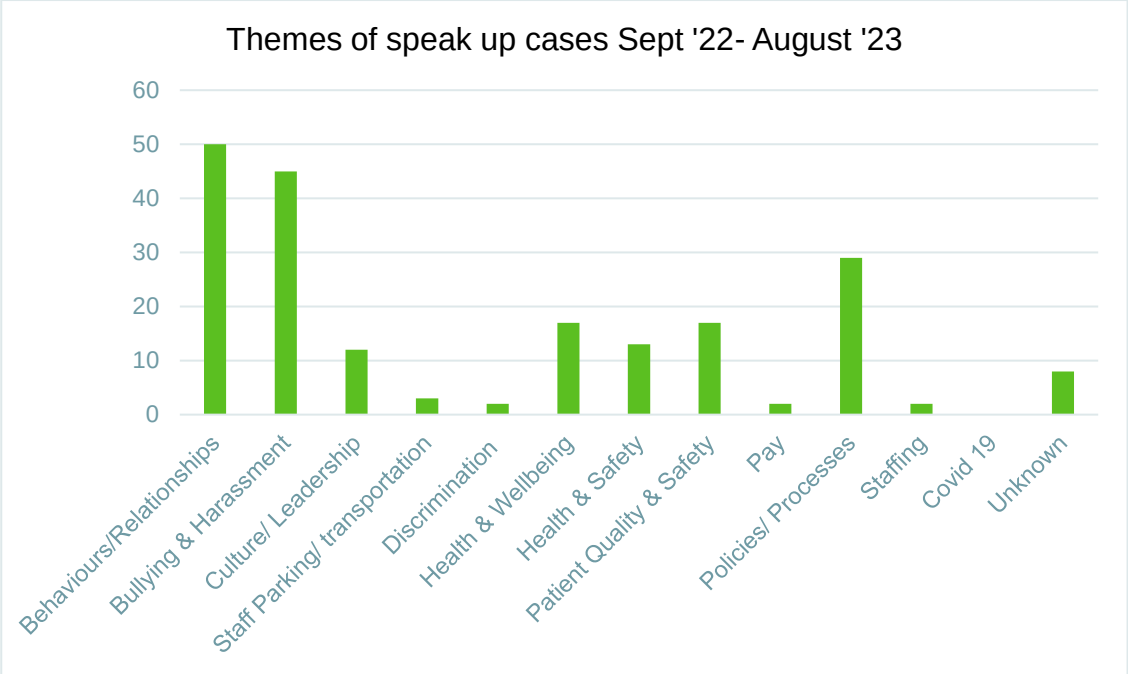
It is reassuring that a wider variety of staff groups are speaking up, and that there has been a slight increase in clinical teams speaking up, however clear and consistent messaging is required to ensure staff are reminded about the importance of speaking up, and how they can speak up.

The increase in speaking up cases could be attributed to the proactive work of the guardian to promote speaking up and the role of the guardian, and working collaboratively and in partnership with groups across the organisation.

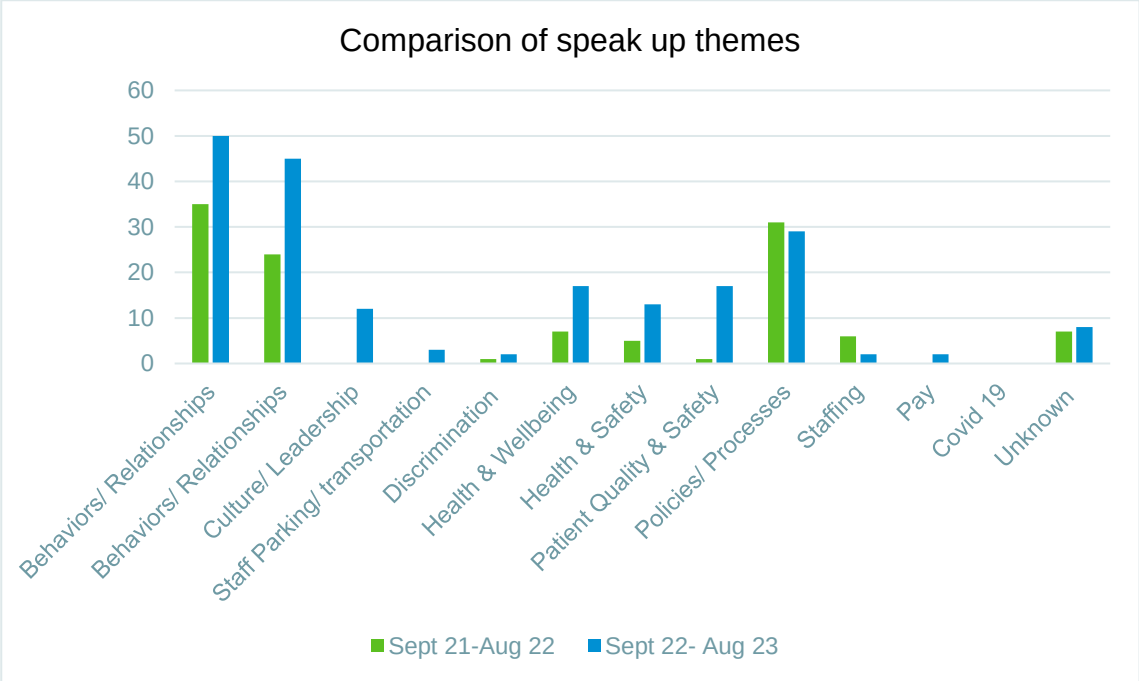
However it is important we continue to ask ourselves who are we are not hearing from and why?

5. Themes

The following charts show the main themes of the issues being raised by workers to the FTSUG between September 2022 to August 2023.



The following chart shows the main themes of the speak up cases comparative to the previous year.



There has been an increase in the following themes, and would like to draw your attention to:

- Behaviours/ relationships from 35 to 50
- Bullying and Harassment from 24 to 45
- Culture within teams/ departments
- Health, Wellbeing and Safety of staff from 12 to 30
- Patient Quality and Safety from 1 to 17

Concerns raised about policies, processes and procedures has not increased yet still remains a distinctive theme.

Concerns are also starting to be raised about racism and transphobia. The guardian has been linking in with the Trust's Lead for Equality, Diversity and Inclusion around these cases, where consent has been permitted.

6. Promotion and breaking barriers

Over the previous 12 months the FTSUG has been actively working to promote the various ways staff can speak up, the role of the guardian and the Fairness Champions.

In order to reach a wide variety of staff groups, and hard to reach groups (staff from marginalised groups, students, volunteers, shift workers etc) the guardian has utilised many forms of communication.

Examples include:

- Attending New Starter Fairs
- Presenting at Nurse preceptorship inductions
- Presenting at HCA Inductions
- Attending Junior Doctor Fairs
- Conducting walkrounds
- Attending all the Staff Benefit Fairs
- Working in partnership with the Wellbeing Team, Staff Psychology Services and Staff Side (e.g tearound in maternity, attending wellbeing awareness weeks)
- Collaborating and working in partnership with the Staff Networks (FTSUG attended Carers Marketplace event in June)
- Holding drop in sessions (one supported by the NED for FTSU)
- Attending team meeting either in person or virtually

Electronic promotion continues throughout the year via:

- Staff Matters
- Chief Executive's Week Ahead
- Screensavers
- Posters/ Postcards
- Journey to Excellence bulletin (April 2023)

Through analysis of speak up cases, the following barriers have been identified and threaten the effectiveness of the speaking culture the Trust aspires to. However it would be prudent for the Trust to conduct a survey to ascertain what barriers staff believe there are for them, and their views to resolve them.

Barrier to speaking up	Focus for improvement
Workers perceiving that there is no point raising concerns as nothing will be done/ nothing will change.	Education and training needed for managers about how to respond to concerns Promotion and encouragement of uptake of Speak Up, Listen Up, Follow Up elearning ?mandatory

	FTSUG to strengthen local Raising Concerns policy and revise in line with new national policy. Implementation of the new policy must be rolled out by January 2024. Greater oversight and actions of concerns by the Executive Team.
Absence of acknowledgement of concern raised and/ or lack of action, and/ or lack of feedback from manager which leads to worker contacting the guardian.	As above
Workers fearful of retaliation, detriment for speaking up/ raising a concern	Culture and Leadership Programme to support wider culture change and living our Trust Values. New Civility, Respect and Resolution Policy How should the Trust respond to allegations of retaliation/ detriment?
Length of time it takes to conduct investigations. Lengthy investigations are expensive, affect performance and productivity, and the wellbeing of those involved.	Investigating Officers and HR to be given adequate time and resource to support the investigation process.
Staff being able to see a difference and using lessons learnt effectively.	Consideration to be given as to how the Trust evaluates learning and shares this across the organisation.

7. Triangulation of concerns and data

The FTSUG attends a number of different meetings to strengthen and triangulate any soft intelligence with data. This helps the guardian to create a “heatmap” across the organisation of where may be experiencing issues or may need further support or training. The effectiveness of this relies on the relationships built and collaborative working between the guardian, senior leadership teams, management teams, Workforce, Patient Safety, ODIL etc. An example of this is where the guardian has been able to identify themes through the Quality and Safety Meeting and is therefore conducting a listening exercise for the department.

The guardian meets the Executive Directors on a regular basis to ensure they have appropriate oversight, and also meets with the Deputy Director of Workforce on a monthly basis to discuss themes, patterns and any current issues occurring operationally which help us to respond accordingly.

To support the guardian triangulate intel, the guardian attends:

- JNCC
- LNC
- Health & Safety Committee
- Quality and Safety Committee
- Emotional Wellbeing Steering Group
- Junior Doctor Forum
- EDI Workstream

The Board is asked to consider where the Trust triangulates its data as part of its governance and as an opportunity to address issues and support culture change.

Recommendation: A formal monthly meeting to triangulate the following data and discuss themes, evaluate and share learning.

Data you could compare

Patient safety	Worker experience
Patient complaints	Grievance numbers and themes
Patient claims	Employment tribunal numbers and claims
Safeguarding issues	Exit interview themes
Patient safety incidents	Sickness rates
Near misses	Retention figures
Never events	National Staff Survey results, including response rates
Patient experience dashboard data	The National Quarterly Pulse Survey
Friends and Family Test data	Polls or pulse surveys
	Workforce Race Equality Standard, Workforce Disability Equality Standard, Stonewall Equality Index data
	Levels of suspension
	Use of settlement agreements
	Leadership behaviours survey
	Thematic reviews
	Use of suggestion and similar schemes
	Engagement in worker reward and recognition schemes

8. Recommendation

The Board of Directors are asked to consider the following recommendations:

- Prioritise HEE Speak Up, Listen Up, Follow Up elearning being made mandatory.
- The Trust to conduct a survey to find out from staff whether they know how to speak up, would they speak up, and what stops them from speaking up and their ideas to resolve this.
- A formal monthly meeting to triangulate data, discuss themes, evaluate and share learning.
- Board to receive 2 FTSU update reports a year (page 33 of **B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk).**

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Item 13.1

Minutes

People and Culture Assurance Committee
19 July 2023

Attendance:

Lorraine Boyd Non-Executive Director ('The Chair'), Jenny McAleese Non-Executive Director, Polly McMeekin Director of Workforce & Organisational Development, Lucy Brown Director of Communications, Dawn Parkes Interim Chief Nurse, Karen Stone Medical Director, Mike Taylor Associate Director of Corporate Governance and Sue Smith (Governor observing).

Apologies:

Jim Dillon and Matt Morgan

Welcome and Introductions

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

17-23/24 Declaration of interest

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

18-23/24 Minutes of the meeting held on 17 May 2023

The Committee:

- **Received and agreed the minutes of 17 May meeting.**

19-23/24 Matters arising from the minutes and any outstanding actions

No matters arising from the minutes.

Action PC02: concerns were raised as to the length of time the 'yellow and red card' system is taking to develop. PM advised an update will be given in September.

Action PC06: recruitment plans will be presented to the Committee in September. An update regarding 'alternative roles' will be provided at the conclusion of a nurse staffing review in October/November 2023.

Action PC08: PM to provide an update at September's Committee.

20-23/24 Escalated Items

No escalations were received from other Committees.

21-23/24 Risk Management Report; Board Assurance Framework and Corporate Risk Register

Mike Taylor presented the report and highlighted the risk in relation to staffing.

It was queried why e-rostering continues to be delayed if it is apparent a full roll out would have a positive impact on staffing and the quality and safety of care.

PM advised the Committee that the electronic rostering business case was initially rejected due to the benefits not fully realised. However, NHS England have since carried out an assessment which concluded e-rostering to be implemented Trust wide. An action plan to secure a business case approval will be presented at Executive Committee.

Action: The NHSE report and action plan is to be shared at September's Committee

22-23/24 Library Annual Report

The report was considered by the Committee.

The Committee:

- **Received and noted the report.**

23-23/24 Mandatory Training Update

PM presented the training update.

PM advised compliance is gradually increasing following the Learning Hub incident earlier in the year. It was agreed at Board that August will be "mandatory training catch up month" with added capacity throughout the month to cope with the demand of extra training sessions for both virtual and face to face.

PM highlighted a new policy for Bank staff and if their mandatory training is not up-to-date they will be unable to book shifts.

24-23/24 Nursing Workforce Update

Dawn Parkes provided the Nursing Workforce Update which includes data from April to May 2023 and confirmed a full nursing review has been commissioned and will commence in October.

DP advised of the good fill rates within the care groups, however, a continuing challenge with the retention of HCA's. The team are working on a review to improve recruitment, retention, and experience. DP acknowledged temporary staffing is not ideal, but with the majority of temporary staffing being filled by the bank it ensures quality and reduces the need for agency staff who may not share the same Trust standards.

DP is rolling out flexible working and self-rostering with an implementation target of twelve weeks which is hoped to assist in providing flexibility for the staff.

The team is collaborating with a local Trust to establish a 'Healthcare Academy' which will be based in Bridlington and supported by NHSE. The Academy will provide induction and simulation training and at the conclusion of the training the HCA's will receive a certificate.

The committee would like the ongoing position regarding the retention of HCA's should be shared with the Board due to the financial and potential quality impact.

25 - 23/24 Workforce and OD update and Trust Priority Report

PM provided the update.

Workforce priorities over the next two years are to focus on 'our voice our future' together with workforce productivity i.e. e-rostering, line management and leadership development.

The organisation has created a network with local schools and sixth form colleges to provide work experience, taster sessions and site visits. A challenge to ensure the Trust meets safeguarding and DBS standards of the education sector therefore a review of our Policy is underway to ensure the positive work continues.

PM made the Committee aware of a paper that is to go to Executive Committee highlighting an employment claim against Leeds Teaching Hospital regarding international nurses joining the Trust. In short when international nurses join a Trust they start on the lowest pay point of their band irrelevant of experience. Our organisation has carried out an audit with the results detailed on page 47. PM confirmed immediate steps are being taken to remedy the situation.

LB referred to page 60 of the TPR and sought assurance with the speed of the improvements being made to tackle cultural factors affecting the 'shop floor' and care group management. PM confirmed the care group restructure is to commence in September when

specific training will be provided. The 'Line Management Toolkit Programme' will focus on leadership development, management and line management.

Discussion concerning the development of the 'Speak Up' network and recruitment of more 'Fairness Champions'. The Fairness Champions are to be made more visible with the expectation of the role be defined.

26-23/24 Issues to escalate to Board, other Committees, BAF or CRR

Ongoing situation regarding retention of HCA's should be shared with the Board due to the financial and potential quality impact.

27-23/24 Any Other Business

Following the extremely successful recruitment event on 4th July which attracted over a thousand people more events are to be scheduled in the future. It was very encouraging that the event attracted a large amount of student nurses enquiring about newly qualified positions.

28-23/24 Summary of actions

Action: The NHSE report and action plan is to be shared at September's Committee

29-23/24 Date of next meeting

20th September 2023, 1pm

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	CQC 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 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:

Progress with delivery of actions within the Trust CQC Improvement Plan is being overseen through the fortnightly Journey to Excellence meeting.

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

A written report from the Ionising Radiation (Medical Exposures) Regulations, IR(ME)R, Inspection was received by the Trust on 18 July 2023. An action plan in response to the findings of the report was submitted to the CQC on the 29 August 2023 following approval by the Trust Corporate Directors.

There are 10 open enquires with the CQC.

Recommendation:

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 Exempt from Public Disclosure

No ☐ Yes ☒

Inclusion of CQC IRMER Action Plan – this has been submitted to the CQC but not formally approved.

Report History		
Meeting	**Date**	**Outcome/Recommendation**
Quality Oversight Group	13 September 2023	*Presented*
Quality and Safety	19 September 2023	*Not yet presented*

CQC Update

1. CQC Inspection

The Board of Directors has agreed eight improvement workstreams providing a framework for the Trust's 12-month quality recovery programme; Journey to Excellence. Each of the workstreams will include actions to deliver each of the CQC Must and Should actions.

The workstreams are as follows:

- Maternity Services
- Governance; Corporate / Quality
- Staff and Public Engagement
- Urgent Care
- Elective Care
- Leadership and Culture
- Safe Staffing
- Fundamentals of Care

An Executive Lead has been assigned to each workstream and 'plans on a page' have been developed and presented to the Journey to Excellence meeting on 21 August 2023.

Executive led 'check and challenge' meetings for Care Group level improvement plans will be held in September 2023, with delivery of the plans overseen through the Care Group Oversight and Assurance meetings.

If an action is considered 'complete' by the Care Group, and sustained impact of the action is evident, then a proposal can be made to close the action. Closure of the action must be supported by the Executive Lead and approved through the Journey to Excellence meeting. A copy of the approved proforma is attached in **Appendix 1**.

Any extension to the target completion dates for actions must also be approved by the Executive Lead and through the Journey to Excellence meeting. A copy of the approved proforma is attached in **Appendix 2**.

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

The Trust CQC Inspector / Lead has confirmed that Maternity Services will be the focus of the next Engagement Meeting on 5 September 2023.

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

An IR(ME)R inspection took place on 29 June 2023. An improvement notice was received on 4 July 2023. The inspector believed 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.

The contravention must be remedied by 12 September 2023. Actions are in train and progress was reported at the Trust Regulation and Accreditations Group on 17 August 2023.

A written report from the inspection was received by the Trust on 18 July 2023. An action plan in response to the findings of the report was submitted to the CQC on the 29 August 2023 following approval by the Trust Corporate Directors **(Appendix 3)**. Receipt of the action plan has been acknowledged but feedback had not been received at the time of writing this paper.

An internal audit review on Radiation has been commissioned, the scope of the audit discussed and is due to commence in quarter three (October to December 2023).

4. Mental Health Risk Assessment Section 31

In January 2020 CQC imposed a Section 31 as they were not assured that patients who presented to the York and Scarborough emergency departments with mental health needs were being risk assessed and cared for safely.

The CQC have asked to be updated when the new Mental Health Risk Assessment form has been transferred onto Nucleus, when staff have received training on use of the form and monthly audit results to be provided once launched.

The Mental Health Risk Assessment will be going into the Nucleus test system at the start of September 2023, a pilot run with the aim of it going live by the end of the month.

5. 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 one CQC enquiry in August 2023 (CAS-18872-Z0R9V6 – Ward 34), which was closed after the response was received. At the time of writing (1 September 2023) the Trust has 10 open enquiries.

It should be noted that:

- Two enquires relate to maternity services with queries relating to triage.
- Two enquires relate to care of deteriorating patients.

The enquiry dashboard can be viewed in **Appendix 4**.

6. CQC Updates

Restrictive Practice

The CQC Interim Director of People with a Learning Disability and Autistic People and the Director of Mental Health, discuss the CQC's new cross-sector policy position on restrictive practice and how this translates to providers and people who use services. Click here. The article has been circulated to the Safeguarding Team.

7. Recommendations

The Board of Directors asked to:

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

Date: 8 September 2023

Appendix 1

York and Scarborough Teaching Hospitals NHS Foundation Trust

CQC Improvement Plan
Proposal for Closure of an Action

Action	
Action Reference	
Enforcement Level	
Care Group	
Executive Lead	

Key Outcome Metric/s	

Evidence for Closure

Ongoing Monitoring and Improvement Actions

Recommendation

Date	
Author	
Contributors	

Presented to	
Date	
Outcome	

Appendix 2

York and Scarborough Teaching Hospitals NHS Foundation Trust

CQC Action Plan
Request to Extend an Action Deadline

Action	
Action Reference	
Care Group	
Executive Lead	

Original Completion Date		**Proposed Completion Date**	

Has the Completion Date been previously extended?	Yes / No
If yes, please provide further detail:	

Reason for the extension request

Mitigations and assurance that a further extension will not be needed

Date	
Contributors	

Presented to	
Date	
Outcome	Approved / Further Information Needed / Declined

CQC Action Plan Request to Extend an Action Deadline Proforma v2.
J2E Approved: 4-09-2023.

Appendix 3

CQC Improvement Plan – Response to Ionising Radiation (Medical Exposure) Regulations Inspection of York Computed Tomography (CT) Service 29/06/2023 Report Findings

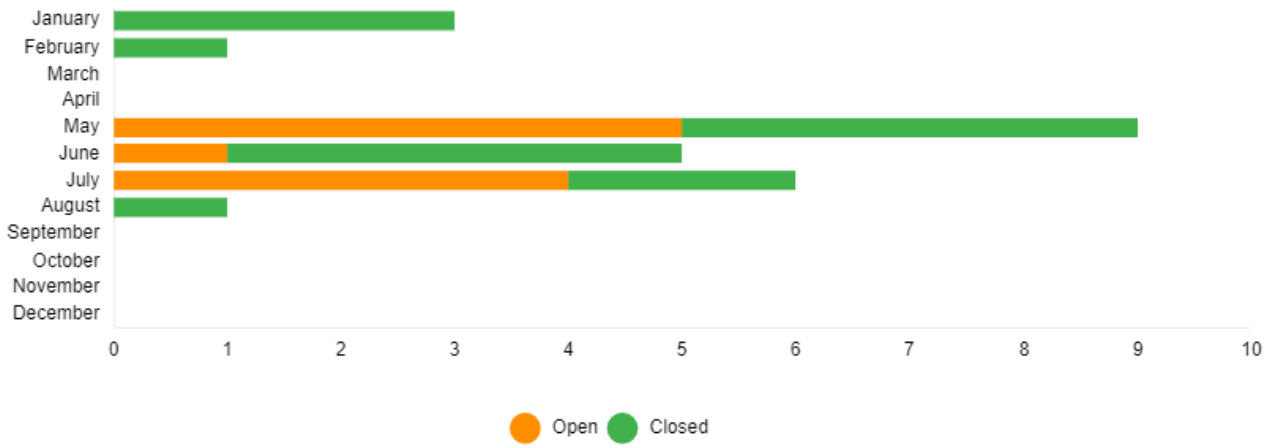
Ref.	CQC Improvement Action	Service	Site	Regulation	High Level Actions for Improvement	Outcome metric	Target Date to Complete	Radiology Lead	Senior Responsible Officer
1	**Improvement Notice:** The employer must ensure that written procedures are in place in respect of those matters described in Schedule 2.	Radiology	Cross site	**6**(1)(a)	Review content of all documents relating to Employer's Procedures and consider the format and content of the index document. Progress monitored via weekly in-person meetings with Medical Physics and catch ups with senior management.	Completed documents to be approved via virtual circulation to the Radiology Directorate Meeting and Radiology Radiation Protection and Quality Assurance Group.	12/09/2023	Rebecca Kranz	Karen Priestman
2	**Improvement Notice:** The employer must establish quality assurance programmes for written procedures and written protocols.	Radiology	Cross site	**6**(5)(b)	Develop a quality assurance document review process for written procedures and protocols.	Process approved via virtual circulation to the Radiology Directorate Meeting.	12/09/2023	Rebecca Kranz	Karen Priestman
3	**Area for Improvement:** The employer must establish a programme of review or audit to ensure referrer, practitioner and operator compliance with written procedures that are in date and reflective of practice.	Radiology	Cross site	6(2) Employer's Duties	Develop a quality assurance and regulatory audit programme, including referrer, practitioner and operator compliance audits.	Quality assurance programme and audit template approved by Radiology Directorate Meeting.	12/09/2023	Debbie Brian	Marcus Nicholls
					Specific action for the non-medical referrer audit. Non-compliance uncovered by the audit (such as inappropriate clinical sponsors or out-of-date Ionising Radiation (Medical Exposure) Regulations training) will result in non-medical referrer entitlements and / or agreements being withdrawn if compliance is not achieved within a defined period.	Paper to be approved at Care Group Board in September 2023 ahead of communications being sent to referrers for advanced notice of the audit.	30/11/2023	Jimmy Hamilton / Louisa Coxon / (Debbie Brian)	
4	**Area for Improvement:** The employer must ensure diagnostic reference levels (DRLs) are regularly reviewed and available to the operator.	Radiology	Cross site	6(5)(c) Employer's Duties	CT to ensure dose-length product (DLP) is entered on RIS for each examination.	Dose-length product added to Radiology Information System (RIS) completion screen.	31/07/2023	Lisa Shelbourn / Steve Rimmer	Karen Priestman
					Implementation of TeamPlay dose monitoring system for Medical Physics to have access to all dose information.	All users set up and trained – to be confirmed via Picture Archiving and Communication System (PACS) team.	30/09/2023		

Ref.	CQC Improvement Action	Service	Site	Regulation	High Level Actions for Improvement	Outcome metric	Target Date to Complete	Radiology Lead	Senior Responsible Officer
					Medical Physics to produce new local diagnostic reference levels and displayed in the departments. Going forward, the diagnostic reference levels will be reviewed annually as part of the Medical Physics annual report.	Full dose audit completed and resultant local diagnostic reference levels received. They will be published in protocols and displayed.	31/01/2024		
5	**Area for Improvement:** The employer must implement and maintain a quality assurance programme for the equipment.	Radiology	Cross Site	15(1)(a) Equipment	Equipment quality assurance summary document to outline the quality assurance programme with the frequency of tests for each modality.	Equipment quality assurance summary document completed as part of the Employer's Procedures in ref 1.	12/09/2023	Modality Leads / Steve Rimmer	Karen Priestman
					Ensure quality assurance spreadsheets are in place for the recording of results.	Quality assurance completion to be monitored via the modality meetings and Radiology Radiation Protection and Quality Assurance Group.	12/09/2023		
					Develop a central storage system for quality assurance records.	Allocated space(s) in X-Drive restructure.	30/11/2023		
6	**Area for Improvement:** The employer must specify acceptable performance criteria for the equipment and specify what corrective action must be taken.	Radiology	Cross Site	15(6)(b)(c) Equipment	Ensure all equipment quality assurance procedures specify acceptable performance criteria (and when a test is out of tolerance) and what actions to take (e.g. check settings, repeat test, who to inform, what that person does e.g. call manufacturer).	Completed / updated standard operating procedures to be approved via modality meetings and Radiology Radiation Protection and Quality Assurance Group.	30/09/2023	Modality Leads / Steve Rimmer	Karen Priestman
7	**Area for Improvement:** The employer must ensure practitioners and operators are adequately trained and have available up to date records of all relevant training.	Radiology	Cross Site	17 Training	Training matrices and strategy to be approved.	Training matrix and strategy approval: Radiology Directorate Meeting.	30/09/2023	Debbie Brian / Clinical Educators / Modality Leads / Clinical Leads (for radiologists)	Marcus Nicholls
					Training documents to be reviewed and / or approved across modalities. Ensure locums are included in all plans. Developing question and answer training (more than tick sheet).	Completed training documents approved via modality meetings against the training matrices.	31/12/2023		
					Review staff training records and fill existing gaps.	Gap analysis undertaken in each modality and progress in filling these to be monitored via modality meetings.	31/01/2024		
					Develop a central storage system for training records; a short-term improved solution then a formal strategy for long term plan.	Storage system – short term: X-drive solution. Long term solution to be explored via the Trust Regulations and Accreditations Group.	31/01/2024		

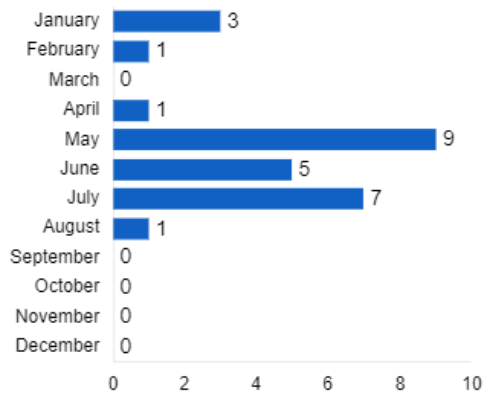
Appendix 4

CQC Enquiries
1 January 2023 to 5 September 2023

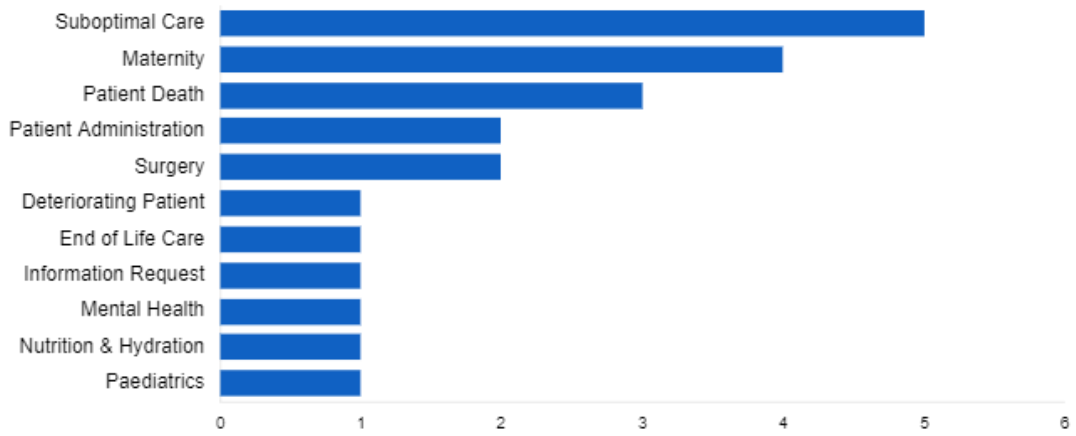
CQC Enquiry Status



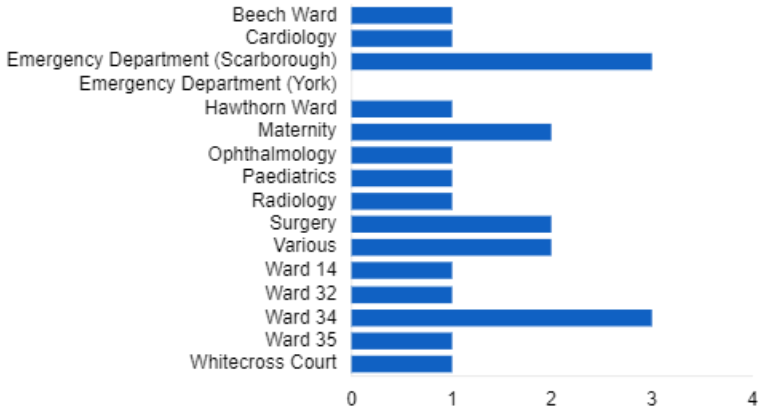
Number of Enquiries Received by Month



Number of CQC Enquiries by Theme



Number of CQC Enquiries by Ward / Dept



Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Bi-annual Midwifery, Maternity and Neonatal Staffing Report January to June 2023
Director Sponsor:	Dawn Parkes, Chief Nurse
Author:	Sascha Wells-Munro, Director of Midwifery Caroline Alexander, Associate Chief Operating Officer

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

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2. **Executive Summary**

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

3. **Birthrate Plus Workforce Planning**

A formal Birth Rate Plus assessment was completed in June 2021, which reviewed the acuity of women who used maternity services, at what was then, York and Scarborough Teaching Hospitals Foundation Trust.

NICE (2017) recommend that an assessment is carried out every three years. Although the service is still within the time to enable an updated position of the current workforce with the support of the Maternity Improvement Advisor and Birth Rate plus, we have undertaken a refresh of the 2021 data. Whilst this has allowed us to reflect on our current position, it is recognised that certain issues such as increase in acuity, geographical uplift and changes to the role of the LWC may demonstrate the need for further investment when BR+ assessment is formally repeated. The refresh recommended a birth to midwife ratio of 23.3 for York and 24.1 Scarborough. However, it is recognised nationally that due to the fluctuation in complexity of the women and acuity of services, the refresh does not provide us with enough assurance that the assessment will not be forthcoming with additional recommendations. Our ambition is to repeat a full assessment with Birth Rate + in Q3 2023.

The refresh highlighted a deficit of 2.47 WTE between Bands 3-7; there is recognition the staffing establishment deficit can be address through skill mixing. To achieve the 90/10 York recommendation, the Trust is partaking in the LMNS Level 4 HCA to MSW Training Programme designed to upskill Band 2 Health Care Assistants to Band 3 Midwifery Support Workers. The programme commences in September 23 with 24 HCA's enrolled across 3 cohorts.

Additionally, a full Workforce Review is underway in conjunction with our Maternity Improvement Advisors and newly appointed Director of Midwifery.

4. **Planned Versus Actual Midwifery Staffing Levels**

The following table outlines percentage fill rates for the inpatient areas by month.

Site 1: York

York	Day qualified %	Night qualified %
Jan 2023	91	105
February 2023	88	95
March 2023	87	91
April 2023	89	94
May 2023	85	90
June 2023	83	88

Site 2: Scarborough

SGH	Day qualified %	Night qualified %
Jan 2023	92	99
February 2023	88	100
March 2023	92	103
April 2023	95	102
May 2023	92	102
June 2023	95	99

York have seen a slight downward trajectory due to maternity leave, sickness, and number of supernumerary teams joining our Trust (international and newly qualified midwives). Scarborough's fill rates remain static. On occasions where fill appears to exceed 100%, this would be accounted for by additional scrub and telephone shifts which have been in place since January 2023 as the recruitment to a substantive scrub practitioner team in theatres is completed to ensure a robust workforce model for maternity theatres which reduces the need for midwives to scrub.

The Ward Managers and Matrons are being supported with roster management and key performance indicators; many are new in post and have not previously received any structured training. Work is ongoing to split rosters according to teams, to allow for a more detailed understanding of shift fill and roster management. This support is being provided in a variety of ways to include from the roster management team, the Workforce Lead, and the Interim Director of Midwifery.

The escalation policy is under review to incorporate an out of hours maternity on call.

When staffing is less than optimum, a range of measures are taken in line with the escalation policy such as:

•Request midwifery staff undertaking specialist roles to work clinically.

•Elective workload prioritised to maximise available staffing.

•Managers at Band 7 level and above work clinically.

•Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles is maintained.

•Activate the on-call midwives from inpatients / community to support labour ward.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. Historically, rosters have been created to have higher fill rates during the night shifts and weekends when there is less support available from specialist midwives and managers. Roster reviews will become more robust and managers trained in accordance with best practice and this training and focused work on rosters will be complete by 30th September 2023. A range of development modules including roster management will be offered on our newly designed B7 Fundamentals of Management course. Actions taken to support safe staffing are captured in the live birth rate

plus acuity tool. Training sessions are being delivered by BR+ during September to increase LWC understanding of the tool and compliance with completion. In October this will be rolled out in antenatal and postnatal areas.

At York, inpatient midwives have participated in an escalation on-call for several years. A recent consultation has concluded at Scarborough with the plan to undertake escalation on call which would enhance the availability for community midwives for homebirths. Progress has been paused as a full Workforce Review and BirthRate + Assessment is first required. This approach has not commenced as the output from both the review and assessment is required to enable the Director of Midwifery to support.

Band 7 managers and specialist midwives undertake a manger of the day role at each site, which supports escalation, staff breaks and patient flow. This role will be reviewed against recommendations for a dedicated flow midwife role as part of the Workforce Review.

There is recognition a Maternity Staffing SOP; which will include an escalation policy, is required to support less than optimum staffing levels. The Maternity Staffing SOP will be produced following a full Workforce Review which is expected to commence in September 2023 following the successful appointment of a substantive Director of Midwifery.

5. **Birth to Midwife Ratio**

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio. * This metric is included in the maternity dashboard, it is noted that it only counts the numbers of births and does not reflect the acuity of the women delivered.

2023	January	February	March	April	May	June
Ratio	1:26	1:27	1:28	1:27	1:27	1:27
Births	313	307	344	317	322	297

**Midwife: Birth Ratio calculated as number of births / WTE midwives. This is not adjusted for staff absence such as sickness, maternity leave etc.

6. **Specialist Midwives**

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for York and Scarborough January-June 2023 is calculated to be 6.8%.

7. **Birth Rate Plus Live Acuity Tool**

The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas on both sites in April 2021 and on the other inpatient areas on June 2021. It is a tool for midwives to assess

their ‘real time’ workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of ‘acuity’, and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

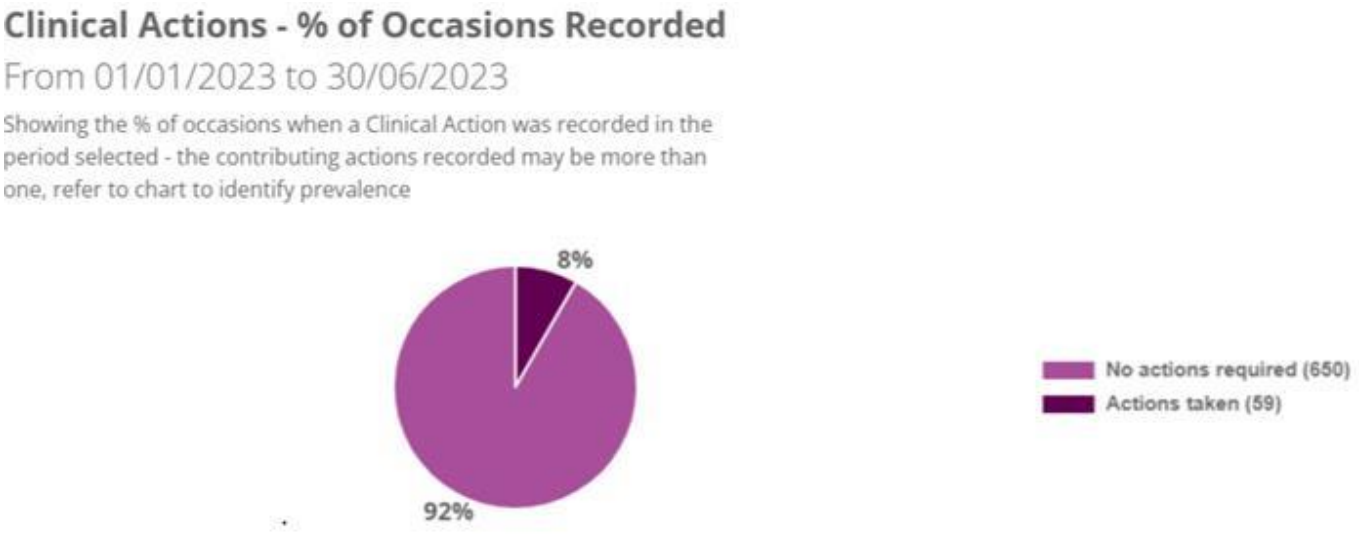
The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

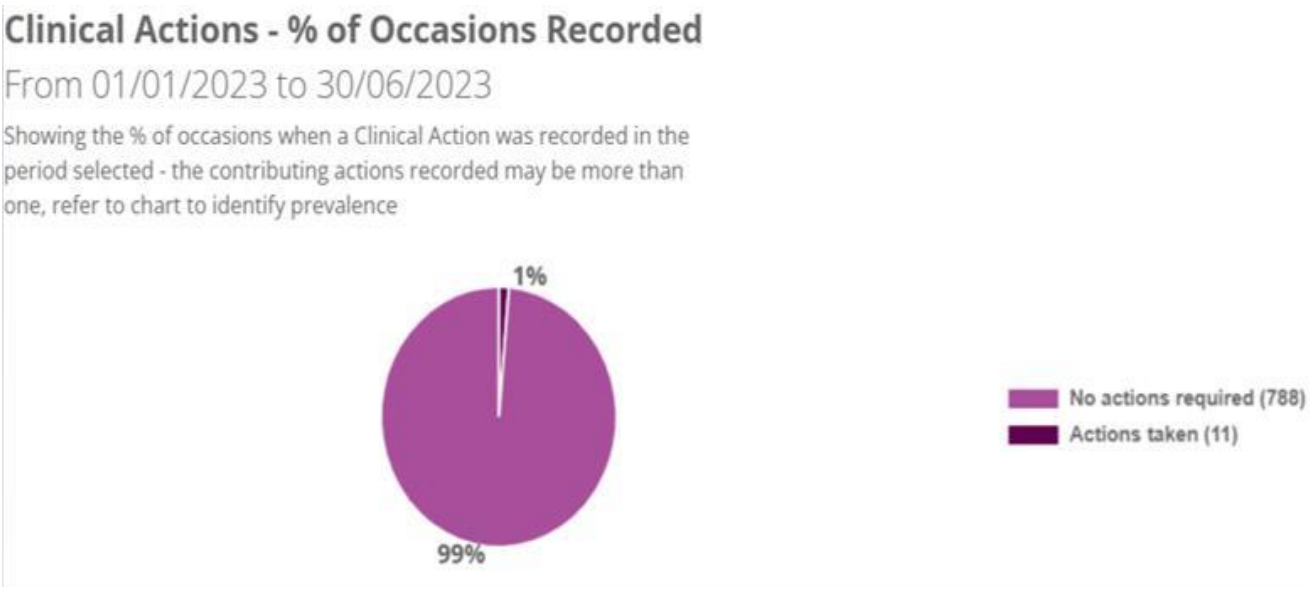
The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

The graph below shows that actions were required on 51 occasions (8%). These actions included decline in in-utero transfers and delay in accepting transfers to labour ward. The delay in accepting transfers to labour ward, accounted for the majority of clinical action to mitigate acuity and to improve reporting. A further metric has been added to the BR+ acuity which asks LWC to detail if the delay in transfer was related to induction of labour.

York Q4 and Q1 01/01/23-30/06/23



Scarborough Q4 and Q1 01/01/23-30/06/23



The graph above shows, actions were required on 11 occasions (1%). These actions included decline in in-utero transfers, delay in elective c-section and delay in transfer to theatre.

The updated training for BR+ and escalation policy which is under development will aid LWC in reporting activity where acuity is not met in a more robust way.

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. Data supporting this compliance monitoring will be reviewed during October 2023 to confirm the quality and refresh compliance levels before the next bi annual workforce report.

The following table outlines the compliance by month:

Site 1: York

York	Number of days per month	Number of shifts pe month	Compliance
January 23	31	62	100%
February 23	28	56	100%
March 23	31	62	100%
April 23	30	60	95%
May 23	31	62	100%
June 23	30	60	100%

Site 2: Scarborough

Scarborough	Number of days per month	Number of shifts pe month	Compliance
January 23	31	62	96%
February 23	28	56	86%
March 23	31	62	86%
April 23	30	60	92%
May 23	31	62	83%
June 23	30	60	85%

As demonstrated, SGH report non-compliance more frequently than York. In part this is due to not having a dedicated maternity triage which means the LWC regularly reviewed these attendees on labour ward. In May BSOTs was implemented in York and a modified approach on Labour Ward in Scarborough in July which will support the supervisory status of the LWC. The newly launched Maternity Incentive Scheme provided guidance for the categorisation of this metric, and the Deputy Head of Midwifery is working with the LWC's to improve adherence against this standard. The first week of July saw 100% compliance across site, this will require close monitoring and embedding to evidence an improvement. Refresher training is being organised by the Deputy Head of Midwifery for the Labour Waed Coordinators on the Birth rate plus acuity tool and it is also recognised there are new Labour Ward Coordinators in post. This will ensure assurance can be provided against the quality of data reported. However, the Trust was not able to declare compliance of supernumerary LWC in MIS Y4, further work is required to ensure this key role remains supernumerary.

8. **One to One in Established Labour**

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month.

Site 1: York

York	January 23	February 23	March 23	April 23	May 23	June 23
One to one Care in labour	100%	100%	100%	100%	100%	100%

Site 2: Scarborough

SGH	January 23	February 23	March 23	April 23	May 23	June 23
One to one Care in labour	100%	100%	99%	100%	100%	100%

Both sites achieved 100% compliance across Jan-June 2023 except in Scarborough where 1 woman in March chose to free-birth opting to have no midwifery presence.

9. **Red Flag Incidents**

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events on each site:

Site 1: York

	Red Flag Incidents York	Jan 23	Feb 23	March 23	April 23	May 23	June 23
1	Delayed or cancelled time critical activity				6	9	2
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)						
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)						
4	Delay in providing pain relief Delay of more than 30 minutes						
5	Delay between presentation and triage Delay of 30 minutes or more						
6	Full clinical examination not carried out when presenting in labour						
7	Delay between admission for induction and beginning of process Delay of 2 hours or more				1		

8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)						
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour						
10	Coordinator not able to maintain supernumerary/supervisory status				3		
Subtotal:		0	0	0	10	9	2
Total red flags for January – June 2023		**21**					

Site 2: Scarborough

	Red Flag Incidents Scarborough	Jan 23	Feb 23	March 23	April 23	May 23	June 23
1	Delayed or cancelled time critical activity						
2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)		1				
3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)						
4	Delay in providing pain relief Delay of more than 30 minutes						
5	Delay between presentation and triage Delay of 30 minutes or more			1		1	
6	Full clinical examination not carried out when presenting in labour						
7	Delay between admission for induction and beginning of process Delay of 2 hours or more	1	3	1	2	1	
8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)						
9	Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established						

	abour						
10	Coordinator not able to maintain supernumerary/supervisory status	3	3	3	5	11	9
Subtotal:		4	12	10	7	12	9
Total red flags for January – June 2023		**54**					

During Q1 2023 the red flag data reflected delays in both induction of labour admissions and transfer to labour ward. Data entry for time critical delays included delays in patient flow which was not necessarily time critical and therefore should not have been included. Ongoing work is taking place to support accurate data entry. Local red flag data is collected and reviewed on a monthly basis.

10.0 Obstetric staffing

The rotas and skill mix on both sites for obstetric staffing on the labour ward are in line with RCOG guidelines for entrustability and include the use of locum staff where necessary to ensure rotas do not have gaps.

The summary of obstetric staffing across both sites is summarised below:

York				**Scarborough**		
	No. of Drs	**WTE**			**No. of Drs**	**WTE**
Tier 1 (ST1-3)	11*	10.5		**Tier 1 (ST1-3)**	7^	7
Tier 2 (ST4-ST8)	6**	4.6		**Tier 2 (ST4-ST8)**	6^^	5.8
Tier 3 (Consultant)	18***	17.5		**Tier 3 (Consultant)**	9***	9
* includes 3 locum drs				^ includes 3 locum drs		
** includes 1 Speciality dr				^^ includes 2 Specialty drs and 2 locum drs		
*** includes 2 Consultants working cross-site						

The non-resident Consultants will come on to site if there are gaps which cannot be mitigated with locum staff and time compensated for them if they do the following day for rest. The on-boarding of locum medical staff is overseen by the Trust medical staffing team and is supported by a defined SOP which ensures all qualifications and competency is reviewed. From January to June 2023 there were only two locums used by the obstetric service and these are both long-term locums and both these individuals are fully integrated

into the obstetric team with the same training, compliance and oversight as with employed medical colleagues. All long term locums employed on the middle grade rota are assigned Consultant Clinical and Educational Supervisors and are initially after a period of supernumerary induction role, supervised directly on site by Resident Consultants in the day on both sites and out of hours on York site, before progression to indirect supervision where deemed appropriate after assessments by the Educational Supervisor and the Consultant team.

There has been successful recruitment to one of the vacant obstetric Consultant established posts at the York Hospital site and rota. The Scarborough rota has one unfilled Consultant vacancy and one long-term absence in the rota. Both vacancies are covered with the long-term locums.

There is daily monitoring of Consultant compliance with Consultant attendance at ward round in person. The attendance rates for the period January to June 2023 have been reviewed and audited. This is monitored through the Consultant meeting with escalation where needed from the Clinical Director and with oversight from the Maternity Senior Leadership Team weekly to support any action plans as required to prevent further non-attendance. This oversight has been shared through both the QPAS monthly report and the Quality and Regulatory Assurance Framework workforce report with the Board champions. From October 2023 the medical workforce reporting will be incorporated as part of a new maternity neonatal measurement programme development to ensure that there is robust ward to Board reporting.

The Trust follows the RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. The daily handovers have the operational administration team in attendance to support any changes to the rota required to support provision of compensatory rest at short notice.

The Maternity Staffing SOP incorporating the requirements for agency and locum staff and to capture the processes for mitigating rota gaps and covering absence and compensatory rest. is in development and will be ready for review by the clinical governance committee in October 2023 to support the compliance for Safety Action 4 of the MIS.

The rota is audited bi-annually by the O&G operational team. The rotas for January to June 2023 have been reviewed and audited and there are no recorded incidents of uncompensated rest periods for non-resident staff after a night on call.

There is a full review of the obstetric workforce scheduled for July 2023 supported by the Maternity Safety Support Programme (MSSP) which will inform any further rota management, recruitment and succession planning as well as finalising job planning for the Consultant team by September 2023. This review will incorporate insight from the current audit (diary log of activity) for non-resident on-call which will be used to check if impact on activity the following day will be expected.

11.0 Anaesthetic staffing

The trust can confirm that there is a duty anaesthetist immediately available for the obstetric unit 24 hours a day and the unit has clear lines of communication to the supervising

anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they are able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients in line with ACSA standard 1.7.2.1. The anaesthetic rotas for the period January to July 2023 have been reviewed and audited and this demonstrates 100% compliance.

12.0 Neonatal medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

An action plan is for MIS Y5 is currently being developed to meet requirements and mitigate against BAPM non-compliance. The ODN were sighted on previous years action plans and will be sighted on Y5's action plan following Trust Board approval.

The BAPM guidance for junior medical staffing of neonatal units recommends that, as York is a Local Neonatal Unit, it requires immediately available at least one resident tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7 and also an immediately available resident tier 2 practitioner dedicated solely to the neonatal service during the periods which are usually the busiest in a co-located Pediatric Unit e.g. between 09.00 - 22.00, seven days a week.

The number of junior doctors on both the tier 1 and tier 2 child health rotas are insufficient to meet this requirement and to allow a separate tier 1 rota for the neonatal service out of hours. Currently there is a separate tier 1 doctor for the neonatal unit and postnatal ward during 9-5 hours every day. Two tier 1 doctors are on shift in the evening from 5-9pm (weekdays only) then only one overnight who covers both paediatrics and neonates. The neonatal unit tier 1 doctor is usually the first doctor to get reallocated if there is a rota gap during the daytime. At weekends, the tier 1 doctor covers both paediatrics and neonates.

A twilight registrar (tier 2) shift was introduced in September 2021 which means two tier 2 doctors are available from 9am to 10pm (one of whom is responsible for the neonatal service) but this can be covered on weekdays only with the current number of tier 2 doctors on the rota. Locum twilight shifts at the weekend are not always covered.

The neonatal network are aware of the medical workforce gaps and are trying to identify a regional solution to this problem. This has also been placed as a risk on the trust risk register. Appendix 1 outlines the current action plan for the York site for Year 5 to support meeting the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

13.0 **Neonatal nursing staffing**

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN)

BAPM nurse staffing tool is completed every 6 months for Neonates cross site. This demonstrates a short fall of one supernumerary band 6 nurse on shift at all times. This is being progressed at the early stages as an options appraisal/business case. The Trust meets the 70% Qualified in Speciality (QIS) staff for York and is slightly below in Scarborough due to a recent leaver in a small team. This will be addressed with additional training for one staff member.

There is a surplus of non-registered staff in York however 2 members of staff are currently undertaking the Nursing Associate training and 2 more will commence next financial year.

Band 7 roles is established for Nurse Education (including journal club) and time is allocated for breast feeding, BLISS and UNICEF work.

<u>York staffing review summary.</u>

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 37.94, of which 26.56 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	28.96	30.64	32.26	-3.30	-1.62
Total reg nurses	19.76	21.24	28.17	-8.41	-6.93
Total QIS	15.04	15.04	19.72	-4.68	-4.68
Total non-QIS	4.72	6.20	8.45	-3.73	-2.25
Total non-reg	9.20	9.40	4.10	5.10	5.30
Reg nurses as % nursing staff	68.2%	69.3%	87.3%		
QIS as % reg nurses	76.1%	70.8%	70.0%		

<u>Scarborough staffing review summary.</u>

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 18.21, of which 12.75 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	16.26	17.61	14.03	2.23	3.58
Total reg nurses	11.99	13.36	12.14	-0.15	1.22
Total QIS	5.73	7.54	8.50	-2.77	-0.96
Total non-QIS	6.26	5.82	3.64	2.62	2.18
Total non-reg	4.27	4.25	1.94	2.33	2.31
Reg nurses as % nursing staff	73.7%	75.9%	86.6%		
QIS as % reg nurses	47.8%	56.4%	70.0%		

Scarborough SCBU is a small level one unit with a current staffing model of 2 Registered Nurses (1 QIS) and 1 non-registered nurse. The options appraisal will include looking at the need for a supernumerary nurse pragmatically.

Action	People responsible	Time Frame	Update
Develop Options Appraisal for supernumerary nurse in charge.	Interim ACN (HoN) Matron for Neonates Operational Manager	End September 2023	
Create business case for above dependant on options appraisal	Business Manager ACOO HoN	End October 2023	

14.0 Recommendations

The Board is asked to note the contents of the report and formally record to the Trust Board minutes compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce if compliance is met,or agree to the action plan if not met.

Appendix 1 Action plan to support meeting the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

Neonatal medical workforce York

Essential Action:

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level

Action no.	Issue to be addressed	Recommendation lead	Embedded/ Evidenced	GAP/ Deficiency	Financial investment required	Action No.	Action Owner	Action/update	Target Date for completion	Evidence	RAG
1	Neonatal Critical Care Review	Sunny Sandhu / Ianthe Abbey				1.1	Sunny Sandhu	Neonatal Critical Care Review completed	2021/22		Completed
						1.2	Sunny Sandhu	Awaiting outcome from the ODN response to the Neonatal Critical Care Review. 06/09/23: NCCR response being re-reviewed by ODN at present to determin if the proposed plan is still appropriate (originally expected to be down graded to L2-).			In progress
2	GIRFT review and action plan	Sal Katib				2.1	Sal Katib	GIRFT review took place on 08/02/21. Following the review a working group was established. Additional info required. Attendance, effectiveness etc. 06/09/23: Separate action plan created although meetings not currently taking place to review progress. 20/09/23: GIRFT meeting is currently paused. Chaired by Sal Katib. Most recent action plan is from April 23?			In progress
3	Review tier 2 medical gap (BAPM standard)	Sunny Sandhu / Ianthe Abbey		Deficient of 2 tier 2 doctors to be able to provide twilight medical cover on weekends	Funding required to employ two additional doctors so that weekend twilight shifts can be incorporated within the rota	3.1	Sunny Sandhu	Framework for LNU completed.			Completed
						3.2	ODN	Framework results highlighted locum twilight shifts at the weekend are not consistantly covered. ODN are looking at regional medical recruitment			In progress
						3.3	Sunny Sandhu / Laura Banks	Meeting planned with finance team to review funding available. 07/09/23: Possibly some additional funding may be available via the ODN - email response provided and awaiting outcome			In progress
						3.4	Donna Williams	20/09/23: Dicsussion with Donna Williams (Ops Manager) regarding funding. Awaiting update.	Oct-23		In progress
4	A review is required to identify how many additional tier 1 doctors are required to ensure emergency cover 24/7 to the neonatal service is provided (BAPM standard)					4.1	Donna Williams	Tier 1 doctors often pulled to cover other parts of the service if there are rota gaps. What evidence do we have? Non-compliance of 24/7 cover if pulled. 20/09/23: Supernumery Trust Grade has been employed. We may be able to adjust the current rota (March 24 onwards). Awaiting update from Donna.	Oct-23		In progress
5	Newborn examinations - BAPM recommends that midwives should be trained to deliver this aspect of care (rather than the tier 1 doctor)	Sunny Sandhu / Susie Kinsella / Cara Hayes / Bev Waterhouse				5.1	Sunny Sandhu	Meeting took place on 06/09/23 (SS/SK/CH/BW) - action plan to be developed and escalated.	06/09/2023		Completed
				Allocated midwifery time to complete NIPE checks		5.2	Cara and Susie	20/09/23: Cara Hayes developed an SOP regarding midwife annual NIPE assessments. Cara and Susie to ratificy SOP with Senior midwifery team.			In progress

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	CQC Section 31 Update
Director Sponsor:	Dawn Parkes - Interim Chief Nurse
Author:	Jo Mannion, Care Group Director Caroline Alexander, Associate Chief Operating Officer Sascha Wells-Munro, Director of Midwifery Ben Adekanmi, Clinical Director Obstetrics

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:

- To approve the September 2023 monthly submission to the CQC which provides assurance on progress and impact on outcomes for August 2023.
- To note that the Trust engaged with the CQC for a dedicated update on maternity on the 5th September 2023 with a focus on the immediate actions underway to respond to their on-going concerns in relation to incident reporting in maternity
- To note weekly quality improvement sessions, where anyone who is interested can join and work together on a Hot Topic are becoming embedded. The sessions are supported by our trust QI team, Maternity Programme Manager and Maternity Improvement Advisor. The sessions are proving to be a valuable way to get real-time anonymised feedback from staff on topics which require our attention and are using interactive tools such as mentimeter, padlet and Microsoft teams whiteboards to be efficient and effective.
- To note the following areas of continued achievement and progress made:

- CTG training compliance met across midwifery and medical staff
- MEOWS compliance met in all five areas on both sites of over 90%
- CTG availability across both sites with no incidents reported relating to unavailability of appropriate equipment
- Birmingham Symptom Specific Obstetric Triage System (BSOTS) compliance of 85.6% York and 91.5% at Scarborough
- Continued improved compliance with 'Fresh Eyes' for CTG monitoring
- Recruitment to scrub practitioner team with on-boarding plans in development and confirmation of timelines to team going live to be confirmed in September
- Completion of the York security system upgrade

To note that the work to undertake a review of the approach and impact of all current interventions to date on S31 improvement workstreams during September in order to support embedding sustainable changes in practice, policies as required and meetings as part of the maternity governance framework

- PPH
- incident investigation and reporting ('sprint approach')
- BSOTS delivery on each site
- fetal monitoring new clinical guidelines and training programme

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 improvement work is now incorporated into an established maternity improvement programme with a dedicated programme management office. The national mat neo measurement programme has launched the support offer to the Trust to develop the data, information, and intelligence to support the maternity improvement programme demonstrate the impact of improvement work on outcomes.

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. There are currently 32 midwives (22 at York and 11 at Scarborough) who have completed the additional training and a further course in September 2023 with 12 midwives booked to attend. The additional training will allow for 24/7 availability of enhanced maternity care on the labour wards at both sites from 1 October 2023.

The service has cascaded the training content and plan for delivery to the Local Maternity and Neonatal System (LMNS) to share good practice.

A.2 Fetal Monitoring and CTG

A.2.1 CTG Machines

There have been no reported incidents of CTG machine shortages on any of the wards, or reported incidents where there has been a delayed CTG undertaken because of lack of availability, in August 2023.

The ward managers also undertake a weekly equipment inventory to ensure they have enough equipment available; this will be added to the ward managers monthly assurance report for Matron oversight and assurance from September and reported in the CQC October report.

The procurement for telemetry equipment (seven units) is in progress and a revised quote for the equipment will be resubmitted to MERG committee in September to enable procurement to progress. The timelines for delivery will be confirmed as soon as possible.

York Hospital Area	No of CTG Machines (SOP Requirement)	8 September 2023
Labour Ward	10	11
Triage	3	3
G2	6	6
Antenatal Day Unit	2	3
In repair	2	2

Scarborough Hospital Area	No of CTG Machines (SOP Requirement)	8 September 2023
Labour Ward	11	9
Hawthorn Ward	4	5
Antenatal Day Unit	2	2
Floating	0	0
In repair	0	1

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.

One CTG machine is with Medical Engineering for repair at Scarborough; however, there has been sufficient machines available to meet the needs of the service as this contingency was accounted for in the procurement.

A.2.2 CTG Training

Following targeted efforts, the CTG training figures are much improved with all staff groups meeting the 85% compliance target.

Current Fetal Monitoring compliance figures, by site, at the end of August 2023 are outlined below.

Staff Group	York	Scarborough
Midwives	92%	95%
Consultants	100%	100%
Obstetric medical staff	100%	100%

CTG training compliance projections for September 2023

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

CTG training compliance projections for October 2023

	York	Scarborough
Midwives	96%	97%
Consultants	100%	100%
Obstetric medical staff	90%	100%

A training plan for 2023 and 2024 has been devised by the practice development midwife and new obstetric clinical education lead with staff rostered to attend training before they are non-compliant. The plan encompasses the entire maternity workforce (midwifery, medical and obstetrics) and has been mapped against the NHS England Core Competency Framework v2.

	Sept Projections				Oct Projections			
York %	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**
Midwives (172)	94% (161/172)	87% (149/172)	98% (168/172)	60% (103/172)	92% (159/172)	88% (151/172)	97% (167/172)	69% (119/172)
HCA/MSW (40)	98% (39/40)	N/A	N/A	N/A	95% (38/40)	N/A	N/A	N/A
Obs Cons (14)	71% (10/14)	N/A	100% (14/14)	N/A	93% (13/14)	N/A	100% (14/14)	N/A
All other Obs Drs (16/11 FM)	75% (12/16)	N/A	100% (11/11)	N/A	75% (12/16)	N/A	100% (11/11)	N/A
Scarborough %	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**
Midwives (71)	96% (68/71)	92% ((65/71)	93% (66/71)	79% (56/71)	97% (69/71)	90%(64/71)	97% (67/71)	89% (63/71)
HCA/MSW (21)	95% (20/21)	N/A	N/A	N/A	100% (21/21)	N/A	N/A	N/A
Obs Cons (7)	100% (7/7)	N/A	100% (7/7)	N/A	100% (7/7)	N/A	100% (7/7)	N/A
All other Obs Docs (8)	100% (8/8)	N/A	100% (8/8)	N/A	100% (8/8)	N/A	100% (8/8)	N/A
Combined York & Scarborough %	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**	**PROMPT**	**NLS**	**Fetal Monitoring**	**Personalised Care Year 2**
Midwives (243)	94% (229/172)	88%(214/243)	96% (234/243)	65% (159/243)	94% (228/243)	88% (215/243)	96% (234/243)	75% (182/243)
HCA/MSW (61)	97% (59/61)	N/A	N/A	N/A	97% (59/61)	N/A	N/A	N/A
Obs Cons (21)	81% (17/21)	N/A	100% (21/21)	N/A	95% (20/21)	N/A	100% 21/21)	N/A
All other Obs Docs (24/19 FM	83% (20/24)	N/A	100% (19/19)	N/A	83% (20/24)	N/A	100% (19/19	N/A

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.

In August 2023, 357 women who gave birth at York or Scarborough with 246 women (68.9%) requiring continuous CTG monitoring during their labour. A small-scale audit was undertaken to ascertain "fresh eyes" compliance.

Five records of women who birthed in August were randomly selected from both York (three) and Scarborough (two). It was found that:

Length of CTG in hours	No hourly fresh eyes expected	No actual fresh eyes completed	No <1hr 15m	No. <1hr 30m	No. <2hr 15m	Documentation for delay
2hrs40	2	2	2			
5hrs	5	6	5	1		
17hrs	16	16	15	1		
9hrs 30	9	7	3	2	2	No midwives available
6hrs 40	5	5	5			

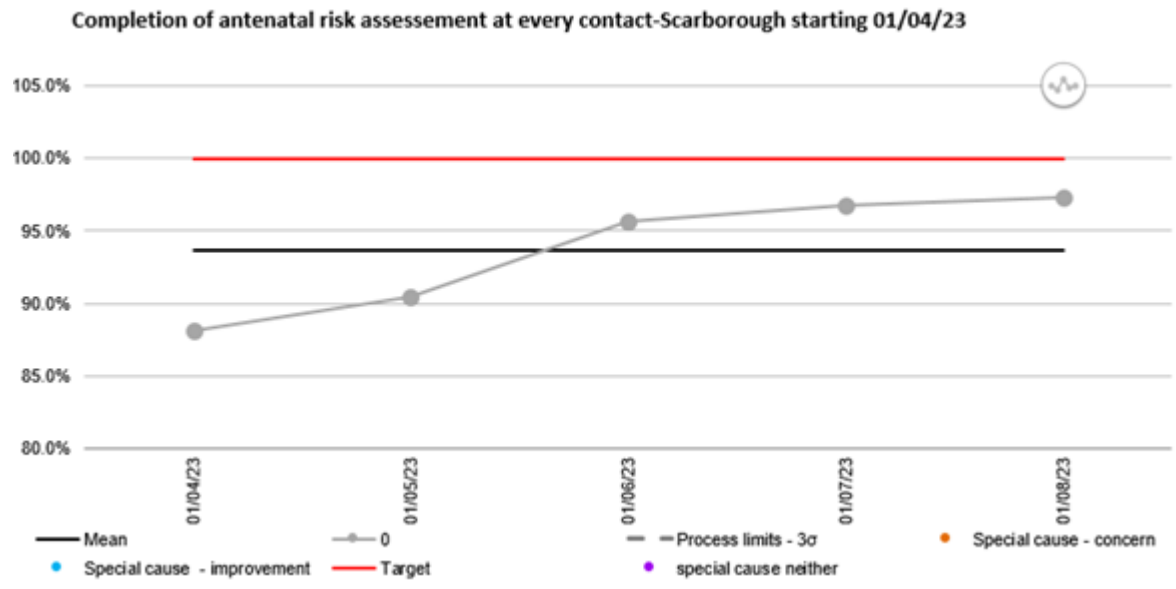
The total number of expected “fresh eyes” was 37 and a total of 36 peer reviews were completed.

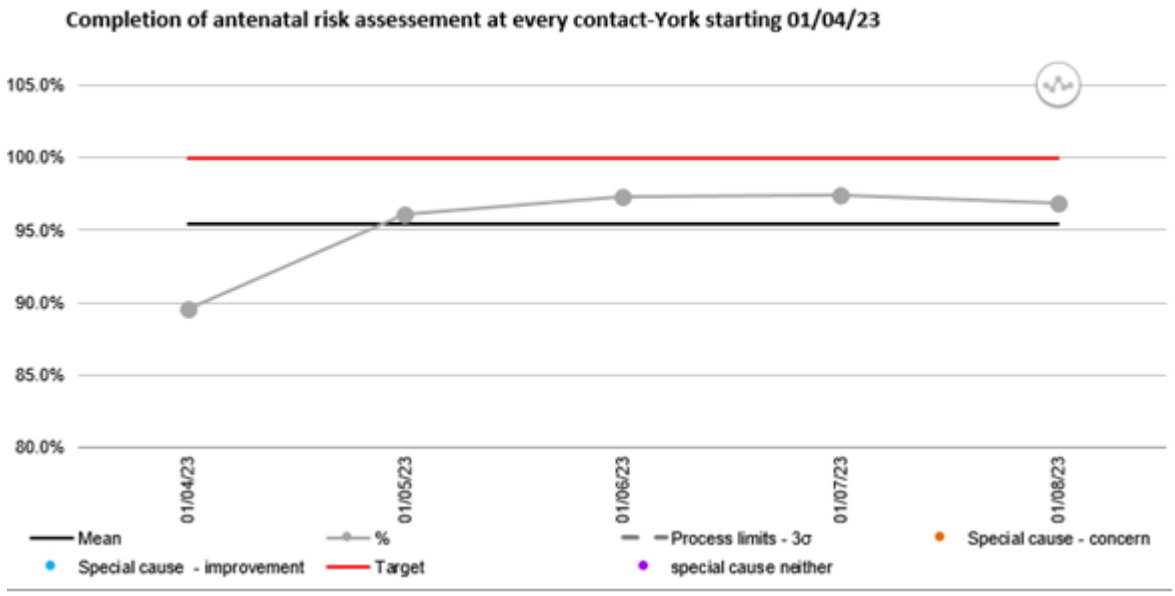
- 78 of fresh eyes were completed within 1hr 15 minutes.
- 89.2% of fresh eyes were completed within 1hr and 30 minutes.
- There was only one record where the number of fresh eyes was less than expected. In this record Nine fresh eyes were expected yet only seven were performed. The notes for this record gave a rationale for delayed fresh eyes which included “no available Midwives”. The woman was transferred to theatre immediately after a fresh eye was performed and delivery was planned. This record will be reviewed with the MSSP MIA to consider whether this could have been a contributing factor.

All though this sample is small and represents only 2% of women who required fetal monitoring in labour, it does demonstrate a good compliance rate for staff undertaking “fresh Eyes” in a timely manner. Overall, this was a 78% compliance (i.e. 28 in 1 hr 15 column, 6 over time and 2 not done). Further audits of notes will be undertaken with greater numbers of women to ensure that hourly “fresh eyes” are embedded in staff culture. This has been incorporated into the audit plan for September. Where a fresh eyes is delayed, staff will be asked to complete the from and to give a rationale for the delay. These can then be reviewed for themes and learning identified.

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 and are a mandatory field on the patient record.





Staff are becoming more familiar with using BadgerNet and receive support from the Digital Midwives. The data set is currently too small to identify any special cause improvement, however the trajectory indicates improved compliance. November 2023 has been identified as the target for 100% 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 and is awaiting review by the Maternity Services Support Programme Maternity Improvement Advisor Obstetric lead before ratification and approval at Women's Health Clinical Governance meeting on 13 September 2023.

Assurance was provided on the appropriate classification of c-sections through the audit undertaken by the Maternity Improvement Advisor in August 2023. A monthly long sprint approach, to review all outstanding PSIRs, will be undertaken in September 2023. If any themes arise which relate to the classification of C-sections, these will be reported next month.

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 partially 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.

York site

Triage Rapid Review	31/07/2023	07/08/2023*	14/08/2023**	21/08/2023
Number of women admitted to triage	130	145	147	154
Number of women eligible for a rapid review in triage	119	133	131	137
Rapid review complete <=15 minutes	80.6%	81.2%	90.8%	89.7%
Red Flags waiting over 30mins for review	7.6%	11%	9.1%	4.8%
Women waiting 30mins-1hr for initial review	5%	7%	7.5%	2.4%
Women waiting 1-2hrs for initial review	2.5%	3%	2.5%	1.6%
Women waiting 2+hrs for initial review	0.8%	0%	0%	0.8%
Number of women attending for scan review	5	1	1	2

* and **There was an increase in red flags these weeks (especially 1st and 2nd August) which was attributed to increase acuity and staffing issues due to sickness and the merging of ANDU/MTU on the 15th and 17th August in order to undertake urgent works to the new call bell system. The red flags were monitored, action taken and reduced to 4.8% on 21 August 2023.

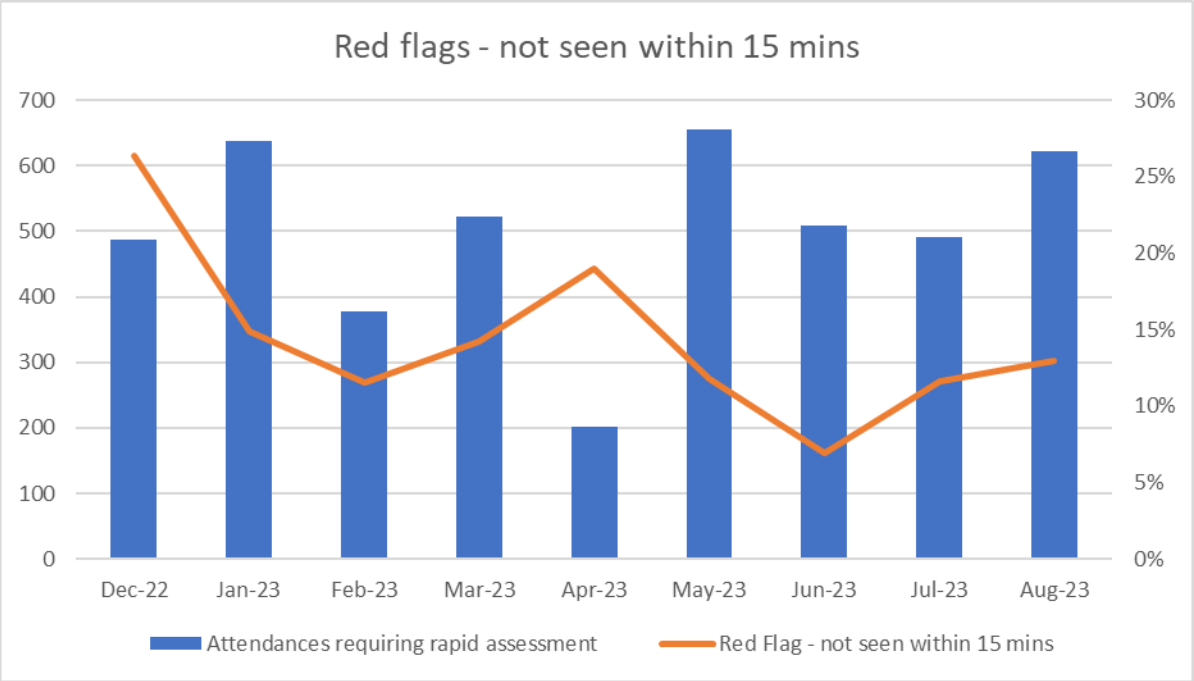
Triage Rapid Review	31/07/2023	07/08/2023	14/08/2023	21/08/2023
Number of women admitted to triage	59	43	31	45
Number of women eligible for a rapid review in triage	56	42	31	44
Rapid review complete <=15 minutes	94.64%	90%	90.30%	90.90%
Red Flags waiting over 30mins for review	0%	9%	6.40%	4.4%
Women waiting 30mins-1hr for initial review	0%	2%	6.40%	6.66%
Women waiting 1-2hrs for initial review	0%	5%	0%	0%
Women waiting 2+hrs for initial review	0%	2%	0%	0%
Number of women attending for scan review	1.69%	0%	0%	0%

Scarborough site

The triage ward manager is reviewing how the triage data is presented and will be working with the information team to provide further details on how long women wait to be seen in triage after the initial review at 15 minutes. An internal audit review has been commissioned to gain assurance on the triage process. This will commence in September 2023.

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.

York site



Due to the estate and staffing at the Scarborough sites, triage is currently situated in the labour ward. Recruitment is ongoing to ensure this is independently staffed and there are plans to relocate triage to the ward area next to Hawthorn Ward. Recruitment is anticipated to support the relocation by January 2024 at the earliest. Capital investment request for the adaptation to create this space has been submitted to the Capital Planning and Equipment Group on the 12th September. There will be ongoing monthly reports to identify any new risks requiring escalation.

A trend chart for red flags for the Scarborough site will be included in October once there is three complete months of data available,

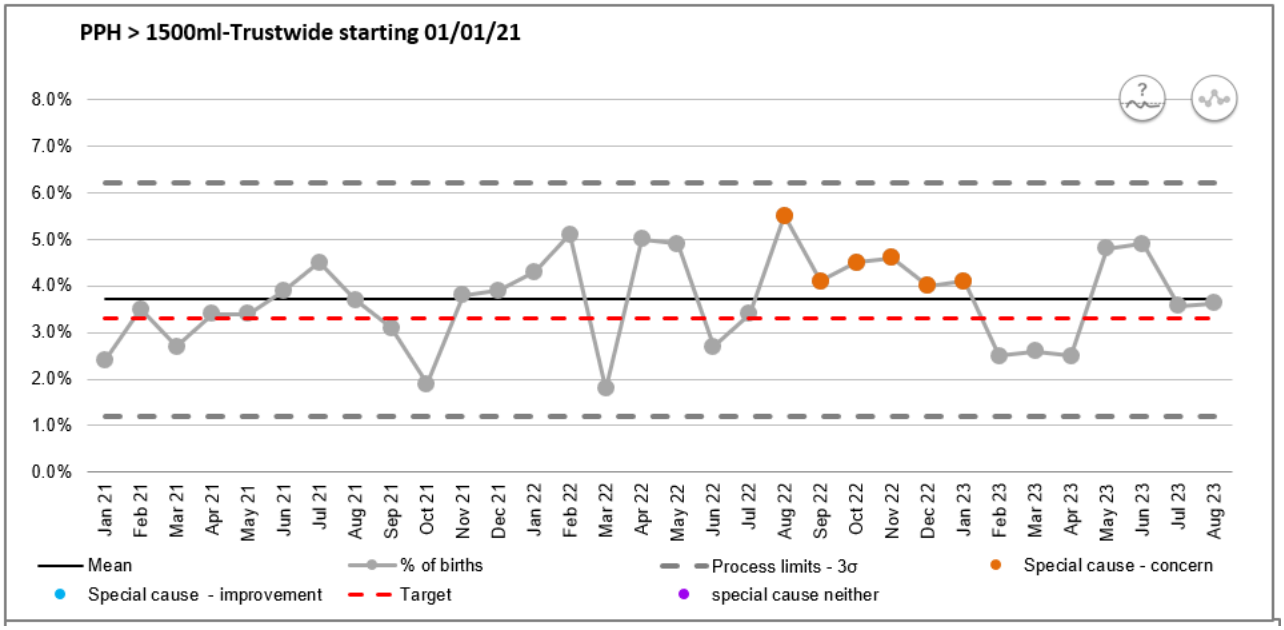
B. Governance and Oversight of Maternity Services

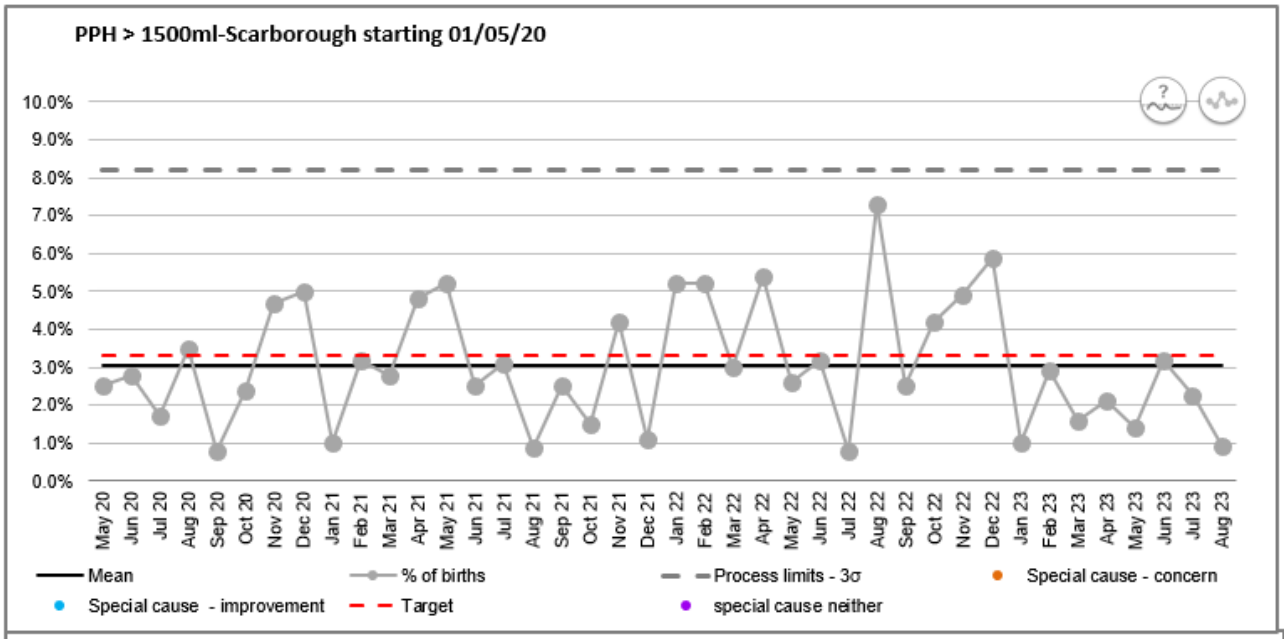
B.1 Post-Partum Haemorrhage

PPH over 1.5 litres

The Trustwide PPH rate remains relatively static overall at for August 2023; however, York rates have increased while Scarborough rates have reduced. The PPH Scrutiny Panel was paused due to clinical capacity pressures during July and August; however they will continue to meet to scrutinise and oversee PPH with an ambition to see three consecutive months of improvement as evidence of sustained change in practice. The mat neo measurement programme has now mobilised and PPH has been identified as a first priority area to consider data and approach alongside the QI methodology. The PPH scrutiny panel will meet in the week commencing 18th September and 25th September to consider the rates on each site and each case with a 'fresh eyes' review on the approach of the panel to date and moving forward.

Blood Loss	Number in August 2023
1.5l – 1.9l	6 (range 1.5l – 1.950l)
2l – 2.4l	3 (range 2l – 2.199l)
> 2.5l	4 (range 2.5l – 2.8l)


PPH > 1500ml-Trustwide starting 01/01/21
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Mean
% of births
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither


PPH > 1500ml-Scarborough starting 01/05/20
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
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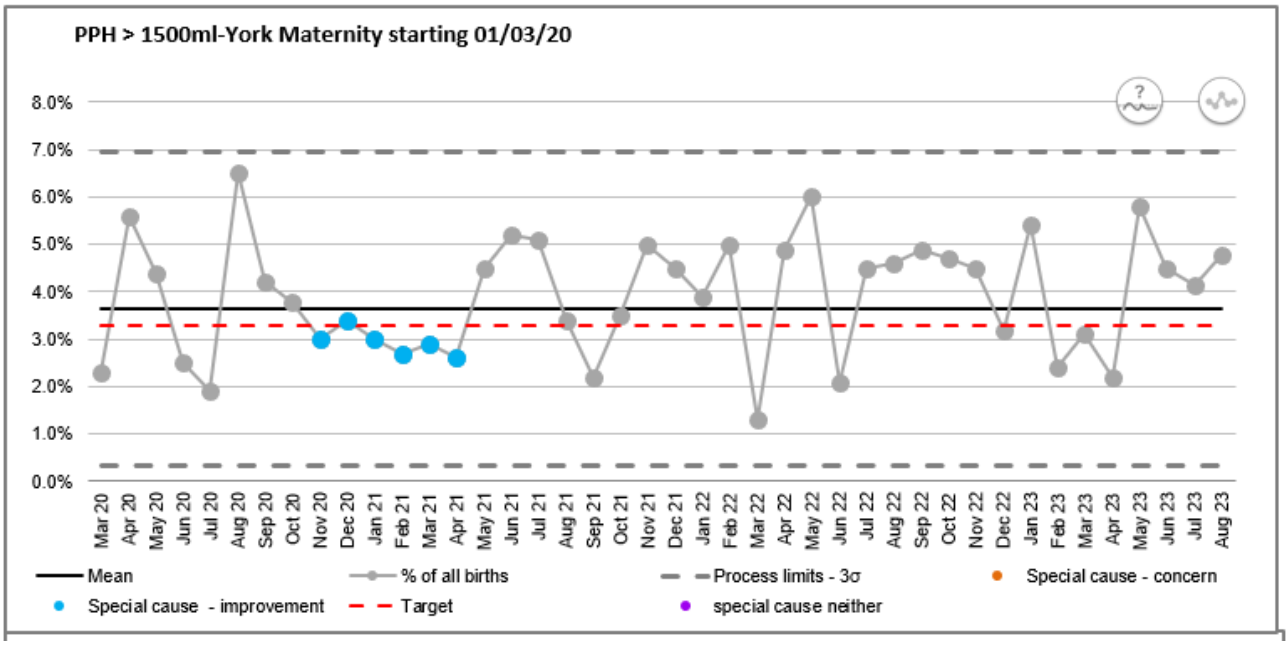
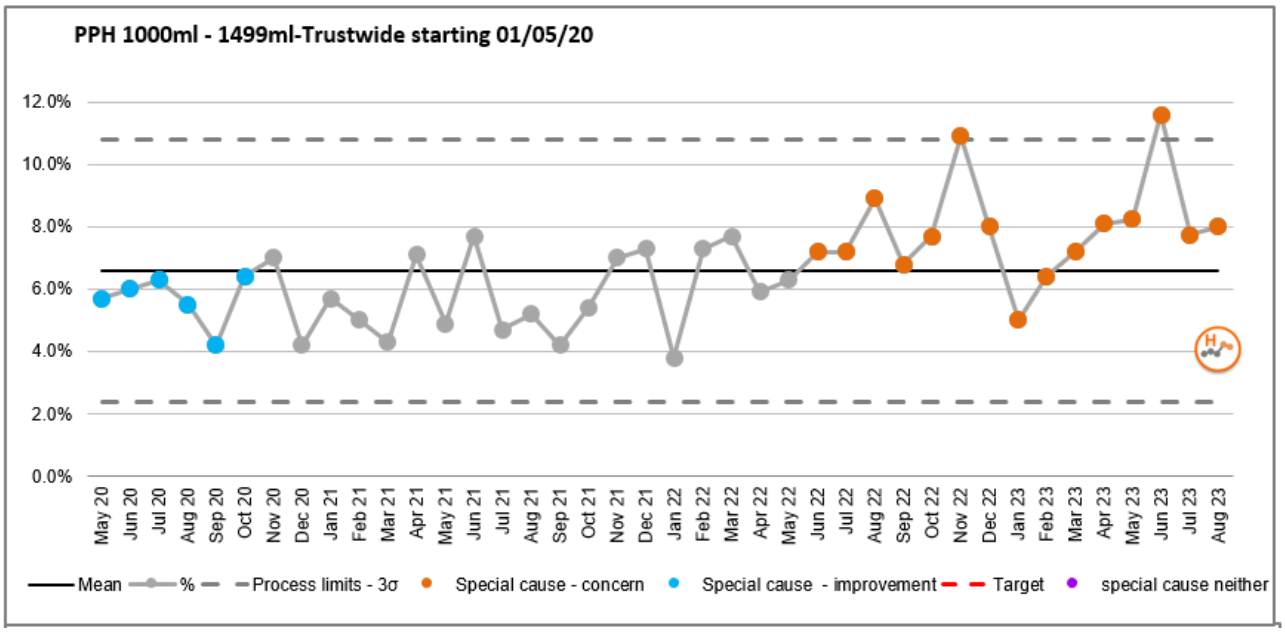
Mean
% of births
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
special cause neither



PPH between 1000ml – 1499ml



PPH loss between 1L - 1.499L remained static at 8% in the month of August. This is compared against a reduction in the overall rate of blood loss over 1.5L. Whilst improvement work will continue with an aim to reduce the rate of PPH, it is recognised that any reduction in the rate of loss >1.5L may lead to an increase in the category 1L-1.499L. This category will then become our next focus for improvement.

B.2 Incident Reporting

The following moderate harm incidents were reported in August 2023:

Datix Number	Incident Category	Outcome/Learning/Actions	Outcome
59	Sudden deterioration.	Case reviewed for immediate learning - Appropriate escalation and transfer in a timely manner.	To be reviewed at the SPRINT
1302	Delayed category 2 caesarean section (over 75 mins). Delay was approximately 6 hours.	PSIR awaited Potential to add to high risk audit (see section A 3.1)	To be reviewed at the SPRINT
1368	Failure/ delay in diagnosis (all speciality)	PSIR complete and being reviewed	To be presented at Maternity Incident Panel
1410	31+6 delivery - Twin 2 APGAR 6 at 5 minutes	Discussed at Maternity Case Review meeting – no safety concerns raised. PSIR review awaited.	To be reviewed at the SPRINT
1231	PPH 1.8L following CS	PSIR awaited	To be reviewed at the SPRINT
1259	PPH 2.4L following EMCS	PSIR completed and case discussed at the Maternity Incident Panel on 05.09.23.	Remains moderate harm following presentation at incident panel – local level learning
1264	PPH 1.8l	PSIR awaited	To be reviewed at the SPRINT
1265	Twin birth, PPH of 1600ml following caesarean section. APGAR<7	PSIR awaited	To be reviewed at the SPRINT
859	Secondary Post partum haemorrhage 1700ml.	PSIR awaited	To be reviewed at the SPRINT
917	Post partum haemorrhage 2058mls	PSIR completed with local actions suggested for improvement	To be presented at the Maternity Incident Panel

1270	PPH of 1700ml (15.51%) following cat 4 caesarean section	PSIR awaited	To be reviewed at the SPRINT
1402	Baby delivered <32 weeks at SGH	PSIR awaited	To be reviewed at the SPRINT
870	Readmission of mother to any part of the hospital within 6 weeks of delivery	PSIR awaited	To be reviewed at the SPRINT
1255	Antenatal stillbirth at 31+3	PSIR presented at Maternity Incident Panel	Declared SI
1297	Third degree tear (3a), Post partum haemorrhage 1020ml (20% blood loss)	PSIR awaited	To be reviewed at the SPRINT
897	Unanticipated admission to SCBU	Error in reporting – baby not admitted to SCBU	Case rejected
738	Unanticipated admission to SCBU	PSIR awaited	To be reviewed at the SPRINT
65	Delayed recognition of and action on abnormal vital signs e.g. sepsis, urine output	Initial midwifery review completed – requires obstetric input. PSIR awaited	To be reviewed at the SPRINT
1254	Incorrect medication administered leading to additional treatment	PSIR awaited	To be reviewed at the SPRINT

There were 19 moderate harm incidents reported in August 2023. The common themes from these incidents are PPH >1500ml, Born Before Arrival and Caesarean sections performed at full dilatation.

The number of moderate harm cases remains raised demonstrating the responsive approach to more appropriate categorisation of harm. This is then reflected in the quality of investigation and learning that is being gained from incidents within the care group.

A daily senior midwifery review of the incidents reported in the previous 24 hours continues to take place. This ensures there is sufficient oversight and awareness of clinical activity and incidents are acknowledged and any immediate safety concerns are actioned. The planned two week 'sprint' approach to fully review the moderate harm incidents will be held between the 11th September and 13th October 2023. This collaborative MDT approach will address the backlog of incidents requiring review and focus on identifying themes for quality improvement projects which will feed into the Maternity Transformation Programme.

The Department has continued 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. All patient safety incident reviews (72hr reports) that are not part of the SPRINT approach continue to be reviewed and presented at the weekly Maternity Incident Panel, chaired by the Medical Director for oversight. The Clinical Governance meeting on 13.9.23 will consider the progress with all completed and outstanding PSIRs and consider the future

processes for allocating PSIRs still requiring completing to available MDT members who have non-clinical capacity.

B.3 Modified Early Obstetric Warning Score (MEOWS) Compliance:

All five clinical areas achieved over 90% compliance with MEOWs completion in August 2023. Since the introduction of production boards in the ward areas there has been improved oversight and engagement with the staff, and the change in behaviours and practice has led to the improved compliance position. Ward managers will continue to review compliance and Matrons will start to take a deep dive into the sepsis triggered patients to make sure adequate escalation and treatment is taking place.

Area	August 2023 (90% target)*
Labour ward York	100%
G2 York	100%
Triage York	96%
Labour ward SGH	93%
Hawthorne SGH	98%

* this data was collected on 1 September 2023 and does not include all of the August data as this was not all collated and validated.

B.4 Management of Risks

B.4.1.1 Project Updates York

The security update is complete in York with ongoing training on the use of the system.

B.4.1.2 Project Updates Scarborough

Upgrades to the security system have been planned to align with York. The new Director of Midwifery and the Neonatal and Maternity teams have reviewed the programme to ensure all security concerns identified by both CQC and subsequent MSSP diagnostic programme are addressed.

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. There is also a single oversight and assurance meeting with the facilities management senior leadership team established in September 2023 with the Care Group Associate Chief Nurse to ensure coordination and delivery assurance across all Care Group works and facilities contracts including all maternity priorities.

Installation of X-tag systems is due to start on 11 September 2023 with an expected go-live date of 31October 2023.

B.4.2 Scrub and Recovery Roles

The training and recruitment programme for scrub and recovery practitioners continues with a rolling advert to recruit to these roles. The scrub team leader has met with the MSSP MIA’s and will refresh the approach for rapidly developing the team with the new Director of Midwifery in September 2023.

An initial four new scrub practitioners have been recruited with the expectation that the on-boarding and preceptorship will take between three and five months to complete There is a scrub shift dedicated on both sites on every shift in addition to the core midwifery teams.

It is estimated that it will take four to five months for the new staff members to be fully inducted.

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board
Date of Meeting:	27 September 2023
Subject:	Annual Medical Appraisal and Revalidation Update
Director Sponsor:	Karen Stone, Medical Director and Reponsible Officer for York and Scarborough Teaching Hospitals NHS foundation Trust, St Leonard's Hospice and St Catherine's Hospice Scarborough
Author:	Paul Whittle, Appraisal and Revalidation Specialist, Medical Directorate Rob Newton, Associate Director, Medical Directorate

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:

As a Designated Body, the Trust has responsibilities regarding appraisal, revalidation and professional standards of doctors in its employment. An increased focus on improving processes and systems in these areas is being placed by the Responsible Officer. For the 22/23 year the trust achieved 87% compliance for medical appraisal.

Recommendation:

Trust Board is asked to:

- Note the information provided on medical appraisal and revalidation
- Note the ambitions and plans for improvement in in these areas
- Confirm commitment to supporting the progress of this work

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**

Appraisal and Revalidation Update

1. Introduction and Background

Every licensed doctor who practises medicine must revalidate every five years and should have an annual appraisal. The General Medical Council's (GMC) aims for medical revalidation are that it:

- enables licensed doctors to demonstrate that they are up to date and fit to practice
- supports doctors in their professional development, contributes to improving patient safety and quality of care and sustains and improves public confidence in the medical profession
- facilitates the identification of the small proportion of doctors who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors

To achieve these aims, the GMC requires that all doctors identify the Designated Body (usually their employer) that monitors and assures their practice. York and Scarborough Teaching Hospitals NHS Foundation Trust is the Designated Body for over 600 doctors.

Designated Bodies have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations. It is expected that Boards oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors and
- ensuring that appropriate pre-employment background checks are carried out to the required standard.

This report provides information about how these duties have been discharged and improvement actions for the next twelve months.

2. Medical Appraisal

2.1. Appraisal Process

Doctors are assigned an appraiser by the Appraisal and Revalidation Specialist. Appraisals can be completed in person or online. Online appraisal meetings are increasing in frequency and these support cross-site working and efficiency for medical appraisal. The record of appraisal and supporting documentation is held on an online system called PReP.

System-generated emails and formal reminder letters are sent at varying intervals to encourage completion of appraisal. Care Group management teams are provided with monthly appraisal completion data and this forms part of Care Group accountability reporting.

2.2. Appraisers

There are currently 72 active medical appraisers within the Trust. This is not sufficient, and it is estimated that 95 appraisers are needed in the Trust with time assigned in their job plans to facilitate timely appraisal for our doctors. The Trust has lost a considerable number of appraisers since the pandemic, due largely to retirements, and additional recruitment and utilisation of appraisers is required.

Appeals for new appraisers are being communicated to doctors across the Trust. Three training sessions for new appraisers are held each year and a programme of workshops

are being established for existing appraisers. A new Medical Appraisal Lead (Dr Oliver Prince, Specialty Doctor, Anaesthetics) was appointed in August 2023 to facilitate this recruitment and training.

2.3. Appraisal Completion Rates

	Number of appraisals	% of appraisals
Total number of doctors with a prescribed connection on PReP as at 31 March 2023	**514**	
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**446**	**87%**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**68**	**13%**
Total number of agreed exceptions	**22**	**4%**

At the start of the 22/23 cycle the trust had a considerable number of appraisals which were a year or more late. This was in part due to the disruption to appraisal caused by Covid-19, when appraisal and revalidation were temporarily paused. An increased focus and improvements in processes have been introduced in 22/23, including sending out formal letters and increased liaison with Care Groups and Directorates. These actions have improved the appraisal compliance rate from 75% in April 2022 to 87% in April 2023.

The target set by NHS England is 90% and the aim for the Trust is to far surpass this in 2023/24 through a number of actions listed below.

2.4. Action Plan

The Medical Directorate Team are currently undertaking a baseline assessment of appraisal within the Trust. This assessment will include reviewing data, peer review from neighbouring Trusts, review from GMC and feedback from appraisers and appraisees. A provisional action plan is being established to coincide with the appointment of the new Medical Appraisal Lead, the current version of which is copied below.

Objective	**Action**
1. Training of new appraisers	• Establish 12 month programme of appraisal training • Design and refine appraisal training material and sessions
2. Improve internal processes	• Improve the identification of and communication with new starters • Improve the data quality and consistency between doctors' records on internal Prep system and GMC. • Review the process following new appraiser training and inclusion of Appraiser responsibilities within job plans
3. Increase the recruitment, retention and utilisation of appraisers	• Increase communication regarding appraiser recruitment and training • Review appraiser contributions in job planning withing specialties and care groups
4. Support the ongoing development of appraisers	• Provide opportunity for feedback, coaching and review for appraisers

	• Facilitate programme of workshops for existing appraisers
5. Support the improvement in quality of appraisals	• Re-establish system of audits on input and output forms

3. Medical Revalidation

3.1. Revalidation Recommendations

Revalidation recommendations are reviewed weekly by the Deputy Medical Director (Professional Standards) and the Appraisal and Revalidation Specialist. Doctor's portfolios are reviewed as to whether they have sufficient evidence to be recommended for revalidation. Where they have sufficient evidence, a positive recommendation is made to the GMC.

If the doctor doesn't have sufficient evidence at the time of recommendation, then their recommendation may be deferred. On rare occasions, doctors do not engage with the appraisal process despite multiple interventions from the Medical Directorate Team. In these cases, a non-engagement notification is made to the GMC, which is a serious intervention and significant efforts are made to avoid.

The deferment rate at the Trust is 19%, compared to a national average of 17%. The team will improve the deferral rate in 23/24. This will be enabled in part by the improvements within timely medical appraisal, refinements in processes regarding revalidation and continued liaison with the GMC. The format and methods of collecting patient feedback will also be reviewed with opportunity for volunteers and online feedback, as per changes in GMC guidance regarding patient feedback.

4. Recruitment and Engagement Background Checks

All doctors employed by the Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors.

5. Maintaining High Professional Standards

A weekly meeting is in place, chaired by the Medical Director, which reviews doctors who require action by the GMC or the Trust internally for matters concerning conduct, capability and health. Action is taken in accordance with the Trust's disciplinary policies.

6. Policy

The GMC publishes 'Good Medical Practice', which sets out the standards of patient care and professional behaviour expected of all doctors in the UK, across all specialties, career stages and sectors. These standards have been updated and updated guidance comes into effect on 30 January 2024. These standards will also apply to physician associates and anaesthesia associates in the future, once they're regulated by the GMC.

7. Recommendations

Trust Board is asked to:

- Note the information provided on medical appraisal and revalidation
- Note the ambitions and plans for improvement in in these areas
- Confirm commitment to supporting the progress of this work

Dr Karen Stone
Medical Director
Responsible Officer

Date: 27 September 2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Report to:	Trust Board
Date of Meeting:	27 September 2023
Subject:	Safeguarding & Mental Capacity Act Team Annual Report 2022/2023
Director Sponsor:	Dawn Parkes
Author:	Nicola Cowley

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 the Trust Board with a summary of the Safeguarding & MCA Team Annual report 2022/2023 presented at the Executive Safeguarding Group on 27th April 2023 with key escalations noted.

The Board is asked to receive the following escalations:

- Challenges are escalated to Care Groups (CG) by the Safeguarding & MCA team in relation to variable and at times limited medical engagement in MCA.
- Training compliance has been affected by technical difficulties within the Learning hub during quarter 4.
- Workforce structure within the team does not meet the requirements of the Safeguarding Accountability and Assurance Framework (herein referred to as SAAF) published July 2022.
- Systems (ED Scarborough & Badgernet) do not link with national alert systems to safeguard children.

Recommendation:

This reports represents the picture at May 2023 and for assurance there has been progression in the items escalated within. The Board receive the report and escalations.

Report History

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

Integrated Safeguarding Group	**27/04/2023**	**1) Complete Risk Matrix to include on Safeguarding & MCA Team Risk Register/ Care Groups to complete risk matrix to include on own Care Group Risk register.**

Safeguarding and Mental Capacity Act Team

1. Introduction and Background

The annual report cites the activity of the Safeguarding and Mental Capacity Act (hereinafter referred to as MCA)Team (adult and child) and highlights trends which inform service development. For example, in reviewing the attendances in our emergency departments we can identify common patient need and escalate through multi-agency working. This will not only improve safeguarding services within the Trust but by sharing with partner agencies increase safeguarding measure in other providers.

a. Safeguarding Team – portfolio

Safeguarding Children	Safeguarding Adults
Multi- agency Safeguarding Children processes	Multi-agency Safeguarding Adults processes
Staff Supervision	Mental Capacity Act Compliance/Deprivation of Liberty Safeguards
LADO support and compliance	PREVENT Duty
Maternity/Midwifery support	Learning Disability Liaison
ED Safeguarding Liaison	Autism Liaison Service development
Paediatric Liaison	PIPOT (Person in a position of Trust) support and compliance
CDOP representation	LEDER representation
Domestic Abuse	
MAPPA/MATAC/MACE – responding to external intelligence regarding risk	
Female Genital Mutilation	

This list is not exhaustive.

The safeguarding portfolio has a number of activities where quantity is not reflective of safeguarding performance. This is because for certain elements quantity is beyond our control as referrals are raised by external organisations and the requirement to make referrals is based on individual need.

These include:
Safeguarding Adult instruction to investigate
Safeguarding children referrals.

The team however do collect data relating to the above to identify whether there are gaps from areas where we would expect safeguarding contact. Additionally, where we observe trends both internally and externally, this is explored and where necessary shared with the partnership – as there is a possibility there could be a wider public interest, e.g.: concerns from the same care provider, or agency.

Measurable aspects of Safeguarding & MCA Team activity include:
Audit outcomes
Training compliance
Supervision compliance

For these areas, comparative data will be reported where exceptions arise in annual and quarterly reporting.

Partnership engagement (including external safeguarding reviews) and Statutory responsibility are also considered measurable.

In assurance throughout the year the Trust has achieved significant compliance with all relevant Partnership board and subgroup meetings across each of the three relevant Local Safeguarding Partnerships.

2. Current Position/Issues

2.1 Mental Capacity Compliance

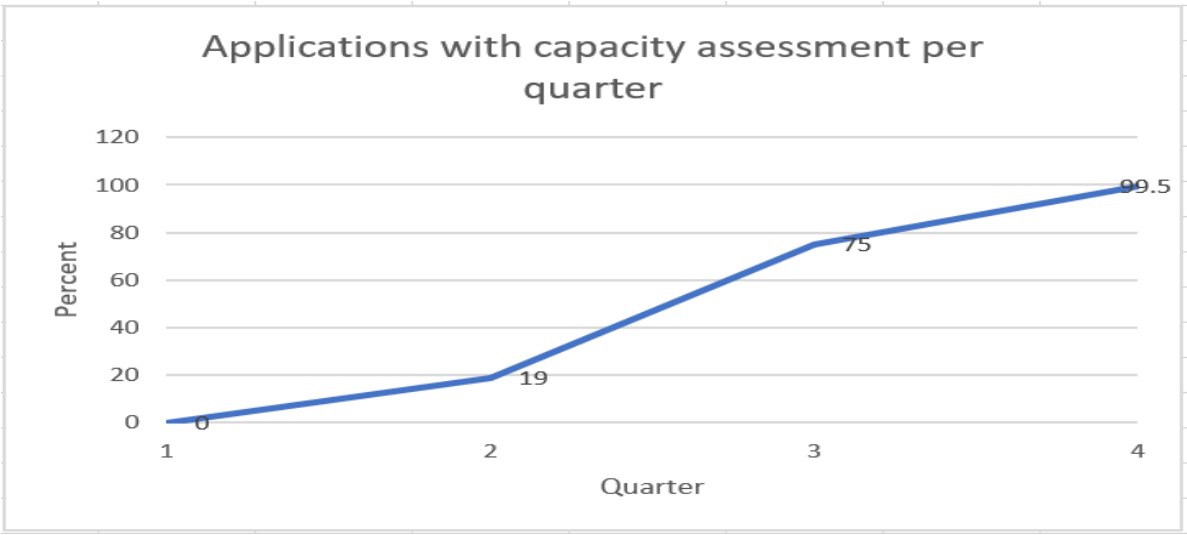
Underpinning our journey to assurance is the following approach.

Where we were	Where we are	Where we need to be
Findings of CQC Inspection	MCA Improvement Work Plan	Trust Strategy Priorities

There has been both an increase and improvement in compliance with the Act in terms of Deprivation of Liberty Applications. The qualitative audit, however, indicates there is still work to do to raise staff's understanding of their responsibilities within the Act when proposing treatment.

2.1.1 Deprivation of Liberty Applications (Hereinafter referred to as DOLS)

Applications have increased along with compliance with the act in that we have seen a significant rise in applications received with capacity assessments since April 2022. The chart below demonstrates improvement from zero in the first quarter moving to 99.5% in quarter 4.



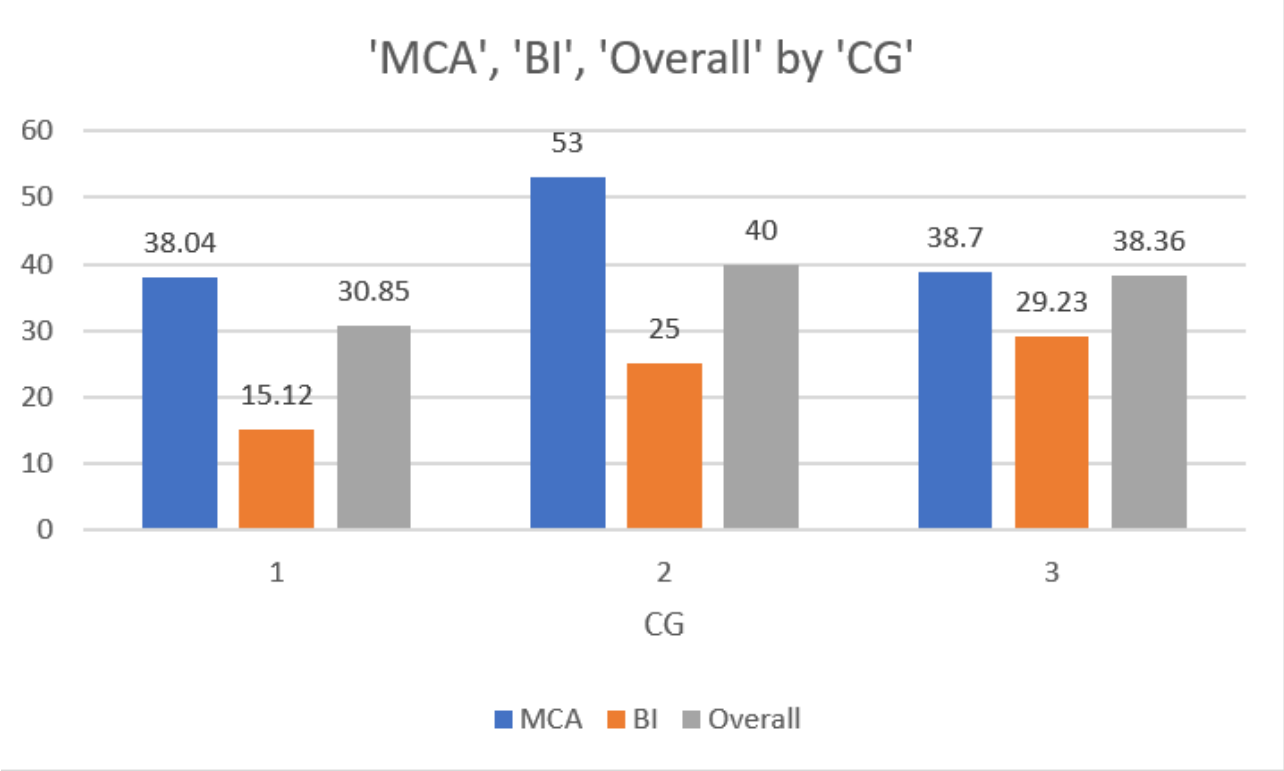
Next steps to DOLs process improvement, is to quality control applications on arrival with the MCA Team which will both provide a good quality application adhering to the Act but also act as education those regularly responsible for making applications.

2.1.2 Qualitative Audit

A qualitative audit model commenced in January 2023, having seen that the "quick audits" did not evidence adherence with the Act. As this is the first audit, this will act as a baseline audit and quarterly reporting will provide ongoing monitoring. So far, we have only been able to audit CG1, 2 and 3 but are working with CG4, 5 & 6 to develop a bespoke auditing process.

Despite the efforts made to support staff recognise the importance of considering capacity when supporting patients make decisions, there remains concerns over the misunderstanding by some staff regarding their role. At times there is resistance and challenge to advice/guidance provided by the team. This is escalated when encountered.

This audit data forms the base line of the audit and future audits will demonstrate where there is improvement. The objective is to increase quality to 85% by Q3 or that there are robust actions owned by Care Groups to address gaps. This data will be presented within the monthly reporting process to Care Group quality/governance forums assurance will be sought.



The chart below demonstrates the rate of compliance per care group in specific principles of the Mental Capacity Act, for example in care group 1 from the audit 38% of the capacity assessments audited met the requirements of the act. It has been identified that targeted work is essential for improving quality of evidence, in particular the principle of Best Interests. Targeting identified gaps is part of day to day work plan of the MCA Lead Practitioners.

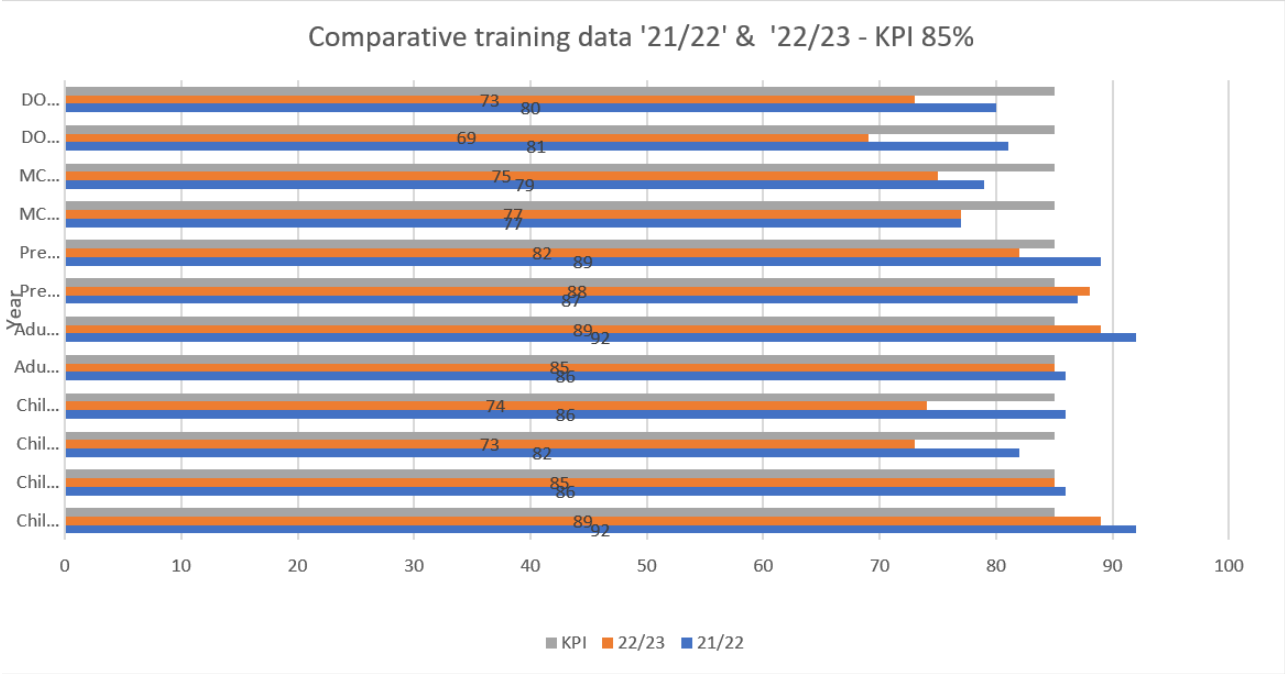
MCA compliance was agreed to be included on the Safeguarding & MCA Team risk register at the Executive Safeguarding Group and Care Groups were asked to consider the same.

2.2 Training Compliance

The Safeguarding Team's training portfolio is as follows (as per Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) & Adult Safeguarding: Roles and Competencies for Health Care Staff (2018))

Safeguarding Children L1/L2/L3 Core

Safeguarding Adult L1/L2 (L3 externally sourced)
Prevent Basic Awareness & Level 3
Mental Capacity Act L1 & L2
Deprivation of Liberty Safeguards L1 & L2



Training compliance in 2022/2023 was typically less than compliance in 2021/2022. KPI was agreed at 85% and during 2022/2023 this was not consistently met. This could be in part due to a recent interruption to the functionality of the Trust Learning Hub.

The Safeguarding and Mental Capacity Act Team are routinely represented at Care Group quality/governance meetings and form part of their standard agendas. Reports are provided by the team which include training compliance. Now the learning hub issue has been rectified the reporting schedule will continue.

2.3 Workforce planning

2023/2024 investment request was submitted to the Finance Committee in December 2022. At time of writing, we are unclear what has been agreed following this request.

Investment request includes the following:

- Named Nurse for Safeguarding adult.
- Named Nurse for Looked after children.

These requests were made to comply with the safeguarding roles and responsibilities set out in the SAAF.

- Autism Lead resource to scope an Autism service to support autistic patients access acute health care should ICB finding cease.

In April 2022 funding was secured from Commissioning Manager for Adult Mental Health, Learning Disabilities & Autism, North Yorkshire, NHS-Humber, and North Yorkshire Integrated Care Board (ICB for 12 months (from June 22) to recruit an Autism Lead to scope an Autism service to support autistic patients access acute health care. A report was presented to the ICB in December to secure ongoing funding to embed the service as next steps. The scoping exercise has indicated that resources are required to create a substantive service in line with the Autism Strategy. The ICB have

agreed to commission a further £80,000 for continuation of scoping and service development. This will cover the costs for the Autism Lead so further investment would not be required in 2023/2024. However, provision should be planned for future years.

- To meet continue to meet the needs of the patients with learning disabilities accessing acute services increased establishment is required to ensure that complex cases are coordinated effectively with reasonable adjustments to guarantee first time success.

- Organisations were asked by the ICBs to plan a workforce and finance to manage the Proposed Liberty Protection Safeguards responsibilities.

  However, on 5 April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, will be delayed "beyond the life of this Parliament" (therefore likely beyond Autumn 2024).

  On scoping compliance and the work required to support staff understand compliance with the act, there is a risk that the current establishment cannot consistently meet this need without and increased specialist workforce. Any investment in MCA compliance would be financially beneficial to the Trust in the long term, (reputational damage, risk of litigation and subsequent claims where clinicians have not protected themselves from liability by failing to comply with the Act).

2.4 Emergency Department – Every Child attendance Safeguarding Check

Following an incident where a child presented and was not coded safeguarding and was subject to a multi-agency safeguarding children review, it was queried at the weekly Trust Q&S meeting why all children attendances are not reviewed – regardless of apparent safeguarding concerns. This resulted in exploration of this task and a scoping exercise into other Trust practices.

The scoping exercise has indicated that routine safeguarding checks on all child attendances is not typically the role of the ED Safeguarding Liaison practitioner (EDSLN).

We have also extended our scoping exercise to trusts who do review all attendances and examine the model used to consider viability within our own team and where necessary develop a business case for additional establishment given that the task is not one which could be undertaken on current resources.

It is understood that 2 Trusts (Barnsley and Mid Yorks) do review every child ED attendance and liaison has commenced with a view to a feasibility study using their model.

2.5 Initial Health Assessment

Concerns have continued throughout 2022/2023 in the Trust ability to provide IHA (Initial Health Assessments) to looked after children within the timeframe. In regular internal and external meetings, we have attempted to manage this and collected data. Unfortunately, despite strategic escalation and inclusion on both CG5 and Safeguarding & MCA risk register we have been unable to determine formally how we recover long term. The capacity to deliver has continued to deteriorate with extreme operational demands. It is understood that the ICB Contracting has been contacted to explore the Trust giving notice on our commitment to continue to provide this service.

2.6 CPIS

The Child Protection Information Sharing System (CP-IS), available in England, allows staff, within urgent care settings and maternity, to ascertain if a child or unborn baby is on a child protection plan or is a looked after child. CP-IS is a system that gives information as to the authority in which the child is living and a contact number for relevant social care staff. It also automatically alerts the authority that the child's records have been accessed and where this access occurred. This system is particularly important in identifying children who may be at risk of exploitation.

CP-IS has been in operation within both Trust ED departments. There has been a reduction in the uploading of this information within the ED department at Scarborough hospital and is not always consistently applied. This reduction is likely to have been due to the introduction of the new booking and triage systems within the Scarborough ED department. The Team is working with care group 2 to address this risk and improve compliance.

As part of this work, SCT have identified that CP-IS is also not embedded into the maternity triage system across site, and work has been initiated to address this risk also.

3. Summary

The key issues which require escalation are described above. In-depth detail is provided within the specific service area reports available on request. In summary, priorities for the Safeguarding and Mental Capacity Act Team are as follows:

- **Make MCA adherence everyday business in care delivery.**
- **Support Care Groups equip staff with training to safeguard patients in our care.**
- **Develop and enhance support provided by the Safeguarding and Mental Capacity Act Team by investing to expand capacity.**
- **Safeguard patients at point of entry in our emergency departments**

Whilst above highlights the challenges to effectively carrying out our Safeguarding duties, it should be acknowledged that an improved revised structure formalised in October 2022 has meant that roles and responsibilities of the team are more defined within the team allowing for:

- **Raised profile of responsibilities and Increased compliance in adherence to MCA due to dedicated MCA Lead Practitioners roles across site.**
- **Increased partnership representation,**
- **Service development**
- **Expansion of existing duties to add a further layer of safeguarding (Adult attendances in ED affecting children liaison, support for staff caring for 16 -17 year olds on adult wards)**

4. Next Steps

Summarily the next steps will depend on the outcome of the investment request to increase capacity within the team. The request is underpinned by the increasing needs of our patients and the risks of harm they may face. As the scope of the work of the safeguarding team expands, more opportunities to reduce/escalate risks of harm are

identified and in doing so, ways in which the service needs to evolve to meet these demands are highlighted.

There is potential risk to patients if investment not made or sustained. There will be challenge if:

a) **We do not comply with the SAAF.**
b) **We do not invest in a service to support staff with (what has been identified by the CQC as poor) compliance with the Mental Capacity Act.**

The work of the Safeguarding teams supports several strategic healthcare priorities and fully implements more than one priority and providing additional capacity will improve performance against targets.

Finally careers in safeguarding within an acute Trust are highly sought-after and therefore likely to attract staff to the Trust.

Date: 04/05/2023

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Quality and Safety Assurance Committee
18 July 2023

Members in Attendance:

Stephen Holmberg (SH) (Chair), Lorraine Boyd (LB), Karen Stone (KS), Dawn Parkes (DP) and Caroline Johnson (CJ).

Attendees:

Karen Priestman (KP) and Lee Fry (LF) (for Item 65-23/24) Sue Glendenning (SG) and Ben Adekanmi (BA) (for Item 73-23/24), Mike Taylor (MT) and Sally Light (SL) – Public Governor for York and governor that observes this Committee.

59-23/24 Apologies for Absence

Jenny McAleese (JM)

60-23/24 Declaration of Interests

There were no further declarations provided.

61-23/24 Minutes of the meeting held on 20 June 2023

Minutes of the meeting were accepted as an accurate record of the meeting.

62-23/24 Matters arising from the minutes and outstanding actions

Q&S09 – Closed
Q&S10 – To be reported at the September meeting
Q&S15 – SH has underway of a programme of risk assurances required across the Board Sub-Committee impacting on quality and safety
Q&S17 – Remains open
Q&S 18 – Closed
Q&S 19 – Not yet due
Q&S 20 – Closed
Q&S21 – Closed

63-23/24 Escalated Items

There were no escalated items.

64-23/24 Care Group 4 Assurance Report

Karen Priestman, Associate Chief Operating and Lee Fry, Associate Chief Nurse presented the report and explained that the specificalities will be retained in the new care group structure in the main.

A CQC inspection took place regarding IR(ME)R regarding radiology over exposure incidents. The report was yet to be received, but the main aspects raised were out of date SOPs being addressed with a group systematically now reviewing, employers' procedure concerns with recommendations on a re-write with the care group working on this with training record audits another area to address. SH asked to clarify the over exposures and CQC's response, with Committee discussion noted that scans were made to an out-of-date procedure with the new procedure not followed completely by all staff, not requiring pelvis scans from chest CT requests. Two further clinical educators have been recruited in the CT team which will help to address the issues.

Elsewhere, the human tissue authority inspection was noted on 24 July with the last in 2018. A task and finish group has been working through this to ensure compliance, with SOPs and audits, service level agreements with local undertakers for example the focus. Expected concerns are likely the Scarborough body store not fit for purpose with a temporary fixed solution in place with a capital expenditure request drafted to address permanently in an initial feasibility study to be conducted alongside the new ED build completion. The ACOOs have met on the capital expenditure plans into next year and asked that this is prioritised. Conversations with local undertakers on additional body storage are underway with the intention of producing service level agreements although not concluded in time for the inspection.

RAAC at the microbiology service at Scarborough was presented with the mitigation of a modular build as phase 1 with the longer-term plan for relocation to York with the SHYS service. Phase 1 is planned for a future Executive Committee.

Timely diagnostics on cancer and routine elective recovery is a significant issue with increased GP referrals, with the Care Group part of the weekly elective recovery group working with the specialities to work as best as can be done with key escalation processes in place. The future development of the community diagnostic centres with Selby and York centres being pushed to commence as quickly as possible. The subsequent mobile units at the Trust will be moved to these locations. Diagnostic equipment downtime is an ongoing issue such as nuclear medicine only available at the York site but the scanner not available at times. LB enquired on clinical harms with the clinical risk on delays it was replied for example being reported through Datix on patient harms with prioritisation in place with longer waits than is clinically safe in requests for further CDC capacity.

The Committee raised concerns of patient harms over the longer waits and the impact on patient experience with delays not potentially proactively communicated to patients in dependent on the specialities.

Ward 31- haematology and oncology ward was discussed in the high intensity cleaning regime needed to be followed with a similar layout to all wards at the York site with only 5 side rooms and subsequently 4 C-Difficile cases attributable to the ward in the last year. With the intense HPV cleaning required with the ventilation system in place, decanting of the ward is a distinct issue. Reconfiguration has been discussed with further work to be developed if that is feasible. DP noted the estates issues but noted the re-focusing needed on back to basics on hand hygiene for example with temporary side rooms potentially being looked at to help the environment.

Action:

- **Board escalations:**
    - **CQC inspection of scanning over exposures**
    - **Human Tissue Authority visit assurance preparation**
    - **Imaging diagnostics waiting lists**

65-23/24 Risk Management Report

MT presented the Risk Management Report involving the Corporate Risk Register (CRR) for July 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.

The RAAC risk had been amended in linking into Care Group 4 presentation previously heard and a new risk around prescribing practice under the remit of this Committee.

The risks would be further discussed at the next Committee meeting following further scrutiny from the Chair in consultation with Committee members.

66-23/24 Operational Quality Group Escalation Report

KS explained that the group name is to be changed to Quality Oversight group as a non-operational group. The report presented in the papers is last month's meeting, with this month's meeting update provided verbally as agreed at the last Committee.

Assurances have been provided from Childrens' attendances in ED concerning safeguarding with previous issues on safeguarding concerns not being flagged with only those noted as having safeguarding issues previously being addressed. Processes and practices have been looked at in comparison with other Trusts and an audit has taken place with no misses subsequently occurring. The audit will continue for a further 3 months. The Committee discussed if the Trust was an outlier in comparison to other Trusts, which the Trust wasn't as there are different processes in place to capture these concerns, however the further assurances are awaited to confirm. It was agreed to escalate the assurance to the Board.

The ongoing governance review with NHS England support from Lorna Squires is coming to an end with a report coming to the Board in September on proposed changes to the Committee's operation.

Dementia admiral nurses have been appointed with the exception at Scarborough, with discussion with AHP colleagues who could undertake that role as a potential resolution.

PSIRF training is in place from September-March for those who are overseeing the new framework. An encouraging AHP review was received which will be reported to the People & Culture Assurance Committee in future.

Risk wise the coding of York ED is a concern has raised in the safeguarding children issues identification with 1000 patient backlog in York with Scarborough resolved. Electronic solution development is underway which will prevent the logging of a patient in ED until the previous has been concluded. A sepsis report was reported which doesn't provide the level of assurance needed with a task and finish group requested to be set up to ensure education, training, protocols and training development is down to the required standard. The QI team have also been tasked with focussing on sepsis. A risk to be escalated to the Board is the administration of medication by non-registrants, with it needing to be clear that this should only be for specific prescribed medicines in mitigating key risks with future SOPs required for example. A QIA is currently being drafted to understand further. The escalation was agreed by the Committee.

Datix cloud has been problematic with challenges around monitoring and reporting incidents with a settling in period needed. Assurance wasn't identified around mixed sex breaches and further assurances have been requested from Care Group 1.

Elsewhere 8 critical care beds are needing to be closed for work to be carried out with a QIA undertaken with the capacity not being lost over the period. A further risk was with the national joint registry noting that a particular knee replacement process undertaken with 700 Bridlington patients, may be problematic. A review based on patient priority is underway with the potential risk on patient capacity but not identified yet.

A regulation issue other than that described already reported, is the preventing future deaths (regulation 28) notice to be received from the coroner. This refers to a patient being cared for between the Trust and Leeds Trust with the transfer of patient information with reliance on the Junior Doctors in the process. The Trust will have 56 days to respond when the notice is received. This would be included on the reportable issues log reported to Board with a copy to the Quality & Safety Assurance Committee.

Action:

- **Board escalations:**
  - **Mixed-sex accommodation breaches**
  - **Assurance of child safeguarding in ED**
  - **Prescribing of medicines by non-registrants**
  - **Knee replacement national joint registry reporting**

67-23/24 Sepsis Q4

The Committee agreed that the report would be received in September as further work was required on this following review at the Operational Quality Group.

Action:

- **The Sepsis Q4 report to be received by the Committee at September's meeting.**

68-23/24 Dementia Q4

DP presented the report on the Dementia strategy key areas with the re-launch of the John's campaign with a carer's passport being developed with future work on lanyards for example to ensure ongoing ward visiting. Further focus on this by ward by ward is in place with the work being shared accordingly.

The area of concern in the low number of notes being reviewed with the admiral nurse now being able to take on that role. A mental heath lead in previously being identified as a resource need has now been secured and created in a role as a complex care lead looking at mental health in its entirety. The ward moves out of hours have especially been focussed on reducing these where they can be in not being routine where possible. The 'what matters to me' document with the admiral nurses working to this will improve patient experience results in future. Signage in particular although not mentioned in the report has improved which improves patient care for dementia patients alongside refurbishment of the wards which has helped under the delirium agenda.

The Committee agreed that in looking at complex needs overall is the way to progress with the biggest challenge is understanding those patients that have dementia rather than those that have received a diagnosis. Work is to be done across all the complex care needs with reasonable adjustments and care packages in place across all wards mitigating the risk of

those who haven't been identified. The nucleus system provides an opportunity to flag care needs and this is being further looked at in future.

69-23/24 CQC Compliance Update Report

DP presented the report and talked through the draft should and must do actions of the plan that was to be sent to CQC on Thursday of this week. Comments were invited for any amendments to be made with the plan heading to the next private Board. The actions have been mapped to the 7 workstreams to deliver this across the Trust and the paper explaining these will come to the Board. Overall, 140 actions have been merged together across the Trust to produce a more manageable amount and link these together where relevant. The governors will receive a timeline of the CQC work underway to date and the broad themes of the action plan to be agreed at Board and CQC, for the final plan to be shared with governors. The Committee has the opportunity now to comment before submission to Board.

The plan has outcome measures assigned to ensure the Trust knows it has delivered. On maternity further CTG training to address the section 31 has taken place which Sue Glendenning will go into more detail further on the agenda.

The workstream format will subsequently provide the report in a different method providing the assurance to the Committee in future.

70-23/24 Serious Incidents Report

KS presented the report inviting questions from the Committee. LB enquired on safety advice and guidance on page 63 on what has been done on improvements in this area in who had responsibility and potential continuity of care issues. KS recollection noted that this was a complicated case with Nicola Topping leading on the oversight and procedure is being kept to well overall, with the issues on the handover of the patient in these cases in overall continuity of care. The Committee noted the report.

71-23/24 Quality and Safety Assurance Metrics (TPR)

SH commented that it will take some time working with the DIS team to attain the suite of metrics needed but there is work with the existing metrics that can be done working with KS and DP. KS explained that this involves the principle risks and the BAF aligned with the top quality metrics seen at Trust Board and the subsequent further quality metrics at Committee level and further reported in more detail at the Quality Oversight Group for further assurances on mitigations. The Committee noted the report.

72-23/24 Mental Health Q4 Report

CJ presented the report concerning the work of the Mental Health Strategy Group which includes patient experience, TEWV colleagues and 3rd sector partners involved. The priorities include the mental health risk assessment with has experienced challenges of implementing with nucleus providing a solution with the content of the assessment been difficult to agree with mental health professionals and doctors. The challenges have been valid and this is looking to be rolled out in the next 6-8 weeks with all patients screened for mental heath for a full risk assessment if required addressing potential complex needs.

Patient voice has been worked from the healthwatch mental health care in York with a co-produced workshop planning underway for patients and departments to manage patients moving forward. Further training is planned for future weeks with elsewhere a perinatal

mental health nurse at York increasing her team and in great work on coproducing with York Ending Stigma.

On therapeutic restrictions a policy has been drafted aligning Trust approach to the Use of Force Act regarding detainees under the Mental Health Act. Violence and aggression are also tracked through the group to reduce instances for mental health patients. SH commented on where are the areas of biggest concern with CJ commenting with staff needing to be equipped to deal with mental health difficulties such as self-harm and eating disorders to support patients. Currently the security teams are potentially involved more than they could be should the correct skill be in place for more staff.

DP commented on children's mental health and the NHSE guidelines on acute services and education in the Committee needing to hear more on assurances in that particular area. Engagement with paediatrics had been a challenge with reductions in time with the group CJ commented with further work needing to be done. LB commented on the position of the mental health lead with the assurances by DP provided that the resource had now been secured.

73-23/24 Maternity Update Report

Perinatal Clinical Quality Surveillance Report

DP presented and noted that the paper going forward will change to note the workforce model and workstreams much like the CQC format to pull out areas of Ockenden or Section 31 as required.

In this report the maternity sub-committee process with the workstreams was presented in how the report will change over time. The QIG paper information included also provided the highlighted projects on a page to report in that was shared with the ICB recently. There were no questions from members.

Sue Glendenning explained the report further in the attain action plans in place to deliver and the work of transitional care underway. The oversight of the Maternity Improvement Programme was presented in the report, its progress on maternity safety improvement actions to date, current position on saving babies lives version 2 and 3, plans for Ockenden benchmarking, foetal monitoring compliance and PPH rates and continuing monitoring and oversight.

The 6 identified workstreams of the Maternity Improvement Programme concerned the outline of the plans and how to move forward with it in reporting through embrace in compliance with the Trust analysis provided being average in comparison to similar Trusts for congenital abnormalities with still births higher than average. BA explained that the figures were double checked that were reported and confirmed as accurate for 2021.

HSIB themes on guidance, clinical risk assessment and oversight have been identified with badgernet helping with documentation assessed as very good following audit. A new starter has been appointed to commence in August to specifically update the guidelines. DP commented that are the HSIB themes and SIs mapped to the existing workstream work to provide assurance on the actions in place which was confirmed that they are and would be reported in the next Committee paper.

All PPH under 1500mls are reviews by the cross-site scrutiny panel with the monthly audit overseen with the pro-forma not always applied as required, addressed through further training. Feedback from staff had been that the introduction of badgernet had been confusing for this process with subsequent communication informing that the paper pro-

forma could be used and later scanned to badgernet. LB commented on this in are staff maximising the digital benefits and what is the long-term plan, with BA commenting that the team are still getting used to badgernet. KS agreed that this was unacceptable for scanning to be happening when badgernet was designed to be inputted digitally and asked that September's or October's paper provided assurance that badgernet has been used appropriately.

There was one serious incident declared in June for which the investigation is ongoing with the patient experience positive. On the RCOG mandate work ongoing there is a list of conditions that consultants must comply and attend which audits must be conducted to provide full compliance. This is being reviewed to ensure consultants attend when they are required.

Two new risks have been recorded provided on CTG training and inadequate foetal monitoring during labour and birth due to the lack of CTG machines. No datix incidents have been raised on these over the reporting period. DP commented that are the rotas been drafted to ensure the skilled midwives are present when required, with SG noting that those who haven't been trained have been identified with further training days being planned for August when available. SG noted that she is assured that there are sufficient staff in place to ensure STG monitoring when required. KS thanked SG and BA for ensuring the CTG training has been planned and conducted throughout the month.

Key metrics have been provided and reported to QIG on a monthly basis with the labour ward forum re-established to monitor these moving forward which is a real positive, with saving babies lives version 2 Q1 2023/24 having been audited with improvement plans in place to deliver for saving babies lives version 3 compliance by March 2024. The current position of MIS is non-compliance on the 10 actions safety actions with 2 actions being well developed.

DP commented on the unexpected term admissions to SCBU which SG commented that there has been a targeted piece of work with a comprehensive action plan developed with MDT working. Observation, hyperthermia, feeding support, hypoxaemia and core gases for admittance when not required were the key themes identified.

The length of the paper was commented on by SH in needing a good executive summary drawing out key points on the paper supported by key evidence.

The Committee thanked SG for her hard work on improvements made to the report as this was SG's last meeting in her current role.

74-23/24 Issues to escalate to the Board and/or other Committees

- Board escalations:
    - CQC inspection of scanning over exposures
    - Human Tissue Authority visit assurance preparation
    - Imaging diagnostics waiting lists
    - Mixed-sex accommodation breaches
    - Assurance of child safeguarding in ED
    - Prescribing of medicines by non-registrants
    - Knee replacement national joint registry reporting

75-23/24 Issues to escalate for BAF and CRR consideration

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

76-23/24 Summary of Actions Agreed

This was covered previously on the agenda.

77-23/24 Any other business

There was no any other business.

78-23/24 Date and time of next meeting

The next meeting will be held on 19 September 2023 2.00pm-5.00pm (extended following member feedback).

Item 19.2

Quality Committee – Chair's Assurance Report

Date of Meeting:	19th September 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
8 Maternity Services (Ockenden)		To inform the Board of on-going work to address concerns by CQC and to achieve compliance with Ockenden standards. There remain significant gaps in assurance regarding the safety and quality of services but the committee was assured by a new approach in the leadership team and evidence of sustainability in the improvement trajectory	Information and escalation
9 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	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

		received a progress report with evidence of improvement. There was also assurance around the work required as a result of the improvement notice in relation to the breach in IR(ME)R regulations	
7 MD Report		The committee received assurance in regard of a new approach to IPC with evidence that early signs of improvement are evident particularly in relation to C. diff. MSSA remains a significant concern	Assurance
8 Maternity Services		Concern was noted in regard of gaps in medical neonatal staffing	Escalation

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

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Winter Plan 2023-2024
Director Sponsor:	Claire Hansen - COO
Author:	Richard Chadwick – Head of EPRR

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 Winter Plan for last year has been reviewed and the majority of measures included in that plan have now been brought into core activity as "business as usual" where funding has allowed.

NHSE are not providing additional funding for this year. Instead, they provided planning guidance in the summer titled "Delivering operational resilience across the NHS this winter". This guidance sets out 4 focus areas for systems to develop. These are continuing to deliver the Urgent Emergency Care (UEC) Recovery Plan, the completion of operational and surge planning, working within the Integrated Care Board (ICB) to deliver an effective system response and supporting our workforce.

The table below provides a summary of the winter risks that the Trust will need to mitigate over the winter period and cohorts the Trust proposed responses into the focus areas directed in the NHSE planning guidance. Column (d) provides a link to the appropriate paragraph in the paper describing the response.

Focus Area	Risk Title	Risk Description	Winter Resilience Plan Mitigation Measure
(a)	(b)	(c)	(d)
UEC Recovery Plan	Ambulance Handovers	Long ambulance delays at Emergency Department (ED) reduce the ability of Yorkshire Ambulance Service (YAS) to respond to the most urgent calls and transport patients to hospital.	Integrated Urgent Care Virtual Wards SDEC Internal Professional Standards Integrated Intermediate **Care**
	Prevent Avoidable Admissions	Lack of services designed to provide patients requiring urgent specialist treatment but not necessarily via an ED will increase presentations in the urgent and emergency patient pathway.	
Operational and Surge Planning	Demand and Capacity	Lack of capacity in access to social care, primary care, community health services and mental health services for urgent patients is insufficient and results in patients presenting to emergency and acute services in hospital.	OPEL Framework Flu Plan Bed Capacity Expansion Inpatient Vaccination Cohorting Paediatric Hub and Surge Planning Maintenance of Elective Services ED Flow HPV and UV Planning Community in Reach, Discharge Team including Frailty Cohort Support Voluntary, Community & Social Enterprise Discharges
	COVID-19 & Respiratory Challenges	High numbers of beds are required for respiratory patients during winter resulting in complex bed management challenges and a reduction in patient flow through the acute/emergency patient pathway.	
	Discharge	Significant number of patients spend longer in hospital than they need to occupying beds that otherwise would be used to maximise patient flow.	
Effective System Working	Governance and Monitoring	The inability to identify trends in performance in a timely manner will prevent the agile and timely adaptation of plans to respond to any changes in service delivery.	Trust Resilience Group Monitoring Reports and Returns Communications
	Communications	The public are unaware of the pressure that the healthcare system is under and present to EDs with minor illness/injury that otherwise could be treated in an alternative pathway.	
Supporting Our Workforce	Workforce	Staff fatigue, lack of staff retention and an inability to recruit will reduce availability of staff and the ability to provide the fundamentals of care.	Flu & COVID 19 Staff Vaccination Winter Incentives YTHFM Staff Incentives Industrial Action Planning

Recommendation:

The Board of Directors are requested to note the actions that will be taken in the Trust to respond to the operational pressures envisaged over the winter period.

Winter Plan 2023-2024

1. Context

Historically, the “Winter Period” from the Southern Hemisphere provides a benchmark of what is likely to prevail in terms of General Practitioner (GP) attendances and hospitalisation for the UK in our winter months. An ICB paper has been circulated to support regional NHSE planning for the forthcoming winter and provides an initial overview of the planning scenarios the UK is likely to face this winter.

The latest data from Australia suggests flu levels are close to normal i.e. similar to that seen in pre-pandemic seasons. Hospitalisations are lower than in 2022. It is not clear yet if the peak is going to be earlier than usual again this year. Hospitalisations for influenza positive patients are also running low and are well below the peak activity seen around the same time last year. Overall, this suggests the UK should plan for a normal flu season but be prepared for high activity in the usual time window - January to February.

On other infections, it is difficult to predict peaks in advance but there is likely to continue to be a considerable number of cases of COVID-19 and Respiratory Syncytial Virus (RSV)

through winter. As with last year, co-incidence of peaks in infection can lead to peaks in demand which will put pressure on services.

For planning purposes, a base scenario would include:

- Rise in respiratory admissions through September
- Rise in COVID-19 cases through autumn
- Rise in flu in early January
- Peak RSV in November
- Normal levels of scarlet fever and Invasive Group A Streptococcus (iGAS)

2. System Overview

The Humber and North Yorkshire Health and Care Partnership covers a geographical area taking in cities, market towns and many different rural and coastal communities.

The area stretches along the east coast of England from Scarborough to Cleethorpes and along both banks of the Humber and incorporates the cities of Hull and York, along with rural areas across East Yorkshire, North Yorkshire, and Northern Lincolnshire.

The local population is diverse with pockets of deprivation and isolated communities both geographic and social. The area has relatively low levels of ethnic diversity, however ethnically diverse communities across the area require consideration in both service delivery and communications. Mental health and economic deprivation are key issues across the area and have been exacerbated by the impacts of the pandemic.

Together the Partnership forms the system of organisations that are responsible for planning, paying for and providing health and care services within the area known as Humber and North Yorkshire. The Partnership serve a population of 1.7 million people all with different health and care needs and had a total annual cost forecast for 2022/2023 of £3.3 billion.

There are different organisations from across the health and social care sector which are formal members of the Partnership. This includes four acute hospital trusts, three mental health trusts, four community / not for profit providers, two ambulance trusts, and six Local Authorities (upper tier and unitary authorities).

These organisations, however, only represent part of the health and care system across the area. There are 181 GP practices in 42 Primary Care networks, 550 residential care homes, 10 hospices, 180 home care companies and thousands of voluntary and community sector organisations all helping to keep the local population well.

York and Scarborough Teaching Hospitals NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles. Our annual turnover is approaching £0.5bn. We manage eight hospital sites and have a workforce of around 10,000 staff working across our hospitals and in the community.

3. Planning Approach

Winter Plans have historically, been planned by a bespoke Winter Working Group that has been stood up in the summer to consider the funding available and to coordinate the Care Group delivered schemes to match that funding. The scope of the schemes being developed regularly resulted in Winter Plans being issued as late as November. In April this year the Trust Resilience Group (TRG) was established to meet monthly throughout the year to coordinate business as usual operational planning for events such as Industrial Action and Winter Planning. The Winter Planning for 2023/2024 commenced in May 23.

The TRG conducted an audit of last year's Winter Plan and reviewed 40 schemes. The audit concluded that of those 40 schemes 24 had been incorporated into business as usual, 8 were schemes that needed to be repeated this year and 8 were not to be repeated as a result of not achieving the desired impact or the scheme being deemed too difficult to implement. A further 7 new schemes have been added to the planning for this year's plan.

The Trust Resilience Group has established 4 Task and Finish groups to develop major winter schemes, and these are: Flu and Respiratory Virus Infection Plan, In Patient Vaccination, Trust Operational Pressures Escalation Level (OPEL) Framework Review and a Workforce Group to consider staff vaccinations and financial incentives. The Trust Resilience Group has invited healthcare partners from place and the Hull & North Yorkshire (H&NY) ICB to improve collaboration across the system to implement the plan. The governance timeline for the delivery of the plan is as follows:

- 06 Sep 23 Trust Resilience Group confirm Winter Plan
- 20 Sep 23 Winter Plan to Executive Committee
- 27 Sep 23 Winter Plan to Board of Directors
- 04 Oct 23 Issue Winter Plan

4. NHSE Direction

NHSE published direction to ICBs and providers on 27 July 23 entitled "Delivering operational resilience across the NHS this winter"; it can be accessed here: 

The letter sets out 4 areas of focus for systems to prepare for winter as follows:

- **UEC Recovery Plan.** Continue to deliver the UEC Recovery Plan by ensuring high-impact interventions are in place. NHSE, together with systems, providers and clinical and operational experts have identified 10 evidence based high impact interventions. These are focused around waiting times for patients and crowding in Emergency Departments (EDs), improving flow, and reducing length of stay in hospital settings. NHSE allocates the ICBs with the responsibilities to deliver on the following 6 interventions:

    1. Care transfer hubs.
    2. Intermediate care demand and capacity.
    3. Virtual wards.
    4. Urgent Community response.
    5. Single point of access.
    6. Acute Respiratory Infection Hubs.

Acute NHS Trusts are responsible for delivering the following 4 high impact interventions:

7. Same Day Emergency Care (SDEC). Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days a week.
8. Frailty. Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
9. Inpatient flow and length of stay. Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care pathways / conditions / cohorts by implementing in hospital efficiencies and bring forward discharge processes for pathway 0 patients. This includes through:
    - Delivering improvements in ambulance handover times.
    - Ensuring documented internal professional standards are in place for rapid specialty in reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the ED in line with these standards. Putting in place mechanisms to monitor performance against these standards and taking action to course correct delivery where required.
10. Community bed productivity and flow. Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.

- **Operational and Surge Planning.** Complete operational and surge planning to prepare for different winter scenarios. Systems are being asked to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Multiple scenarios require consideration in order that providers can respond to peaks in demand driven by external factors i.e very high rates of influenza or COVID-19 and potential further industrial action.

- **Effective System Working.** Work with the ICB and healthcare partners to ensure an effective system working across all parts of the system. NHSE have developed a set of recommended roles and responsibilities to ensure clarity on what actions should be undertaken by each part to the system. To assist system working, NHSE have published an updated specification for System Coordination Centres and an updated OPEL Framework to ensure there is a consistent and coordinated approach to managing pressures across all systems. The Trust will implement clear governance and monitoring processes to ensure there are robust processes in place to work collaboratively with healthcare partners.

- **Supporting Our Workforce.** Steps are to be taken to protect and improve the wellbeing of the workforce. It is vitally important that both the public and the healthcare workforce are protected against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. In addition, providers are expected to establish a pathway for identifying patients at risk of COVID-19 and flu in their care, including those who are immunosuppressed.

5. Internal Objectives

The Trust objectives for the 2022/2023 winter plan are:

- To provide safe, effective, and timely care for our patients and population through delivery of recovery plans amidst any subsequent resurgence of COVID-19 and anticipate demand on services throughout winter including Respiratory Virus Infections (RVI) pressures.
- Return to normal activity levels for emergency and urgent care against the backdrop of continuing to increase elective capacity.
- To manage activity levels with a reduced workforce, acute bed capacity and the effect of the impact of infection control measures arising from the increased prevalence of COVID-19 and RVI.
- To ensure in working together we improve the experience of working in the NHS for all staff.
- To ensure we place safe, effective, timely and patient centred care at the heart of everything we do.

6. Areas of Focus

6.1 UEC Recovery Plan

6.1.1 Integrated Urgent Care (IUC). The IUC Project aim is to co-produce a new integrated care model to be in place by April 2024, including single point of access for health care professionals and improved signposting to service users. Specifically for winter 23/24 a partnership arrangement is being developed between Totally PLC, Nimbuscare and York and Scarborough Teaching Hospitals NHS Foundation Trust (Y&STHFT) to improve staffing resilience and thus capacity within the Urgent Care Service to ensure patients can be treated in the right place at the right time to meet their needs.

6.1.2 Virtual Wards. The Virtual Hospital Project aim is to develop the Virtual Hospital Infrastructure required to support multi-specialty pathways to care for acutely unwell patients in their own homes. Specifically for winter 23/24 The Frailty ward capacity is to increase with additionality being scoped for other specialties including respiratory and heart failure as winter priorities.

6.1.3 Same Day Emergency Care (SDEC). The aim of the SDEC project is to maximise use of all SDEC areas in line with four pillars: SDEC direct, protect estate, rapid diagnostics, capacity & demand. The focus for winter 23/24 is on SDEC direct to ensure that patients who require an SDEC service can access it directly rather than having an ED attendance as well. This will ensure these patients can access the right care at the right time to meet their needs.

6.1.4 Internal Professional Standards (IPS) / Discharges. Two key aims of the successful implementation of the new standards are 1) to reduce length of inpatient stays and 2) bring discharges forward in the day (pre 1200 and 1700). The standards will set out what inpatients can expect, including estimated date for discharge and a senior daily review. They will also include processes for working and referral arrangements between specialties. The standards are due to be formally implemented from October, with engagement work and pilots already underway.

6.1.5 Integrated Intermediate Care. The aim of the Integrated Intermediate Care project is to develop and implement an integrated intermediate care model for York achieving efficiencies and improvements to quality of care. The scope is to include community services and social care services such as reablement. Specifically for

winter 23/24 a single one team joint decision making for Hospital Discharge pathway 1 will be in place, the integrated Frailty Hub Multi-Disciplinary Team (MDT) will be tested, and a single community prescription chart is to be used.

6.1.6 Implementation Timelines. A UEC stock take took place on 11 Sep 23 to review any projects or schemes that could be advanced more rapidly assist with winter operational demand. The focus for the review was: frailty and virtual hospital, review of available beds, speciality in reach to ED, development of ambulance cohorting procedures, use of SDEC and discharging teams.

As part of this rapid improvement approach several immediate operational actions have been identified and will be implemented. This includes:

- Enhanced measures for matrons on wards to support discharges, including supporting the wards for the first two hours of the day to increase the number of discharges that take place before midday.
- Increase in the matron and operational presence in the emergency department to support the emergency physician in charge (EPIC) and nurse in charges (NIC).
- Implement refreshed escalation process for ED against key triggers (including ambulance handover times, time for speciality review, time in department, etc) through the operational, nursing and medical leadership to support earlier support and decision making.

6.2 Operational and Surge Planning

6.2.1 OPEL Framework. The National OPEL framework has been released. This will be implemented by the end of September 2023 following Executive Committee approval. The approval will also cover the associated escalation framework to enable appropriate and timely action to be taken to deescalate operational pressures. Associated work to align internal escalations and actions are ongoing with full site workshops scheduled for mid-September 2023. This will include delayed discharge escalations and will have proportionate decision making upon discharging pathway 1 patients “at risk” to enable acute flow.

Upon approval the organisation will have a full operational framework which includes appropriate and proportionate escalations up to Executive level. Real time data including OPEL score will be in place and available to access.

6.2.2 Flu Plan. The Trust Winter Respiratory Virus Plan (including Flu) is being coordinated by the Infection Prevention Team in close collaboration with stakeholder care groups. The plan articulates the testing regime, the protection of patients with a High Risk from COVID-19, the patient pathway and patient placement. In addition, the plan makes provision for support to clinical teams i.e., facilities, diagnostics and increase to testing timings in laboratories. The plan is written in 3 escalatory phases and will be coordinated by the Trust Resilience Group. The plan is linked to the OPEL framework and will therefore be finalised post the mid-September 2023 workshops.

6.2.3 Bed Capacity Expansion. The Trust declared (as at 06 Sep 23) that there were 846 General and Acute (G&A) beds not including maternity and community. In addition to this figure a further 21 escalation beds and 11 areas for boarding were identified to bring the total to 878 beds. It should be noted that escalation and boarding areas will accept a bed or trolley however they do not necessarily have

curtains, a call bell, oxygen, and suction. Using these spaces, for only the fittest patients, will need to be carefully considered.

The UEC audit conducted on 11 Sep 23 identified the possible use of G1 as a ward for the winter period. The option is currently being developed and if fully achieved this would realise a further 21 “escalation” beds for the winter period.

6.2.4 In Patient Vaccination. Eligible inpatients (inpatient for 21 days or more) shall be vaccinated against COVID-19 via the implementation of the inpatient vaccination plan. The pharmacy department cross site has agreed the supply process of the vaccine. The staff to enable the inpatient vaccination plan will come from volunteers supporting with data input and nurses to vaccinate on ward drug rounds. However, the training requirement for nurses is still required before the inpatient vaccination plan can be implemented.

6.2.5 Community Beds Provision. The Trust will continue to support step down admissions and step-up patients from the community. At St Monica’s, they have worked with their GP lead to agree the out of area admissions again to the unit to support flow. As part of the escalation plan there will be the exploration of the addition of one flex bed in Selby Inpatient Unit (IPU) and one boarding bed in Nelsons court 1. In addition, the development of a discharge lounge at Selby and Nelson Court shall be considered to support early transfer. Criteria for transfer will be reviewed to ensure these community beds are optimised.

6.2.6 Cohorting

6.2.6.1 York Hospital. The ED will continue to be supported by a private provider called CIPHER to enable cohorting of patients to allow timely ambulance offloading. This support will remain until 31 March 2024. A review of the use of real estate within the ED is currently underway to identify an appropriate area for this cohorting to take place.

6.2.6.2 Scarborough Hospital. CIPHER also support Scarborough and will be available to the same timeframe as York. The team comprises of a clinician and an Healthcare Assistant (HCA) on each shift. The main role of this team is to take handover from YAS crews when the First Assessment team do not have the capacity to do so in a timely manner. The team are also able to care for patients who are waiting for a cubicle in the main Urgent and Emergency Care Centre (UECC) department, which frees up space in First Assessment and aids flow through the department.

The UECC nursing team staff a cohorting area for clinically appropriate patients who have concluded their treatment with the UECC team and are waiting for an inpatient bed/Rapid Assessment and Treatment (RATS). This type of cohorting aids flow in the main UECC by creating space for patients who are yet to start, or are already having, clinical treatment with the UECC team.

6.2.7 Review of Site Management. The site management at Y&STHFT is currently delivered through site management teams led by heads of site operations at each acute hospital site Monday- Friday daytime. Out of hours the sites are managed by 24/7 bed managers / patient flow practitioners supported by a 1st on call manager at

each site who is on site 1400hrs-2200hrs and then on call. There is also a 2nd on call out of hours to provide executive decision making and leadership.

There will be a review of the site management during Autumn to ensure it provides the most appropriate level of site management over the full 24/7 period with any recommendations provided to the Trust Executive Committee in October 2023.

6.2.8 Paediatric Hub & Surge Planning

6.2.8.1 Ambulatory Care and Community Hubs. The Children's Ambulatory Treatment (CAT) Hub in York could be stood up with 4 weeks' notice working with Nimbuscare to provide opening hours 1430-2030, Monday – Friday. This would utilise community nursing from core Trust teams for 2 days without any additional funding and winter/ other non-recurrent funding to support the other 3 days with bank shift capacity. The trigger for this being enabled would be the confirmation of funding to support Nimbuscare being able to provide their team to the Hub for at least 2 days. The service would benefit in the future from Advanced Nurse Practitioner (ANP) capacity being built into the team and this would enable ambulatory care to be delivered year-round.

Investment will be explored, with a compensating funding reduction, to increase the current Community Children's Nursing (CCN) establishment in Scarborough to enable a Children's Assessment Unit (CAU) in the community or at the hospital to support ambulatory care. Additionally, a new larger ward area for the delivery of increasingly flexible admitting/ assessment and ambulatory care in one area as required would significantly improve capacity as new middle grade medical team is expanded.

6.2.8.2 CAU. The CAU in York is currently open from 0700-2000. This reduction in overnight activity is usual outside of the winter pressures and at times of closure the CAU functions from ward 17 in a reduced capacity and results in poorer patient flow and length of stay but has been necessary due to shortfalls in nurse staffing and removal of 'Off Framework' shifts. Following a targeted recruitment drive ward 18 will be fully staffed by the end of October, allowing ward 18 to open 24/7 for the winter period and allow rapid access, improved patient flow even during busy winter spikes, same day care and earlier discharge.

Delivery of a CAU at Scarborough will require relocation to a larger ward area as outlined above.

6.2.8.3 Virtual Ward. The Outpatient (OPAT) pathway is in place at York and can be further embedded into the pathways running from ward to community. This will reduce length of stay for long term Intravenous Antibiotic (IV AB) therapy. There are trials commencing around several other pathways which will reduce admissions to the ward and CAU at York including the Bronchiolitis pathway to facilitate earlier discharge of babies and young children with or without oxygen. This would be optimised by the ability to be brought back to the CAT hub for next day review. Similarly, the Jaundice Pathway is being scoped based on being delivered from neonatal outreach. All virtual ward pathways and CAT Hub would benefit from the addition of a ANP role 7 days

per week and would be a priority for short-term winter funding or longer-term recurrent funding including a development programme.

6.2.9 Maintenance of Elective Services. The Trust has agreed a cancellation of electives Standing Operating Procedure (SOP). This will ensure that senior decision makers (COO & Dep COO) endorse any in hours requests for cancellation of elective work.

6.2.10 ED Flow. Y&STHFT this winter will implement the Streaming and Minor Injury Plan. This will result in the Trust managing the Injury and Streaming workforce, determining the staffing plan, and recruiting Trust staff to meet any new shift commitments (business case pending). In addition, a Memorandum of Understanding (MOU) has been agreed with NIMBUS and TOTALLY to support the GP Out of Hours service across the Trust footprint to provide better stability and resilience through winter. Planning is now underway to determine streaming processes, develop standing operating procedures and to undertake staff training as required. Winter schemes that are site specific are as follows:

6.2.10.1 York Hospital. The new ED opened on 10th July 2023 and a new clinical model has been implemented. The new clinical model is being continually reviewed to ensure patient safety, clinical effectiveness, and to enable a positive patient and staff experience. The old ED area will be reshaped into the Emergency Assessment Unit (EAU) and the build work has commenced, with the building completion scheduled for the end of September and operational by October 2023. This move will also enable the current clinically ready to proceed floor (CRTP) to move to its originally planned functionality of frailty SDEC.

Additional consultants are being looked at to support upfront assessment due to an increase in ambulance arrivals. Stakeholder engagement is also taking place with CIPHER to agree an SOP to support ambulance offload.

6.2.10.2 Scarborough Hospital. The UECC team are trialling a First Assessment SOP over the summer months. During September the SOP will be reviewed, and amended if necessary, so that it can be fully implemented from October onwards.

The main function for the SOP is to:

- Provide safe, timely, consistent, and effective handover of patients within 15 minutes of arriving by ambulance to Scarborough Hospital UECC.
- Facilitate early first assessment using brief targeted history and focussed examination to ascertain patient's acuity.
- Escalate patients needing immediate / emergency care and transfer to the most appropriate area of the department.
- Initiate investigations and administer time-critical medications to expedite and enhance patient's journey through the department.
- Work cohesively and synchronously as a team within First Assessment and collaboratively with Nurse-in-charge and Emergency Physician-in-charge on shift.

- Stay focussed on a patient centred approach ensuring patient safety, clinical effectiveness to always ensure positive patient and staff experience.

The Emergency Action Protocol has been jointly developed between ED Scarborough General Hospital (SGH) and YAS to:

- To ensure all patients arriving by ambulance receive continued monitoring, appropriate and safe delivery of care and interventions if they are held on an ambulance due to lack of space capacity within the UECC.
- The UECC team are accountable for all treatments instigated under this emergency action protocol, while the YAS team will be responsible for monitoring and escalation to the UECC team in the event of deterioration or change of clinical priority whilst waiting to offload.

YAS now have a rapid release bay in the UECC which, in the event of an unallocated Category 1 call, allows one crew to leave their patient with another crew and attend the call.

6.2.11 HPV and UV Cleaning. York Teaching Hospital Facilities Management (YTHFM) are developing plans for winter to provide Hydrogen Peroxide Vapour (HPV) and Ultra Violet (UV) cleaning capabilities for both Business Continuity and 24/7 service delivery. The Business Continuity capability is being developed on trained additional supervisors and staff to support any peaks, particularly in the use of UV, cross site mutual aid, and the use of a private contractor. A revenue investment application has been submitted to provide a 24/7 service delivery capability and discussions continue at the Cleaning Standards Group, the Clostridium Difficile (C-DIFF) Group and Infection Prevention Steering and Advisory Group (IPSAG).

6.3 Effective System Working

6.3.1 Trust Resilience Group (TRG). The TRG was established in Apr 23 to replace the Winter Tactical Group and its remit was extended to coordinate all operational business as usual (i.e. non CRITICAL or MAJOR incidents) planning for Trust wide resilience issues. Examples of these issues is the Trust response to Industrial Action and the development, implementation and learning from the winter plan. The membership includes representation from the North Yorkshire Health and Care Partnership.

North Yorkshire Health and Care Partnership are coordinating the system winter plan and the first collaborative workshop with health and care partners took place on 18 Aug 23. The Trust Winter Plan will be forwarded to the H&NY ICB once endorsed by the Board of Directors.

6.3.2 Community In Reach, Discharge Team Including Frailty Cohort Support. The NY&Y System are the lead on these schemes. Their aim is to deliver a fully integrated approach outside of the hospital to support admission avoidance. There will be a rapid response model for primary care clinicians to access support and advice who otherwise may have to refer the patient for an ED presentation. Acute crisis support will be included to keep patients at home to reduce admissions and

there will be timely support to facilitate discharge of patients from acute beds. The aspiration is to operate a reach in service to EDs to extract frailty patients.

6.3.3 Voluntary, Community and Social Enterprise (VCSE). The NY&Y System are exploring how to utilise VCSE to improve health, wellbeing, and outcomes for patients. The aim is to tackle health inequalities at a local level to reduce the impact on wider health and wellbeing of communities, which could result in preventable admissions. The system is engaged in shaping and contributing to the co-design of care models and being key partners in strategy development in addition to acting as the voice of service users, patients and carers.

6.4 Supporting Our Workforce

6.4.1 Flu and COVID-19 Staff Vaccination. The 2023 staff seasonal vaccination campaign will be delivered by Occupational Health for 12 weeks from October to December 2023. Income generated by delivering the COVID-19 booster to staff will be used to staff and fund the programme, including food/drink vouchers and a monthly prize draw incentive. Drop-in clinics will be offered in designated hub areas in York and Scarborough, with specific dates offered in smaller community sites to be agreed locally with managers. Vaccinators will also rove out of the hubs to reach those unable to visit a drop-in clinic, and there is an option to use peer vaccinating in the community to reach this group of staff. The Commissioning for Quality and Innovation (CQUIN) target for Flu vaccine uptake is 70-90% of frontline workers.

6.4.2 Winter Incentives. The Trust will explore introducing a package of winter incentives, as it has done in previous years, to support the organisation to maintain safe staffing over the winter period. Incentives will be considered based on CG and staffing group needs, costed, and proposed to Executive Committee for approval during the Autumn. The Trusts financial position will likely impact the scope of incentives available this year, but it is anticipated that incentives will still be offered. Medical rate escalations will be considered as part of the winter incentive package, to ensure this covers the full workforce.

6.4.3 YTHFM Staff Incentives. In line with the winter incentives explored for Trust colleagues, the Head of Resourcing will work with the YTHFM Director of Resources to work up costed proposals. This will go through the YTHFM Management Group and will form part of the submission to the Executive Committee for approval during the Autumn. It will be imperative to have any approved incentives communicated out to the workforce at the earliest opportunity given that a high percentage of staff within facilities do not access digital communications.

6.4.4 Industrial Action Planning. Operational disruption due to Industrial Action (IA) has been ongoing all year with action taken by the Royal College of Nursing (RCN) and the British Medical Association (BMA) for junior Drs and Consultants. The Trust Resilience Group has coordinated the response planning for these periods of activity in accordance with the Trust IA Planning Timeline SOP. This planning and implementation activity coordinated by the Trust Resilience Group has proven successful maintaining patient safety, interacting with the H&NY ICB and providing risk and mitigation awareness to the Executive. The use of these processes will be maintained throughout the winter period.

7. Governance and Monitoring

7.1 Trust Resilience Group

The TRG is responsible for the implementation and coordination of the Winter Plan. The group is chaired by the Deputy Chief Operating Officer (Dep COO) and has representation at senior management level from across all Care Groups and other stake holders such as Digital Information Systems (DIS), YTHFM, Infection Prevention, Chief Nurse Team, and Medical Directors Team. Meetings during planning will occur monthly however there is scope to increase the frequency through the winter should it be required. Issues that are raised at the TRG that require escalation will be taken to the Executive Committee by the Dep COO.

The TRG will, in the Spring, conduct full debriefs of how the Winter Plan delivered intended outputs on order to allow planning for Winter 2024 to commence in a timely manner.

7.2 Monitoring

The Deputy COO attends the weekly North Yorkshire and York (NY&Y) System calls where situational awareness is shared amongst healthcare partners. This forum is used to escalate system issues that directly impact on Trust operational performance.

The TRG agenda throughout the winter period includes updates from the Information Team on Flu and COVID infection rates. This is automated into a SIGNAL desktop dashboard to allow real time monitoring. The agenda also includes updates on staff sickness and absence from the Deputy Director of Workforce to allow proactive mitigation of shortfalls to staffing rosters.

8. Reports, Returns and SITREPS

The Information Team will continue to provide automated reports and returns in addition to Situation Reports (SITREPs) as per the NHSE mandated requirements. The SIGNAL dashboard will continue to be used to analyse data and identify trends to inform decision making. This review of data, both clinical and workforce absences, are standing agenda items on the Trust Resilience Group.

The Trust Single Point of Contact (SPOC) mailbox will continue to operate and be monitored by the Emergency Planning Team and 1st On Call Managers. Winter Reporting templates will continue to be submitted to H&NY ICB throughout the winter period.

9. Communications

The communications team is pivotal in supporting the dissemination of information to staff, patients and the public. The approach to sharing the key messages regarding this year's Winter Plan will build on the approach from previous years and lessons learned.

Information will be cascaded across the Trust via the existing communications channels including the weekly all-staff bulletin and monthly Staff Brief. Where appropriate the trust's social media channels will also be used to share key messages for staff. This will include updates and changes to the plan, what's working well/successes, particular areas of focus/challenge and examples of where we have listened and acted upon staff feedback.

This information will be coordinated through the Trust Resilience Group, who will work closely with the Communications Team to ensure information is disseminated appropriately and in a timely manner.

In addition, there will be a dedicated ‘Winter Plan’ section on the intranet, which acts as a one stop shop for information, local plans, and resources.

Internal communications will be supported through sharing information key operational meetings particularly to specific groups of staff who require more detailed operational information, ensuring relevant staff are briefed on the plans specific to their own area of work.

Externally, the Trust is working with partner organisations in the ICB to develop and deliver a system-wide communications plan. This reflects the outcomes from the ICB-facilitated system-wide Urgent and Emergency Care Summit. The trust will also continue to support any national communications and campaigns.

Date: 20th September 2023

Report to:	Board of Directors
Date of Meeting:	27 September 2023
Subject:	Emergency Planning Resilience and Response (EPRR) – Annual Self Assessment
Director Sponsor:	Accountablle Emergency Officer – Clare Hansen
Author:	Head of EPRR – Richard Chadwick

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

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

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

Summary of Report and Key Points to highlight:

The Board of Directors is asked to:

- Note that following a self-assessment process against the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Standards, the Trust has rated itself as "Partially" compliant. This is the same grade as last year as operational pressures such as winter and industrial action continue to impact on the ability for EPRR plans, policies and action cards to be tested and practiced.
- Note the significant EPRR issues in 2023 and how the EPRR team has been reinforced with an Emergency Planning Manager (EPM) that will enable a return to core business.
- Note the key priorities and updated action plan for EPRR that will be implemented over the next 12 months.

Following this year's self-assessment process, the Trust is declaring a "Partially" Compliant rating as it meets 51 of the 62 applicable standards (82%).

The Accountable Emergency Officer (AEO) has signed the Certificate of Compliance that can be found at Appendix 1.

An action plan to remediate the partially and non-compliant standards can be found at Appendix 2 and brief descriptions of the work required can be found at paragraph 3.

Recommendation:

The Board of Directors is requested to:

- To approve the report and assurance rating of "Partial" compliance with the NHS England EPRR Core Standards.

Report Exempt from Public Disclosure

No ☒ Yes ☐

EPRR CORE STANDARDS – ANNUAL SELF ASSESSMENT

1. Introduction and Background

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

On an annual basis, the NHSE Core Standards for EPRR set out the minimum standards that NHS organisations and providers of NHSE funded care must meet. The Trust is required to undertake an annual self-assessment against these standards and provide assurance to NHSE that robust and resilient EPRR arrangements are in place and maintained within the Trust. In 2016/17 and in 2017/18 the Trust reported that it was "partially" compliant with these standards – meaning it only fully met 77-88% of the core standards. In 2018/19, 2019/20 and 2021/22 the grading improved to "substantially" compliant – meaning that it complied with 89% to 99% of standards. Last year the Trust declared partially compliant as the assessment determined 84% of standards were complied with fully. The reduction in grading was mainly due to the inability to conduct appropriate training and exercising due to the response to COVID-19, winter operational pressures and the resulting limited availability of staff.

Following this year's self-assessment process, the Trust is again declaring a "partially" compliant rating as it meets 51 of the 62 applicable standards (82%). The 2% reduction from last year is attributable to the requirement to recommence Incident Response Training at a tactical level now that the Trust is not enacting those processes through the COVID-19 response and the acknowledgement of work required through the lessons learnt process conducted after Business Continuity (BC) incidents led by the recently appointed EPM.

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

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

2.1 EPRR Core Standards Annual Self-Assessment. There has been little change to the content of the EPRR Core Standards from previous years. The 10 domains that the 62 applicable standards are grouped into remains: governance, duty to risk assess, duty to maintain plans, command and control, training and exercising, response, warning and informing, cooperation, business continuity and Chemical, Biological, Radiological and Nuclear (CBRN). What has changed significantly is the assurance oversight.

Historically, the EPRR Core Standards Annual Self-Assessment when submitted to the Regional EPRR Team was then subjected to a short "confirm and challenge" exercise run by the Local Healthcare Resilience Partnership (LHRP). This year the self-assessment requires examples of evidence to be uploaded to a central database to support the grading for each standard. This evidence will then be reviewed by an independent healthcare organisation (currently awaiting to informed who this will be, but likely to be another Integrated Care Board (ICB)).

2.2 Integrated Care Board. The ICB as a Category 1 responder has provided the EPRR governance and assurance oversight for the past 12 months. The Trust EPRR team have established strong links with their ICB counterparts and collaborative working with other healthcare partners across the ICB has become business as usual. Further work is required to ensure that the ICB and Trust partners are included into our training and exercising schedule going forward.

2.3 EPRR Portfolio. The scale and scope of the EPRR portfolio has continued to increase significantly over the last 12 months. Operational pressures throughout the Winter required the EPRR team to coordinate the command and control of the Trust response to those pressures and then in the Spring multiple incidents of industrial action required planning and response followed by a summer dominated by the beginning of the planning for this winter and an increased number of significant business continuity incidents.

In response to this increase in activity the Trust has employed a Band 7 Emergency Planning Manager (EPM) from April 2023, to take the lead on Trust business continuity planning and response. This addition to the EPRR team has enabled the business continuity programme to be reinvigorated and will over the next 12 months provide the team with the capacity to return to core functions such as training and exercising.

Increased incidents of having to coordinate the planning and response to a wide variety of incidents that fell short of being CRITICAL incidents and to prepare and implement the Winter Plan 2023-2024 has required the establishment of a multi-disciplinary tactical group. This group is called the Trust Resilience Group (TRG) that is chaired by the Deputy Chief Operating Officer (Dep COO) and has representation from across care groups and services at a senior level. It meets at least monthly throughout the year and has a focus for preparing, implementing, and reviewing the Winter Plan however it has picked up additional responsibilities such as Industrial Action (IA) response. The TRG is now well established and reports to the Executive Committee.

2.4 Business Continuity. BC incidents have increased in frequency and severity over the last 12 months. The EPM is leading a review of Business Impact Analyses (BIA) for all Care Groups and support services through the Business Continuity Working Group (BCWG). This review will capture the restructuring of the Trust organisation and complete

a review of the 750+ action cards that are currently in use and be completed in October 2023. It is expected that a proportion of the action cards will require updating and this will take time to complete alongside other competing priorities.

3. EPRR Focus Areas for 2023/24

The Emergency Planning Steering Group (EPSG) provides the assurance for the EPRR work schedule that is risk assessed based and reviewed quarterly. The main focus areas for the coming 12 months are as follows:

3.1 Training and Exercising. Training and exercising opportunities have been much reduced as operational pressures, industrial action and staffing shortages have restricted the availability of staff. The Trust has excellent plans and contingencies however these are only as good as the understanding the staff must have to implement them. This will be the main effort of the EPRR team over the next 12 months.

3.1.1 Training Schedule 2023-2026. The training schedule for the next 3 years has been re-established. The schedule includes responder training (i.e. CBRN), health command training for On Call managers, business continuity training and emergency plans training (i.e. evacuation). The schedule will require the support of Care Groups to release staff to practice the various elements of the Incident Response Plan (IRP) and significant support from BC Leads to cascade BC training down to the operational level.

Further work is required to complete a Training Needs Analysis (TNA) to support the training schedule. This analysis will provide, in the absence of any NHS E guidance, a statement of the competencies required for the EPRR capability, and the numbers of trained individuals required with those competencies by care groups and service support groups. Moving forward this will provide a measure of effectiveness of the training schedule.

3.1.2 LIVEX 2024. The Trust is mandated to conduct a Live Exercise (LIVEX[1]) every 3 years. The Trust conducted a mass casualty LIVEX in 2019 and the COVID-19 response in 2021 was declared a LIVEX event. The Trust is due a LIVEX in 2024 and the Executive Committee approved “evacuation” as the capability to be practiced. The event is planned for July 2024 and will take place on the York and Scarborough sites with a practical phase of evacuating a ward of casualty actors followed by a command post exercise to practice the evacuation of building on the site. The command post exercise will include representation from external healthcare partners (i.e. Regional NHS E, the ICB and Yorkshire Ambulance Service (YAS).

3.2 Plans and Policies. The Trust is due to re-structure in October this year and all EPRR plans, policies and contingency plans will require review in order to capture how the new structure will operate. This will be conducted over the course of the next 6 months with the Annex A to the IRP – Command and Control being the priority to understand the command structure the Trust will implement in the event of a CRITICAL/MAJOR incident.

The Mass Casualty response plan reported as outstanding work last year is now at a working draft status and now awaits internal and external circulation for comment. This

[1] A LIVEX is a collective training exercise that historically will concentrate on one capability to be tested, validated, or practiced. The scale of the exercise is not defined however there is an expectation that command and control is exercised concurrently with operational activity preferably in a free play scenario.

work is on schedule for being completed this year. Once the plan is published a series of tabletop and collective training events will be required to disseminate the content of the plan and confirm roles and responsibilities.

The Evacuation Plan was reported as outstanding work last year and it has undergone internal and external circulation. It will be ready for publication in October 2023. Once published the EPRR team will formulate a training programme to ensure care groups and staff grouping stakeholders are briefed on their roles and responsibilities prior to the LIVEX in 2024. Post LIVEX 24 the debriefs will inform the required amendments for the plan.

3.3 Responder Training - Minimum Occupational Standards for EPRR for Healthcare Commanders. The NHSE Minimum Occupational Standards for EPRR were issued in 2024. Compliance with those standards was staged as follows:

- **Stage 1.** On Call Managers complete the Tactical and Strategic NHSE delivered Healthcare Commander training. This has been delivered to the majority of 1st and 2nd On Call Managers and a sweep up exercise is currently in progress.
- **Stage 2.** The establishment of evidence-based portfolios for Healthcare Commanders in accordance with the minimal occupational standards. Guidance from the ICB on who is responsible for the various elements of the training is awaited prior to the issue of direction to 1st and 2nd On Call Managers. This work will endure through 2024 with the aspiration that portfolio completion will be accessed through a web-based portal.
- **Stage 3.** The expansion of the concept to an operational level. This will involve Stages 1 and 2 being conducted for all On Call staff i.e. consultants and service duty managers. The scale and scope of this stage is significant, and completion is likely to be a 2024-2025 focus once NHS E guidance has been received.

3.4 Business Continuity and Resilience. The appointment of an EPM to lead on the Trust Business Continuity capability is timely as the prevalence of BC incidents and the requirement to upgrade support services and systems increases. In addition to the BIA and action card review the EPM will conduct a review of the Trust Business Continuity Management System (BCMS) with particular emphasis on ensuring processes are in place to assess the effectiveness of the BCMS and how the Trust can take corrective action to ensure continual improvement of the system. The EPM will report to the Emergency Planning Steering Group (EPSG) and the Executive Committee in January 24 on the outcome of the audit of current BIAs and action cards and the review of the BCMS.

4. Conclusion

Business as usual EPRR work continues to be disrupted by unplanned events and incidents. The size and capability of the EPRR team has improved during 2023 and a return to core EPRR business in the remainder of 2023 and 2024 will be achieved. The outstanding actions in the plan at appendix 2 are fully understood and resolution is expected to be completed in routine business.

Appendices:

1. EPRR Core Standards Assurance – Statement of Compliance.

2. EPRR Core Standards Assurance – Action Plan 2023-2024.
3. EPRR Core Standards Assurance – Self Assessment RAG Ratings.

Date: 20 September 2023

Appendix 1 – EPRR Core Standards Assurance – Statement of Compliance

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

York and Scarborough Teaching Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v2.0

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

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

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

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

Signed by the organisation's Accountable Emergency Officer

15/09/2023

Date signed

27/09/2023	27/09/2023	01/06/2024
Date of Board/governing body meeting	Date presented at Public Board	Date to be published in organisations Annual Report

Appendix 2 – EPRR Core Standards Assurance – Action Plan 2023/24

Ref	Domain	Standard	Detail	Self-assessment RAG	Action to be taken	Lead	By When
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	**Partially Compliant**	Testing of all plans in the IRP is required to ensure staff understand their role & responsibilities during all scenarios of incidents.	EPM	Aug 24
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	**Partially Compliant**	Once the plan is finalised and published there needs to be a training programme for stakeholders. Lessons identified to feed into future response.	EPM	Aug 24
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff, and visitors.	**Partially Compliant**	Finalisation and testing of the plan during LIVEX 24 preceded by a comprehensive training plan for evacuation. Lessons identified to feed into future response.	EPM	Aug 24
22	**Training and Exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	**Partially Compliant**	Training Needs Analysis is required to be developed to align to the Training & Exercising schedule.	EPM	Aug 24
23	**Training and Exercising**	**EPRR Exercising and Testing Programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to	**Partially Compliant**	Develop a more detailed action monitoring system for training & exercising. Training Needs Analysis is required to be developed to	EPM	Aug 24

			exercise players or participants, or those patients in your care)		align to the Training & Exercising schedule.		
24	**Training and Exercising**	**Responder Training**	The organisation can maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	**Non-Compliant**	EPM awaits Regional EPRR direction on format of personal development portfolio and then to write the process into policy (Annex A – Command and Control to the Trust IRP).	EPM	Mar 24
34	**Warning and Informing**	**Incident Communications Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	**Partially Compliant**	Ensure 1st & 2nd On-Call teams understand the action cards. Carry out an in hours and OOH exercise around communication.	Dir of Comms	Jul 24
36	**Warning and Informing**	**Media Strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media.	**Partially Compliant**	Review the social media guidance and provide media training to the new executive board members.	Dir of Comms	Mar 24
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to:	**Partially Compliant**	Review the BCP template and align to the NHS toolkit. Then develop BCP's to reflect these new changes.	EPM	Mar 24

			• people • information and data • premises • suppliers and contractors • IT and infrastructure				
48	**Business Continuity**	**Testing and Exercising**	The organisation has a training and exercising schedule, however more work is required to develop an action monitoring system.	**Partially Compliant**	Develop a more detailed action monitoring system for training & exercising.	EPM	Aug 24
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	**Partially Compliant**	Develop a more detailed action monitoring system for training & exercising. Annual report to executive to monitor and evaluate the Trust's BCMS.	EPM	Jan 24

Appendix 3 – EPRR Core Standards Assurance – Self Assessment RAG Ratings

No	Core Standard	Sub-Area	Description	2022/2023	2023/2024
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.		Chief Operating Officer job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.		EPRR Policy
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements		EPRR Board report 2022/2023 EPRR Board report 2022/2023 minutes of meeting
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.		EPRR schedule EPSG TOR
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.		20221003 Emergency Planning Manager JD 20221003 JD Mapping Job Description & Personal Specification - Head of EPRR EPRR policy
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.		EPRR Policy EPSG standard agenda City of York Integrated Emergency Management agenda City of York Integrated Emergency Management TOR
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.		EPSG risk register
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally		Risk Management Strategy 2021-2024 EPRR Policy
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.		City of York Integrated Emergency Management agenda City of York Integrated Emergency Management TOR LHRP TOR HNY Vulnerable Persons Working Group minutes

10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.		Incident Response Plan Annex A - Command & Control Annex C - Trust Call In Plan Annex D - Restricted access plan Annex E - Evacuation plan (new plan and in finalised draft version) Annex F - Business Continuity Plan Annex G - Adverse Weather Plan Annex H - Pandemic Flu Plan Annex I - Fuel disruption plan Annex J - CBRN plan
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.		Annex A - Command & Control Annex F - Business Continuity Plan Annex G - Adverse Weather Plan
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.		High Consequence Infectious Diseases Safe Working Procedure (SOP) Infectious Diseases working group TOR
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic		High Consequence Infectious Diseases Safe Working Procedure (SOP) 2023 Example Fit testing schedule
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment		Occupational Health Influenza and Covid-19 Staff Vaccination Campaign FORMMISC38 - Countermeasures Annex J - CBRN
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.		Incident Response Plan Annex A - Command & Control 20230907 Patient ID Policy v11
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.		Annex E - Evacuation plan (new plan and in finalised draft version) 20230907 Patient ID Policy v11
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.		Annex D - Restricted access plan
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.		External Communications - Media Handling Guideline v4 Jan 22 - Jan 24
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.		DRAFT 2022_23 Mass Fats Plan

20	**Command and control**	**On-Call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.		EPRR Policy On call information screen shot Incident Response Plan Annex A - Command & Control Annex C - Trust Call In Plan The Trust's Digital Information Services have an On-Call arrangement. The contact is through the Trust's switchboard and there are four people On-Call at any one time. A person for triage, platform, network and development.
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions		EPRR Policy Training & Exercise schedule 2023-2025 20230523 Attendance Sheets 20230523 1st On Call Induction Training BaU 20230523 1st On Call Induction Training IRP Audit - 1st On-Call PHC Training Audit - 2nd On-Call PHC Training
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.		EPRR Policy Training & Exercise schedule 2023-2025 BC training log 2023 Copy of CBRN TRAINING DATA 12th April 2023 updated
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)		Training & Exercise schedule 2023-2025 20230613 LIVEX 24 Exec Comm Proposal Ver 2 Audit - 1st On-Call PHC Training Audit - 2nd On-Call PHC Training
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role		Training & Exercise schedule 2023-2025 20230523 1st On Call Induction Training BaU 20230523 1st On Call Induction Training IRP Audit - 1st On-Call PHC Training Audit - 2nd On-Call PHC Training
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.		On call information screen shot
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient		Incident Response Plan Annex A - Command & Control MS team channels screen shot

			to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.		
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.		Staff Room access to EP and BC plans Annex A - Command & Control
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).		Annex F - Business Continuity Plan
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker		Incident Response Plan Annex A - Command & Control Trained Loggists NEW 2023 v4
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.		Annex A - Command & Control
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		20230907 Screenshot EPRR Links
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)		20230907 Screenshot EPRR Links
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.		Incident Response Plan Annex A - Command & Control Annex C - Trust Call In Plan P1 process Digital Information Services on call arrangements
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.		2.1 Silver Communications Lead 29052018 Flow Chart action card comms_bronze checklist 21122022_Critical incident template statement for website
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.		Annex A - Command & Control 21122022_Critical incident template statement for website YSTHFT Annual Report and Accounts 2021-22 (pg. 23) The IPC team utilises the main hospital entrances to display information for the public in general. We also utilise EDs as they are point of entries. Other information bespoke to areas for example measles is also displayed in key identified areas such as the Paediatric ward entrances.

					Messages and information that need to go to inpatients and their families/carers about an ongoing incident would be agreed through the gold/silver structure as part of the overall incident messaging and to ensure it is consistent with what's being said to the wider public, the media and staff. This would be cascaded through SILVER and BRONZE leads via the ward staff.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media		Annex A - Command & Control 21122022_Critical incident template statement for website
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.		LHRP minutes
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.		City of York Integrated Emergency Management agenda City of York Integrated Emergency Management TOR
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.		Incident Response Plan Annex A - Command & Control CBRN mutual aid agreement with NYFRS - NYFRS have stated the Trust don't require a MOU. This has been raised with our CBRN lead at YAS.
43	**Information Sharing**	**Cooperation and information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.		Incident Response Plan Annex A - Command & Control
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.		EPRR Policy
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.		EPRR Policy Annex F - Business Continuity Plan
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).		BIA Pharmacy July 2023 Introduction to BC training presentation
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure		Annex F - Business Continuity Plan Community-Buildings-Archways-BCP SPA Community-Power-Archways-BCP SPA Community-Utilities-Archways-BCP - SPA
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.		Training & Exercise schedule 2023-2025
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.		Improvement Plan v3
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.		EPRR Policy 20220728 - Business Continuity WG - Terms of Reference
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.		EPPR Policy

52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.		EPRR Policy 20220728 - Business Continuity WG - Terms of Reference Debrief reports - York Wi-Fi & CPD downtime
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.		EPRR Policy
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented		Annex J - CBRN plan
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type		Annex J - CBRN plan EPSG risk register
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents		Annex J - CBRN plan CBRN questionnaire - Master 2022
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans, and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders		Annex J - CBRN plan Copy of CBRN TRAINING DATA 12th April 2023 updated CBRN questionnaire - Master 2022
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.		Annex J - CBRN plan Copy of CBRN TRAINING DATA 12th April 2023 updated CBRN questionnaire - Master 2022
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf		Annex J - CBRN plan CBRN questionnaire - Master 2022 CBRNE CHECK LIST EQUIPMENT 2022-2023 RAM-GENE Calibration Certs 2023 PRPS Suit Service 9th August 2023
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with		Annex J - CBRN plan CBRN questionnaire - Master 2022 CBRNE CHECK LIST EQUIPMENT 2022-2023

			manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks		PRPS Suit Service 9th August 2023
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans		Annex J - CBRN plan CBRN questionnaire - Master 2022
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments		CBRN questionnaire - Master 2022
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented		CBRN questionnaire - Master 2022
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7		Annex J - CBRN plan CBRN questionnaire - Master 2022 PRPS Suit Service 9th August 2023
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme		CBRN questionnaire - Master 2022

Note: 40, 41, 42 & 54 core standards aren't applicable to an acute trust.

Minutes

Digital, Performance & Finance Assurance Committee
18 July 2023

01-23/24 / Attendance: Denise McConnell (DM - Chair), Andrew Bertram (AB), Melanie Liley (ML), Mike Taylor (MT), James Hawkins (JH), Claire Hansen (CH)

The Committee welcomed the Governor Paul Johnson to the Committee as the current DPF Governor observer. The Committee also welcomed, Rachael Metcalfe (Governance).

DM highlighted that the meeting of the Committee was not quorate but went ahead primarily due to finance and reporting around the current deficit. The Committee members present wanted to understand the actions and what the implications would be if continued.

02-23/24 / Declarations of Interests

There were no changes to the declarations of interests.

03-23/24 / Minutes of the meeting held on 20 June

The minutes of the last meeting held on 20 June were approved as a correct record.

04-23/24 / Matters arising from the minutes

Action 168 – October report into COO report – this will be included in the October COO report

Action 166 and 167 – AB and JH to provide dates for delivery.

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, Performance & Finance, to include:

6.1 Finance Update

AB noted 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.

- There are four main areas of expenditure giving rise to the deficit Pay expenses £1.1m, Drugs £700k, Core CIP £1.4m and Other £900k.
- 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.

- Strong measures being implemented 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.
- Calculations indicated the current pay award was not being fully funded through increases in rates, with a projected annual shortfall of £1.2m.
- detailed analysis of drugs expenditure 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 if a gap in funding still remains recovery actions will be prepared looking at quality, safety, performance, elective recovery and service delivery.

DM enquired as to the consequences if unable to bridge gaps, resulting in further deficit – AB advised this may lead to capped expenditure, however, quality and safety will be prioritised as long as the Trust can demonstrate productivity and all efforts for improvement.

CH suggested a process for decision making to be introduced to evidence against quality and safety with sign off from Chief Nurse.

Opportunities for undertaking additional work may be reviewed if a funding gap remains.

DM thanked AB and asked what the consequences would be for cash flow if the deficit continued to exceed plan. AB advised cash balances could be an issue at the year end.

Action: AB to provide forecast on cash in September Committee

6.2 Digital and Information Report Update

JH highlighted the following:

- 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 and were moving in a positive direction.
- The number of service desk calls peaked during nhs.net migration and had fallen 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.

6.2.2 Senior Information Risk Owner (SIRO) Report

JH advised the assessment from the Auditors has reduced the overall assurance to a limited assurance rating compared to moderate last year.

The report highlighted that Data Security training was at 77% compared to a target of 95%.

Information Security Policy and Protocols have been updated. Further control required around joiners, movers and leavers. DMc requested a timescale for improvement and JH advised that work is being undertaken in partnership with the Workforce team.

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 initiative.

In addition, failure to identify medical devices could result in an increased cyber risk if they are operated without current security patches. These will be identified as part of the Shadow IT policy and working with YTHFM MD for FM response.

Penetration testing already planned but currently CPD not included due to performance impact. DMC asked when CPD penetration testing would be carried out and JH advised planned to take place over the next couple of months. DM asked that the details of the testing be widely communicated to medical staff.

6.3 Operational Performance

ML advised 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 Emergency Care Standard improvement trajectory with a performance of 69.2% (Trust June trajectory is 70.1%) was noted as an achievement.

- 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.
- For Elective Backlogs: The Committee noted 78 week waits position continues to improve from 163 at the end of May 2023 to 75. DMc 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.

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.

Action: CH to provide update on functioning of acute care model in February 2024 meeting.

07-23/24 Risk Management Update

MT noted the Corporate Risk Register, the amendments over the reporting period and the interdependencies between all risks identified. Specifically, the CRR has been updated for July reporting via the Risk Committee

DM asked whether Finance had been part of the Risk Management, MT advised not currently but going forward it was advisable.

08-23/24 Executive Performance Assurance Meeting (EPAM) Minutes – May

The EPAM minutes were presented and DMc noted the improvement in sickness absence, however AB advised due to the many complexities of sickness absence in the YTHFT not to see this yet as a medium-term trend.

9-23/24 Issues to escalate to Board and/or other Committees

Finance and pressures – formulation of recovery plans
SIRO Report – Training and engagement with
Operational – RTT numbers continuously increasing

10-23/24 Issues to escalate for BAF and CRR consideration

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.

11-23/24 / Summary of actions agreed

DMc and MT to agree outside the meeting

12-23/24 / Any other business

DMc advised LM had requested date for LLP Cyber desktop exercise and asked for assurance to be provided by Executive Directors regarding business continuity plans during the planned CPD outage in September. DM requested Committee is assured of plans in place in September meeting.

13-23/24 / Time and Date of next meeting

The next meeting will be held on 17 October at 9am-11:30am.

Chair Brief: Digital, Performance & Finance (DPF) Board Assurance Committee	Chair: Denise McConnell	Date: 19 September 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 Stephen Holmberg to the Committee . The Committee also welcomed Penny Gilyard (YTHFM) , Sam Marshall (DIS), and Steve Lawrie (DIS) who were presenting agenda items.			
Digital			
i)	- The Committee discussed the KPIs and the new platform being used for the service desk which had seen a reduction in the number of abandoned calls and overall call numbers. - The CPD upgrade to the new infrastructure has been successful and as part of process provided the business the opportunity to review and test their Business Continuity Plans	BOARD	INFORMATION
ii)	- The Committee were presented with the Cyber Assurance Framework Report. The report is based on the review which looked at four main objectives, and the Trust's ability to meet the objectives 1) Managing Security Risk 2) Protecting against cyber attack 3) Detecting cyber events 4) Minimising the impact of cyber security events. This report will be presented to the Board within the next quarter.	BOARD	INFORMATION
ii)	- The Committee were presented with an Overview of the current DIS Portfolio showing the number of Current and future projects.	BOARD planned	INFORMATION
Operational Performance			
i)	- The Committee were informed August had been a very challenging month. - The August Emergency Care Standard position was 69.4%, against the planned trajectory of 71.9% - Time lost to ambulance handover delays and handovers over 60 minutes remains above target with 18% of ambulances having a handover time of over 60 minutes against the target of 10%. - The total number of patients waiting in ED over 12 hours increased to 17% against a target of 8%.	BOARD	INFORMATION
ii)	For Elective Backlogs: The Committee noted 78 week waits position declined from 66 to 83. This position was negatively impacted by the capacity lost due to industrial action.	BOARD	INFORMATION

	The Committee has consistently raised concern over the overall total RTT waiting list position which is unsustainably high and has risen further to over 53k – a sustainable waiting list for open clocks is 26k. - Cancer position – the Committee noted the Trust remains off trajectory for the 62-day Cancer backlog (315 patients versus 165 planned trajectory). The Committee discussed the issues and noted the Industrial Action has contributed to some of the delays.		
Finance			
i)	- The Committee noted the Trust is reporting an adjusted deficit of £22.4M against a planned deficit of £10.6M for the period to August. The Trust is £11.8.M adrift of plan. - Drugs and devices are showing an adverse variance of £4.5m. These items were previously contracted with commissioners on a pass-through cost basis, but now they are within the block contract. Activity on these is significantly exceeding the assessed notional value in the block contract for which no further income is due thereby resulting in a cost pressure. The Committee were informed there needs to be a contractual resolution. - For the first time an analysis of staff expense was provided to the Committee which showed a YTD adverse variance of £7.4m for medical and dental staff. The reasons behind this overspend are being reviewed by the Medical Director. - Cash balances may be under pressure in November because of the level of the current and forecast deficit. A request for an additional £15m has been applied for. - Andrew Bertram presented the working draft of the financial recovery plan. The content was discussed along with the actions being taken by Care Groups and Corporate Teams. The Committee requested routine presentations on progress.	BOARD	INFORMATION
YTHFT			
i)	- The Committee discussed the CIP position and noted there remains a £400k gap in CIP as well as £200k of High-Risk CIP. This is out of an annual total of £1.4m. - The Committee noted the extensive work on sickness absence with May having the lowest level in 12 months at 7.13%. While sickness absence is still above target the work being undertaken to reduce sickness absence is expected to be most evident in the financial year 2024-2025 . - The Committee noted extensive work was being undertaken to manage staff costs within the budget plan, including monitoring overtime, monitoring training, transferring agency staff to bank. The Committee were informed that further work was being undertaken to improve productivity. - The Committee were informed the Green Plan had been refreshed. A Data Carbon Analyst had been appointed.	BOARD	INFORMATION

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		Cyber Assurance Framework report set out work that is needed to meet the four key objectives.	Committee requested a timescale and investment required for the actions identified to meet the objectives, and further information as to the level of progress being made.
PR3 – Performance Targets	Performance Targets		Significant operational pressures noted in August.	Focused plans on acute flow and elective backlog to address significant operational pressures. Admission rates at 38% (pre-covid 24%) COO, Chief Nurse and MD working to together. Matrons attending wards every morning to review ward occupancy.

PR5 – Inadequate Funding	Deficit		Deficit issue for Trust targets 23/4. Deficit forecast is very concerning with risk of significant deficit.	Cash flows showing sensitivity analysis to be presented in future finance reports. Regular update on any progress to resolve the contractual position for Drugs. Regular update to understand the issues behind the adverse cost variance on Medical and Dental staff.

Audit Committee: Items Escalated to the Board

The Audit Committee met on 5 September 2023.

The meeting was quorate. It was attended by Dawn Parkes, Interim Chief Nurse, who accounted to the Committee for progress in relation to outstanding Internal Audit Recommendations and also responded to questions about limited assurance reports. In addition, The Committee asked about BAF risk PR1, for which Dawn is the risk owner, in order to gain assurance that the risk is being appropriately managed. In light of the impending review of the BAF, we did not conduct a deep dive into this strategic risk.

Prior to the formal meeting, Non-Executive Directors held a private meeting with Internal Audit. There was nothing of concern they wished to draw to our attention.

The Committee wishes to draw the following matters to the attention of the Board.

Governance
The Committee had a long conversation about governance and wishes to raise two concerns in relation to this. Firstly, there is a strong sense, confirmed by Internal Audit's knowledge of other trusts, that the Trust does not have sufficient resource in this area so cannot deliver the required change at pace. Secondly, it feels as if people think governance is Mike Taylor's job.

We ask the Board to review the resource required to ensure we have high quality governance and to consider how to make governance a shared responsibility at Board.

Outstanding Audit Actions
The feedback from Internal Audit was that there was not as much progress with these as we might have wished. We encourage the Executive Directors to retain their focus on the delivery of actions in accordance with agreed deadlines.

Strategy and Board Assurance Framework
We encourage the Board to ensure pace in the development of the revised Strategy and the updated BAF that results from this.

Oversees Officer in ED
We ask the Executive Team to consider the possibility of locating an overseas officer in ED so as to minimise the loss of income from foreign patients.

Jenny McAleese
Chair of the Audit Committee
September 2023